STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD

Wayne Franco, M.D. Petition No. 2018-1345
License No. 023684

MEMORANDUM OF DECISION

Procedural Background

On March 26, 2020, the Connecticut Department of Public Health ("Department") presented a Statement of Charges ("Charges") to the Connecticut Medical Examining Board ("Board") against license number 023684 of Wayne Franco, M.D. ("Respondent"). Board Exhibit ("Bd. Ex.") 1. The Charges allege that Respondent's license is subject to disciplinary action pursuant to §§ 19a-17 and/or 20-13c of the Connecticut General Statutes ("Statutes" or "Conn. Gen. Stat."). The Charges and the Notice of Hearing scheduling a hearing on February 5, 2021, were sent to Respondent by certified mail, return receipt requested, and first class mail. Bd. Ex. 2.

On January 22, 2021, Respondent submitted an Answer to the Charges. Bd. Ex. 3.

On January 22, 2022, Respondent filed a request for continuance of the hearing scheduled for February 5, 2021, to which the Department did not object. Bd. Ex. 4. On January 28, 2021, the Board granted Respondent's continuance request and scheduled a hearing for April 6, 2021. Bd. Ex. 5.

On March 26, 2021, Respondent filed a second request for continuance, to which the Department did not object. Bd. Exs. 6 and 7. On March 30, 2021, the hearing was scheduled for June 7, 2021. Bd. Ex. 8.

On March 26, 2021, Respondent filed a Motion for Pre-Hearing Review. Bd. Ex. 9. On June 1, 2021, the Department filed an Objection to Motion for Pre-Hearing Review. Bd. Ex. 10.

On May 26, 2021, Respondent filed another request for continuance of the hearing scheduled for June 7, 2021. Bd. Ex. 11. On June 3, 2021, the Motion for Pre-Hearing Conference was denied, and the continuance request was granted. Bd. Ex. 12. On August 25, 2021, the hearing was rescheduled for October 19, 2021. Bd. Ex. 13.

On October 7, 2021, Respondent requested another continuance, to which the Department objected. Bd. Exs. 14 and 15. On October 12, 2021, Respondent's request for continuance was

granted. Bd. Ex. 16. On October 28, 2021, the hearing was re-scheduled for December 13, 2021, and, if needed, for January 11, 2022. Bd. Ex. 17.

On January 4, 2022, Respondent requested another continuance, to which the Department did not object. Bd. Ex. 18. On January 6, 2022, the continuance was granted. Bd. Ex. 19. On March 15, 2022, the hearing was scheduled for May 13, 2022, and, if needed, for May 16, 2022. Bd. Ex. 20.

Sometime in May 2022, the Department filed a request to postpone the hearing start time from 9:00 a.m. to 3:00 p.m. for the hearing scheduled for May 13, 2022, to which Respondent did not object. Bd. Ex. 21. On May 9, 2022, the postponement request was granted for May 13, 2022, hearing. The May 16, 2022, hearing date was cancelled. Bd. Ex. 22.

On May 19, 2022, the second date of the hearing was rescheduled for June 20, 2022, and another date, July 25, 2022, was scheduled, if needed. Bd. Ex. 23. On June 22, 2022, the hearing was again rescheduled for July 22, 2022 and, if needed, for July 25, 2022. Bd. Ex. 24.

On December 13, 2021, May 13, 2022, June 20, 2022, July 7, 2022, and July 25, 2022, the hearing was held before a duly authorized panel of the Board comprised of C. Steven Wolf, M.D., Raymond Andrews, Esq., and William C. Kohlhepp, DHSc, PA-C. Bd. Ex. 1.

On August 24, 2022, Dr. Wolf recused himself from further participating in the hearing and fact finding, and the Panel composition changed to Raymond Andrews, Esq., and William C. Kohlhepp, DHSc, PA-C, and Dr. Marilyn Katz (the "Panel").[1]

The Panel conducted the hearing in accordance with Chapter 54 of the Statutes and § 19a-9a-1 *et seq*. of the Regulations of Connecticut State Agencies ("Regulations"). Respondent was represented by his attorney, Mary Alice Moore Leonhardt. Attorneys Diane Wilan and Aden Baume represented the Department. The Department and Respondent presented evidence, conducted cross-examination, and provided argument on all issues.

All Panel members involved in this Memorandum of Decision ("Decision") attest that they have heard the case and/or read the record in its entirety. The Board reviewed the Panel's proposed final decision in accordance with the provisions of § 4-179 of the Statutes. The Board considered whether Respondent poses a threat, in the practice of medicine, to the health and

[1] The August 24, 2022, email notifying the parties and the Board about the change in Panel composition was marked for identification and entered into the record as Board Ex. 25.

safety of any person. This Decision is based entirely on the record and the specialized professional knowledge of the Board in evaluating the evidence.

Allegations

1. In paragraphs 1 and 4 of the Charges, the Department alleges that Respondent of Middletown, Connecticut is, and has been at all times referenced in this Statement of Charges, the holder of Connecticut physician and surgeon license number 023684.

Count 1

2. In paragraph 2 of the Charges, the Department alleges that Respondent provided care to Patient 1 at various times between on or about April 1, 2015 and December 10, 2018. Over a period of approximately two years, Respondent prescribed a daily dose of oxycodone in a range of 300 to 480 milligrams ("mg"), and on various occasions within that span also concurrently prescribed Adderall and Diazepam. Respondent's care for Patient 1 failed to meet the standard of care in one or more of the following ways:
   a. Respondent failed to make any record of his care prior to November 22, 2016, including but not limited to encounter notes and prescription records for more than thirty prescriptions of controlled substances, or failed to keep such records;
   b. Respondent's assessments were inadequate and/or his treatment plans were unfounded or inappropriate and/or the documentation of his care from on or about November 22, 2016 through on or about December 10, 2018 is incomplete in that it fails to document a history of present illness, review of systems, problem list, past medical history, basis for prescribing opioids, initial and/or interim assessments and/or re-assessments of pain, function, and/or response to treatment; or discussion with the patient of risks and benefits of the medications;
   c. Respondent failed to monitor Patient 1 by testing, and/or
   d. Respondent failed to make referrals for specialized care.

3. In paragraph 3 of the Charges, the Department alleges that the above described facts constitute grounds for disciplinary action pursuant to § 20-13c(4) of the Statutes.

Count 2

4. In paragraph 5 of the Charges, the Department alleges that Respondent provided care to Patient 2 at various times from on or about August 10, 2010 through on or about December 10, 2018. At various times in the course of care, Respondent assessed for and/or diagnosed lupus, anxiety, depression, ADHD, and chronic pain. At various times, Respondent prescribed various opioids, benzodiazepines, Adderall, and Lexapro. Respondent's care for Patient 2 failed to meet the standard of care in one or more of the following ways:
   a. Respondent failed to adequately assess and/or discern pregnancy in 2015 and/or in 2018;
   b. Respondent failed on any occasion to document a rationale, or an adequate rationale, for the prescriptions of Adderall;

c. Respondent failed to make an adequate assessment of chronic pain, lupus, arthritis, ADHD, and/or depression, or failed to document such assessments;
d. Respondent failed to make referrals to specialized diagnostic and/or treatment care for chronic pain, lupus, arthritis, ADHD, and/or depression, or failed to document such referrals;
e. Respondent failed to coordinate care adequately with specialists in psychiatry, rheumatology, and or obstetrics, or failed to document any such communications, or failed to document such coordination; and/or
f. Respondent prescribed long-term, high dose opioids, with benzodiazepines, and other controlled medications, without baseline assessments, appropriate interval re-assessments, attempts at non-opioid therapy, urine screening, and/or adequate discussion of risks and benefits with the patient or adequate documentation of such discussions.

5. In paragraph 6 of the Charges, the Department alleges that the above described facts constitute ground for disciplinary action pursuant to § 20-13c(4) of the Statutes.

Findings of Fact

1. Respondent of Middletown, Connecticut is, and has been at all times referenced in this Statement of Charges, the holder of Connecticut physician and surgeon license number 023684. Bd. Ex. 3.

Count 1

2. Respondent provided care to Patient 1 at various times between on or about April 1, 2015 and December 10, 2018. Bd. Ex. 3; Dept. Ex. 3, pp. 2-36. Over a period of approximately two years, Respondent prescribed a daily dose of 480 milligrams ("mg") of oxycodone, and on various occasions within that span of time he also concurrently prescribed Adderall and Diazepam. Bd. Ex. 3.

3. Respondent failed to make any record of his care prior to November 22, 2016, including but not limited to encounter notes and prescription records for more than thirty prescriptions of controlled substances, and failed to keep such records. Dept. Ex. 1, pp. 5-6, 8-9; Tr. 6/20/2022, pp. 15-20.

4. On November 22, 2016, Respondent provided medical care to Patient 1, when she was complaining of fatigue. Dept. Ex. 3, p. 33.

5. On February 2, 2017, Patient 1 had a consultation with Respondent complaining of dry mouth, high blood pressure, stress, and diabetes. Dept. Ex. 3, p. 32; Tr. 12/13/2021, p. 108-109. Respondent prescribed 30 tablets of 480 mg oxycodone; however, there is no explanation in the patient's care or assessment plan of why Respondent prescribed the oxycodone. Dept. Ex. 1, p. 28; Tr. 12/13/2021, p. 108.

6. On March 31, 2017, Respondent saw Patient 1 for a complaint of status post-hospitalization. Dept. Ex. 3, p. 30; Tr. 12/13/2021, pp. 109-110. Under patient assessment, Respondent

documented history of cancer, doing well; history of increased ammonia; back pain; and diabetes. Dept. Ex. 3, p. 30. Respondent failed to describe the type of cancer, why Patient 1 was hospitalized, or the reasons for the back pain. Tr. 12/12/2021, p. 110. And Respondent again prescribed oxycodone 480 mg without any explanation. Dept. Ex. 1, p. 28; Tr. 12/13/2021, p. 110-111.

7. On May 5, 2017, Respondent saw Patient 1 for increased blood pressure. Dept. Ex. 3, p. 26; Tr. 12/13/2021, p. 111. For the first time, Respondent documented under "Plan" to "bring all meds." Dept. Ex. 3, p. 26. There is no prior documentation of the patient's list of medications. Tr. 12/13/2021, p. 111.

8. On May 22, 2017, Respondent for the first time documented the list of medications Patient 1 was taking; however, the list does not include opioids and clonazepam, which the patient was taking. Dept. Ex. 3, p. 25; Tr. 12/13/2021, pp. 111-112. This visit's notes are missing the follow-up instructions. Tr. p. 12/13/2021, p. 112.

9. On March 6, 2018, Respondent saw Patient 1 for a chief complaint of back pain. Dept. Ex. 3, p. 16. The assessment in the note from this visit indicates malignant T-cell lymphoma, spinal stenosis, bulging disk, stress, back pain, and diabetes. Dept. Ex. 3, p. 16; Tr. 12/13/2021, p. 112. There is no annotation regarding who made the diagnosis or who was providing care for these conditions. *Id.* This is the first time Respondent noted that he ordered a urine drug screen. Tr. 12/13/2021, p. 113.

10. Approximately one week later, on March 14, 2018, Respondent saw Patient 1 again; however, the notes for this visit do not document a result from the urine toxicology test. Dept. Ex. 3, p. 15; Tr. 12/13/2021, p. 113. While Respondent notes that he performed a pill count, he does not indicate which specific pill he counted. *Id.*

11. Respondent saw Patient 1 a few more times during 2018, but Respondent never documented that the patient suffered from liver cancer. Tr. 12/13/2021, p. 114.

12. At all relevant times, Respondent's assessments were inadequate and/or his treatment plans were unfounded or inappropriate and/or the documentation of his care from on or about November 22, 2016 through on or about December 10, 2018 is incomplete in that it fails to document a history of present illness, review of systems, problem list, past medical history, basis for prescribing opioids, initial and/or interim assessments and/or re-assessment of pain, function, and/or response to treatment; or discussion with the patient of risks and benefits of the medications. Tr. 12/13/2021, pp. 116-117.

13. The evidence is insufficient to establish that Respondent failed to monitor Patient 1 by routine testing. Tr. 7/25/2022, pp. 45-48, 51.

14. The evidence is insufficient to establish that Respondent failed to make referrals for specialized care. Tr. 7/25/2022, pp. 29, 45-48, 51.

Count 2

15. Respondent provided care to Patient 2 at various time from on or about August 10, 2010 through on or about December 10, 2018. Bd. Ex. 3. At various times during care, Respondent assessed for and/or diagnosed lupus, anxiety, depression, ADHD, and chronic pain. At various times, Respondent prescribed various opioids, benzodiazepines, Adderall, and Lexapro. *Id.*

16. There is no documentation in the charts that Respondent discussed potential risks of medications he prescribed should Patient 2 plan to become pregnant or actually become pregnant. Tr. 12/13/2021, pp. 71, 80, 96.

17. On November 15, 2010, Respondent saw Patient 2, whose chief complaint was of neck pain. Dept. Ex. 4, p. 4. However, there was no description of when the neck pain started, what precipitated the neck pain, or what makes it worse or better in the history of present illness. Tr. 12/13/2021, pp. 70-71; Dept. Ex. 4, p. 4. The chart does not detail what specifically is referred to as stress and fatigue, the cause of the neck pain or which part of the neck is involved (for example, whether it is muscular or bone-related, neuro- or radiculopathy). Tr. 12/13/2021, pp. 70-71; Dept. Ex. 4, pp. 1-4. Respondent prescribed the anti-depressant, Celexa; an anti-anxiety medication; a muscle relaxant, Soma; and an opioid, Vicodin. Tr. 12/13/2021, p. 71. Respondent failed to document any discussion with Patient 2 about the risks of these drugs, which include, among other things, lack of focusing related to driving and to taking care of children, especially in light of the fact that Patient 2 was of reproductive years. *Id.*

18. When prescribing medications, the standard of care requires that the physician confirm that the patient is not pregnant, to note such when prescribing medications, and to note the side effects of the medications that he or she is prescribing. Tr. 12/13/2021, p. 72.

19. Additionally, the chart does note document any discussion regarding the patient's past medical issues of addiction or current use of drugs and alcohol, either recreational or prescribed. *Id.* p. 72.

20. Respondent prescribed 120 pills of Vicodin for one month of treatment without a documented justification, whereas the standardized recommendation when "prescribing narcotics . . . you cannot prescribe more than seven days in the State of Connecticut without a justification for new prescriptions for narcotics." *Id.* pp. 72-73.

21. On November 29, 2010, Respondent saw Patient 2 for chief complaints of neck pain and a UTI. Dept. Ex. 4, p. 5. The note identifies stress in the assessment, and the prescriptions now include Percocet. *Id.* p. 73; Dept. Ex. 4, p. 5. However, there is no documentation as to whether the Vicodin prescribed on November 15, 2010, was taken by the patient, whether it improved the patient's symptoms, or whether the patient should discontinue the Vicodin. Tr. 12/13/2021, p. 73. Additionally, there is "no physical exam documenting a neck exam or a neurological exam" or whether any other options were discussed with the patient. *Id.* p. 74.

22. On February 7, 2011, Respondent saw Patient 2, whose chief complaint again was neck pain, as well as stress. Tr. 12/13/2021, pp. 74-75; Dept. Ex. 4, p. 8. The note from that visit reflects that

Respondent prescribed Soma, Percocet, and Xanax. Dept. Ex. 4, p. 8. All of these medications have the similar side effects of sedation and lack of focus. *Id.* There is no indication that the side effects were discussed with the patient. *Id.* While EKG changes are noted in the assessment and plan, it is not clear what the EKG changes are or what the follow-up plan will be. Dept. Ex. 4, p. 8; Tr. 12/13/2021, p. 76.

23. On June 1, 2011, Respondent saw Patient 2 and the assessment plan notes back pain, but there is no documentation of a review of systems, past medical history, physical exam, or neurological exam regarding the back. Tr. 12/13/2021, pp. 76-77. However, Patient 2 was prescribed Percocet and Soma at this visit. Tr. 12/13/2021, pp. 76-77; Dept. Ex. 4, p. 13.

24. On July 28, 2011, Respondent again prescribed Percocet, and prescribed Adderall without documentation or explanation for that new prescription. Tr. 12/13/2021, p. 77; Dept. Ex. 4, p. 15.

25. During the August 3, 2011, visit, Patient 2's chief complaint was ADHD and stress. Dept. Ex. 4, p. 16. Respondent noted ADD[2] under assessment and increased the Xanax. Tr. 12/13/2021, pp. 77-78; Dept. Ex. 4, p. 16. There are no details associated with either ADHD or stress or whether Patient 2 received a neurological evaluation. Tr. 12/13/2021, pp. 78; Dept. Ex. 4, p. 16. There is not documentation to support prescribing a benzodiazepine, such as Xanax, for a chief complaint of stress. Tr. 12/13/2021, p. 78.

26. On December 1, 2011, Respondent saw Patient 2 for a chief complaint for the first time of arthritis for which Respondent prescribed Medrol Dosepak and Percocet. Tr. 12/13/2021, p. 78; Dept. Ex. 4, p. 21. However, there is no documented history of laboratory tests or physical exam of any of the joints to determine the type of arthritis. Tr. 12/13/2021, p. 78. Respondent also prescribed Percocet without any notes indicating why this was the appropriate treatment, or any notes justifying the treatment. Tr. 12/13/2021, p. 79. There was no rationale documented for the prescriptions. *Id.*

27. On February 2, 2012, Respondent saw Patient 2 for a complaint about cat scratch fever and ADD, and Respondent prescribed Adderall, Percocet, and Valium. Dept. Ex. 4, p. 23. There is no documentation about when and where the cat scratch occurred, and which antibiotic was appropriate, whether it had been treated before, or whether it was healing. Tr. 12/13/2021, pp. 81-82. With respect to the ADD, there is no note indicating when the ADD first occurred. *Id.* p. 81. Furthermore, there is no discussion of a follow-up about the neck pain, previous treatment, or whether the patient continued to need the previously prescribed benzodiazepines and narcotics. *Id.* Respondent continued to prescribe full month supplies of Adderall, Percocet, and Valium without documenting side effects of those medications and without documenting any discussion regarding birth control. Tr. 12/31/2021, pp. 81-82; Tr. 5/13/2022, p. 22. The chart does not document the patient's temperature and, while the note documents EKG changes, Respondent does not indicate what those changes are. Tr. 12/31/2021, p. 82.

[2] ADD means Attention Deficit Disorder. Tr. 5/13, 2022, p. 26.

28. On February 27, 2012, Respondent saw Patient 2 whose chief complaint was tiredness, pain, and arthritis. Dept. Ex. 4, p. 24. Respondent did not note which joints were painful, whether the patient experienced more pain in the morning or the afternoon, whether the joints were swollen or red, or whether the prescribed narcotics had been helpful to the patient. Tr. 12/13/2021, p. 83. There was no examination of the joints in the physical exam. *Id.*

29. On June 14 and July 26, 2012, Respondent saw Patient 2 to treat for lupus and arthritis, and Patient 2's chief complaint on July 26, 2012, was "Sinus." Tr. 12/13/2021, pp. 83-84; Dept. Ex. 4, pp. 28, 29. The note for June 14, 2012, references arthritis and the notes for each date reference lupus, however, neither mentions supporting or non-supporting labs for the diagnosis of lupus, examination related to sinuses, the mention of an antibiotic used to treat a sinus infection, or follow-up discussions regarding the use of narcotics. Tr. 12/13/2021, p. 84.

30. Subsequently, in June through August 2013, Respondent continued to treat Patient 2 for complaints related to lupus, joint pain, arthritis, fibromyalgia. Tr. 12/13/2021, pp. 84-85; Dept. Ex. 4, pp. 32-34. However, the notes lack a clinical assessment and definitive diagnosis. *Id.*

31. On September 11, 2013, Respondent referred Patient 2 to a Rheumatologist for consultation. Dept. Ex. 4, p. 35.

32. On March 25, 2014, Respondent saw Patient 2, whose chief complaint was that she needed Lexapro. Tr. 12/13/2021, p. 86; Dept. Ex. 4, p. 36. In the notes there is no history of present illness and there is no neurological or psychological exam. *Id.*

33. Patient 2 was admitted to Middlesex Hospital from December 10 to December 12, 2015, at 35 weeks pregnant, which she was unaware of. Tr. 12/13/2021, p. 90. Respondent had seen Patient 2 on December 1, 2015; however, there is no evidence in the medical notes that he had been aware of the patient's pregnancy. *Id.*

34. On August 29, 2017, Respondent saw Patient 2, whose chief complaint was bilateral knee pain. Dept. Ex. 4, p. 60. The note from that visit reflects that Patient 2 volunteered to stop taking Ambien and to cut down on the Diazepam, however, there is no information about who prescribed those medications, why Patient 2 would be trying to cut down, or what discussion was had regarding those prescriptions. Dept. Ex. 4, pp. 60; Tr. 12/13/2021, p. 94.

35. In 2017, Patient 2 was again pregnant, and still being prescribed Vicodin, Adderall, and benzodiazepines. Tr. 12/13/2021, p. 95. Respondent saw Patient 2 throughout the second pregnancy up until March 18, 2018, when she had the second baby. *Id.* p. 96. On December 18, 2017, Respondent saw Patient 2 whose chief complaint was that she was pregnant. Dept. Ex. 4, p. 64. The note indicates to stop Valium, taper off Vicodin, and ask a psychiatrist about Adderall. *Id.* There is no documentation of any follow-up on those recommendations. Tr. 12/13/2021, p. 95. During this pregnancy, there are no notations showing that Respondent discussed birth control, medications during pregnancy, or the risks of medications during pregnancy. *Id.* p. 96.

36. From November 2017 to March 2018, Respondent prescribed Patient 2 Adderall, diazepam, and hydrocodone acetaminophen, with multiple prescription refills; however, Respondent failed to provide any associated reasoning for such prescriptions in his notes. Tr. 12/13/2021, pp. 97-98; Tr. 5/13/2022, p. 31.

37. During the time for which Respondent treated Patient 2 between 2010 to 2018, Respondent performed a total of six urine screens. Dept. Exs. 4, 5; Tr. 12/13/2021, p. 100. During this time, Patient 2 tested positive for cocaine on one urine tox screen. Tr. 12/13/2021, pp. 100-101. There is no documentation of review of this result or discussion of this result with Patient 2 in the chart. *Id.*

38. Respondent's care for Patient 2 failed to meet the standard of care in that Respondent failed to adequately assess and/or discern pregnancy in 2015 and/or in 2018. Tr. 12/13/2021, pp. 90-91, 152. The Board finds that Patient 2 was a female of child-bearing age to which Respondent was prescribing high risk medications. There is no documentation in the notes that Respondent discussed with Patient 2 birth control or the side effects of any of the medications he prescribed with regard to the possibility that she might become pregnant. Tr. 12/13/2021, p. 80.

39. At all relevant times, Respondent failed on any occasion to document a rationale, or an adequate rationale, for the prescriptions of Adderall. Tr. 12/13/2021, p. 79; Tr. 5/13/2022, p. 23; Tr. 6/20/2022, pp. 20-21; Dept. Ex. 1, pp. 8-9.

40. At all relevant times, Respondent failed to make an adequate assessment of chronic pain, lupus, arthritis, ADHD, and/or depression, or failed to document such assessments. Tr. 12/13/2021, pp. 162-163, 165-166; Tr. 5/13/2022, p. 25.

41. The evidence is insufficient to establish that Respondent failed to make referrals to specialized diagnostic and/or treatment care for chronic pain, lupus, arthritis, ADHD, and/or depression, or failed to document such referrals. Tr. 12/13/2021, p. 85; Tr. 7/25/2022, p. 29; Dept. Ex. 4, p. 34. Respondent's notes show that he referred Patient 2 to a rheumatologist. Tr. 12/13/2021, p. 94; Tr. 5/13/2022, pp. 44-45; Tr. 7/25/2022, p. 18; Respondent ("Rt.") Ex. A, p. 5.

42. At all relevant times, Respondent failed to coordinate care adequately with specialists in psychiatry, rheumatology, and or obstetrics, or failed to document any such communications, or failed to document such coordination. Dept. Ex. 4. The preponderance of the evidence establishes that although Respondent referred Patient 2 to a rheumatologist, there are no other notations as to whether the patient saw the rheumatologist, had other consults, or whether there were any other referrals. Dept. Ex. 4; Tr 12/13/2021, p. 94; Tr. 5/13/2022, p. 25.

43. At all relevant times, Respondent prescribed long-term, high dose opioids, with benzodiazepines and other controlled medications, without baseline assessments, appropriate interval re-assessments, attempts at non-opioid therapy, urine screening, and/or adequate discussion of risks and benefits with the patient or adequate documentation of such discussions. Tr. 12/13/2021, pp. 79-80.

44. The Board finds the testimony of Marcelyn Molloy, M.D., credible.

Discussion and Conclusions of Law

Conn. Gen. Stat. § 20-13c provides, in pertinent part, that:

> The Board is authorized to restrict, suspend or revoke the license or limit the right to practice of a physician or take any other action in accordance with section 19a-17, for any of the following reasons: . . . (4) illegal, incompetent or negligent conduct in the practice of medicine; . . . In each case, the board shall consider whether the physician poses a threat, in the practice of medicine, to the health and safety of any person. If the board finds that the physician poses such a threat, the board shall include such finding in its final decision and act to suspend or revoke the license of said physician.

The Department bears the burden of proof by a preponderance of the evidence in this matter. *Jones v. Conn. Med. Examining Bd.*, 309 Conn. 727, 739-740 (2013). The Board relied on the training and experience of its members in making its findings of fact and conclusions of law. *Pet v. Dep't of Health Servs.,* 228 Conn. 651, 667 (1994).

The Department sustained its burden of proof regarding the allegations in paragraphs 1, 2a, 2b, 3, 4, 5a-5c, 5e, 5f, and 6 of the Charges, except for the charges contained in paragraphs 2c, 2d, and 5d of the Charges. The Board finds that Respondent acted illegally, incompetently, and/or negligently in the practice of medicine. Accordingly, the Board concludes that there is adequate basis upon which to impose discipline on Respondent's license, pursuant to §§ 19a-17 and 20-13c (4) of the Statutes.

Respondent admitted the allegations contained in paragraphs 1 and 4 of the Charges. Findings of Fact ("F.F.") 1. Therefore, these allegations are not in dispute. *See, Jones Destruction, Inc. v. Upjohn*, 161 Conn. 191, 199 (1971); *Comm'r of Pub. Works v. Middletown*, 53 Conn. App. 438, 444 (1999), *cert. denied,* 250 Conn. 923 (1999).

Regarding the allegations contained in paragraph 2a of the Charges that Respondent failed to make any record of his care prior to November 22, 2016, including but not limited to encounter notes and prescription records for more than thirty prescriptions of controlled substances, or failed to keep such records, the Department sustained its burden of proof. Tr. 6/20/2022, p. 67.

The preponderance of the evidence establishes that Respondent failed to make available and provide to the Department, upon the Department's request, any records of Patient 1's care

prior to November 22, 2016, including but not limited to encounter notes and prescription records for more than thirty prescriptions of controlled substances, and failed to keep such records. Dept. Ex. 1, pp. 5-6, 8-9; Tr. 6/20/2022, pp. 15-20. Therefore, the Department sustained its burden of proof regarding the allegations contained in paragraph 2a of the Charges.

Regarding the allegations contained in paragraph 2b of the Charges, the Department alleges that Respondent's assessments were inadequate and/or his treatment plans were unfounded or inappropriate and/or the documentation of his care from on or about November 22, 2016, through on or about December 10, 2018, is incomplete in that it fails to document a history of present illness, review of systems, problem list, past medical history, basis for prescribing opioids, initial and/or interim assessments and/or re-assessment of pain, function, and/or response to treatment; or discussion with the patient of risks and benefits of the medications.

Dr. Marcelyn Molloy testified as an expert witness on behalf of the Department.[3] Tr. 12/13/2021, p. 58; Dept. Ex. 6. She testified that physicians generally create two types of records: one for the initial visit for which the notes should contain extensive patient history, and another one for the physician's known patients, which should include present history and chief complaint. *Id.* p. 60. The medical history should include an assessment of cardiovascular system, GI, joints, hospitalization history, surgical history, medication list, family history, social history, job and occupational history, and drug and alcohol history, as well as the physical exam. *Id.* pp. 60-61. The chart should also include a description of the physical exam assessment: plan, medications, physical therapy, appropriate follow-up, discussion of the plan with patient, discussion of any risks benefits of the treatment, medications, tests ordered, and any recommendations declined by the patient. *Id*. pp. 61-62.

In the instant case, Respondent provided care to Patient 1 at various times between on or about April 1, 2015 and December 10, 2018. Bd. Ex. 3; Dept. Ex. 3, pp. 2-36. Over a period of approximately two years, Respondent prescribed a daily dose of 480 mg of oxycodone, and on various occasions within that span of time he also concurrently prescribed Adderall and Diazepam. Bd. Ex. 3. However, there is no explanation in the patient's plan or assessment of why Respondent prescribed the oxycodone. Dept. Ex. 1, p. 28; Tr. 12/13/2021, pp. 108, 110-111.

[3] Dr. Molloy has significant experience in internal medicine and with patients in the same population as Patients 1 and 2. Tr. 12/12/2022, pp. 56-57; Dept. Ex. 6.

On May 5, 2017, Respondent for the first time asks Patient 1 to bring all medications for the next medical appointment on May 22, 2017. Dept. Ex. 3, p. 26; Tr. 12/13/2021, p. 111. However, the medication list does include the narcotics and clonazepam which the patient is taking. Dept. Ex. 3, p. 25 Tr. 12/13/2021, pp. 111-112. This visit note is missing any indication of a follow up. Tr. p. 12/13/2021, p. 112.

During the March 6, 2018, visit, Patient 1 complained of back pain. Dept. Ex. 3, p. 16. The assessment indicates malignant T-cell lymphoma, spinal stenosis, bulging disk, stress, back pain, mycosis fungoides, and diabetes. Dept. Ex. 3, p. 16. However, there is no annotation regarding who made the diagnosis or who is providing care for these conditions. Tr. 12/13/2021, pp. 112-113. On this date, for the first time, Respondent orders a urine drug screen. Tr. 12/13/2021, p. 113. Approximately, one week later, on March 14, 2018, Respondent saw Patient 1 again; however, the note from that visit is silent with respect to the urine or toxicology test results. Dept. Ex. 3, p. 15; Tr. 12/13/2021, p. 113. Respondent mentions that he performed pill counting, but he does not indicate which specific pill he counted. *Id.*

Respondent saw Patient 1 a few more times during 2018, but there was no definite diagnosis of liver cancer. Tr. 12/13/2021, p. 114.

Respondent diagnosed back pain and spinal stenosis without specific documenting specific details about the diagnosis and prescribed high dosage of narcotics from the first visit on, but he did not document if the reason he was prescribing the narcotics was related to the back pain and stenosis or the mycosis fungoides diagnosed per the dermatology consult. Tr. 12/13/2021, pp. 116-117. Doctor Molloy testified that she did not see any justification for chronic opioid treatment between 2016 and 2018. Tr. 12/13/2021, pp. 116-117.

Dr. Molloy testified that Respondent's conduct did not comply with the standard of care because Respondent failed to explain the risks and benefits, there was no documentation of specific diagnosis, Respondent failed to annotate the patient's medical file for at least a year from the time the patient first presented to Respondent's care, and the notes provide no reference or justification with respect to the patient's chronic condition and the prescription of narcotics. *Id.* pp. 116-117. In 2018, there is no complete medication list. *Id.* Respondent failed to refer the patient to a specialist, such as a pain specialist or an orthopedic doctor, who could address the

chronic pain. *Id.*[4] Dr. Molloy also testified that in this case, it was important to discuss with the patient the risks associated with the use high opioid medications in a manner which was documented, which he did not do. Tr. 6/20/2022, p. 78. Therefore, the Department sustained its burden of proof regarding the allegations contained in paragraph 2b of the Charges.

Regarding the allegations contained in paragraph 2c of the Charges the evidence is insufficient to establish that Respondent failed to monitor Patient 1 by routine testing. Respondent credibly testified that Patient 1 went to the emergency room at least twice per year, where she was always tested for drug screens. Tr. 7/25/2022, pp. 45-48, 51, 53-54. Therefore, there was no need to redo the drug testing in the office. *Id.* The Board agrees with Respondent. Therefore, the Department did not sustain its burden of proof regarding the allegations contained in paragraph 2c of the Charges.

Regarding the allegations contained in paragraph 2d of the Charges, the evidence is insufficient to establish that Respondent failed to make referrals for specialized care. Tr. 7/25/2022, 29, 45-48, 51, 54-55. Respondent credibly testified that he was part of the team which monitored Patient 1, and that there were multiple doctors monitoring Patient 1. *Id.* Therefore, the Department did not sustain its burden of proof regarding the allegations contained in paragraph 2d of the Charges.

Regarding the allegations contained in paragraph 5a of the Charges, the Department sustained its burden of proof that Respondent failed to adequately assess and/or discern pregnancy in 2015 and/or in 2018. Tr. 12/13/2021, pp. 79-80, 90-91, 152; Tr. 6/20/2022, p. 75. The standard of care requires that when a physician is treating a patient of reproductive age, the physician asks about birth control and whether there is any chance of pregnancy because there are medications which should not be used during pregnancy unless it is absolutely necessary. Tr. 12/13/2021, pp. 71-72. Physicians should also note whether the patient is pregnant. *Id.* p. 72.

Respondent provided care to Patient 2, a female of child-bearing age, at various times from on or about August 10, 2010, through on or about December 10, 2018. Bd. Ex. 3; Dept. Ex. 4. At various times during care, Respondent assessed for and/or diagnosed lupus, anxiety, depression, ADHD, and chronic pain, and Respondent prescribed high risk medications such as

[4] Dr. Molloy testified that in 2018, after the allegations were known, Respondent made the necessary referrals and a list with the medication list and pill count. Tr. 12/13/2021, pp. 117-118, 160.

various opioids, benzodiazepines, Adderall, and Lexapro. *Id.* Patient 2's chart, however, was silent regarding any discussion of risk assessment or contraception, urine or blood tests, or documentation regarding OBGYN. Dept. Ex. 4. Dr. Molloy testified that there no documented discussion regarding birth control or any side effects of the prescriptions. Tr. 12/13/2021, pp. 80-82.

Dr. Molloy also testified that internists and a primary care physician should know the patient's last menstrual period and whether the patient is taking birth control, especially if the patient is being prescribed medications which could be harmful in pregnancy, when they are of fertile age. Tr. 5/13/2022, p. 22.

Patient 2 was admitted to Middlesex Hospital from December 10 to December 12, 2015, when she delivered a baby. Dept. Ex. 4, p. 194; Tr. 12/13/2021, p. 90. Patient 2 had been unaware that she had been pregnant. Tr. 12/13/2021, p. 90. Significantly, Respondent had seen Patient 2 on December 1, 2015; however, there is no evidence in the medical notes that he had been aware of the patient's pregnancy. *Id.* During the December 1, 2015, visit, Patient 2 had complained of abdominal pain. *Id.* p. 91.

On January 3, 2016, Respondent again saw Patient 2, when her chief complaint was Lyme Disease and multiple joint pain. *Id.* pp. 91-92. She was assessed for acute Lyme Disease, lupus, joint pain, and ADD. However, the note lacks any discussion about the fact that she was full-term pregnant and had given birth two weeks prior to the visit. *Id.* pp. 91-92. The chart notes also lack any information regarding the prescription of narcotics or medication list. *Id.* p. 93. Therefore, the Department sustained its burden of proof regarding the allegations contained in paragraph 5a of the Charges.

Regarding the allegations contained in paragraph 5b, the Department sustained its burden of proof that Respondent failed on any occasion to document a rationale, or an adequate rationale, for the prescriptions of Adderall. Tr. 12/13/2021, pp. 79-80; Tr. 5/13/2022, p. 23; Tr. 6/20/2022, pp. 20-21, 75, 77; Dept. Ex. 1, pp. 8-9. The preponderance of the evidence establishes that on July 28, 2011, February 2, 2012, and December 1, 2015, and from November 2017 to March 2018, Respondent prescribed Adderall without enough documentation for explanation for the prescription. Tr. 12/13/2021, pp. 77, 81-82, 90, 95-99; Tr. 5/13/2022, pp. 25, 26, 31; Dept. Ex. 4, pp. 14-15, 23. Dr. Molloy testified that with respect to Patient 2, there is no documented rationale for prescriptions, particularly in 2011. Tr. 12/13/2021, p. 79; Tr.

6/20/2022, pp. 75, 77. Therefore, the Department sustained its burden of proof regarding the allegations contained in paragraph 5b of the Charges.

Regarding the allegations contained in paragraph 5c of the Charges, the Department sustained its burden of proof that Respondent failed to make an adequate assessment of chronic pain, lupus, arthritis, ADHD, and/or depression, or failed to document such assessments. Tr. 12/13/2021, pp. 162-163, 165-166; Tr. 5/13/2022, p. 25.

Dr. Molloy testified that with respect to Patient 2, Respondent violated the standard of care in that Respondent did not have a diagnosis outlined and supported by history, an exam, laboratory testing, radiology reports, and specialist consultations. Tr. 12/13/2021, p. 104; Tr. 6/20/2022, p. 73. Respondent also lacked documentation of using non-narcotics for treatment, failed to order a urine test before the first prescription of narcotics, and failed to document any follow up related to whether the treatment with narcotics was working. Tr. 12/13/2021, p. 104; Tr. 6/20/2022, pp. 71-72.

Dr. Molloy also testified that while there was a baseline assessment or interval assessment for the prescriptions, the general assessment was for a specific separate issue, without documentation of whether the plan and treatment on the previous note was a positive, negative, or neutral outcome. Tr. 12/13/2021, pp. 80-82.

There are many instances in which Respondent treated Patient 2 without adequate assessment. On November 15, 2010, Respondent performed an assessment of Patient 2, who complained of neck pain. However, there was no history of present illness describing when the neck pain started, what precipitated the neck pain, what makes it worse or better. Tr. 12/13/2021, pp. 70-71; Dept. Ex. 4, pp. 1-4. The chart does not document details regarding what specifically is referred to as stress and fatigue, the cause of the neck pain, the part of the neck involved, whether the pain is muscular, bone-related, neuro or radiculopathy. *Id*. Respondent failed to document any discussion regarding Patient 2's lack of focusing while driving, taking care of children, especially in light that Patient 2 is of reproductive years. *Id.* Additionally, the chart doesn't document any discussion regarding past medical issues of addiction, or current use of drugs and alcohol recreationally or prescribed. *Id.* p. 72.

On February 7, 2011, Patient 2 again complained of neck pain and stress for which Respondent prescribed Soma, Percocet, Xanax, and Prozac. Tr. 12/13/2021, pp. 74-75; Dept. Ex. 4, p. 8. There is no association between the medication and the diagnosis. Tr. 12/13/2021, p. 75.

These medications all have the similar side effects of sedation and lack of focus; however, there is no indication that Respondent discussed the side effects with the patient. *Id.* There is a note regarding EKG changes. However, there is no plan associated with EKG changes. *Id.* p. 76.

On June 1, 2011, Patient 2's chief complaint was sore ears; however, the assessment plan notes back pain, and the listed prescriptions include Percocet and Soma. Tr. 12/13/2021, pp. 76-77; Dept. Ex. 4, p. 13. The notes lack documentation of the review of systems, physical exam, or neurological exam regarding the back. Tr. 12/13/2021, p. 76.

On July 28, 2011, Respondent again prescribes Percocet and Adderall without enough documentation for explanation for the prescription. Tr. 12/13/2021, p. 77; Dept. Ex. 4, pp. 14-15. During the August 3, 2011, visit, Patient 2 complained of ADHD and stress. Dept. Ex. 4, p. 16. Respondent notes ADD and increases the Xanax. Tr. 12/13/2021, pp. 77-78; Dept. Ex. 4, p. 16. There are no details associated with either ADD or the increase in Xanax, or whether Patient 2 received a neurological evaluation. Dept. Ex. 4, p. 16. There is insufficient documentation to support that the stress warrants a prescription for Xanax, which is a benzodiazepine. Tr. 12/13/2021, p. 78.

On December 1, 2011, Patient 2's complaint was stress, ADD, and arthritis for which Respondent prescribed Medrol Dosepak and Percocet. Tr. 12/13/2021, p. 78; Dept. Ex. 4, p. 21. However, there is no documented history of laboratory tests or physical exam of any of the joints to determine whether the arthritis is caused by an autoimmune cause or osteoarthritis. Tr. 12/13/2021, p. 78. Respondent prescribed Medrol Dosepk, which is prescribed for arthritis caused by inflammation. *Id.* pp. 78-79. Respondent also prescribes Percocet without any notes indicating why this is the appropriate treatment, or any notes justifying the treatment. *Id.* p. 79. There was no rationale documented for the prescriptions. *Id.*

On February 2, 2012, Respondent saw Patient 2 for a complaint about cat scratch fever and ADD, and Respondent prescribed Adderall, Percocet, and Valium. Dept. Ex. 4, p. 23. The patient's chart is silent about when and where the cat scratch occurred, whether it had been treated before, whether it was healing, and which antibiotic was appropriate. Tr. 12/13/2021, p. 81. With respect to the ADD, there is no note indicating when the ADD occurred. *Id.* Furthermore, there is no discussion of a follow-up about the neck pain, previous treatment, or whether the patient continued to need the previously prescribed benzodiazepines and narcotics. *Id.* Respondent continued to prescribe full-month supplies of Adderall, Percocet, and Valium

without documenting side effects of those medications and without documenting any discussion with the patient regarding birth control. Tr. 12/31/2021, pp. 81-82; Tr. 5/13/2022, pp. 25, 26. The chart is also silent about the patient's temperature and, while there was a change in the EKG, Respondent does not reference the changes in the note. *Id.* p. 82.

On February 27, 2012, Patient 2 complained of tiredness, pain, and arthritis; however, Respondent does not note which joints were painful, whether she experienced more pain in the morning or the afternoon, whether the joints were swollen or red, or whether the prescribed narcotics had been helpful to the patient. Dept. Ex. 4, p. 24; Tr. 12/13/2021, pp. 82-83.

On June 14 and July 26, 2012, Respondent saw Patient 2 to treat for lupus and arthritis, with a complaint of sinus problems. Tr. 12/13/2021, pp. 83-84; Dept. Ex. 4, pp. 28, 29. The notes do not mention supporting or non-supporting labs for the diagnosis of lupus, examination related to sinuses, or the mention of an antibiotic used to treat a sinus infection or follow up discussions regarding the use of narcotics. Tr. 12/13/2021, p. 84.

Subsequently, in June through August 2013, Respondent continued to treat Patient 2 for complaints related to lupus, joint pain, arthritis, fibromyalgia. Tr. 12/13/2021, pp. 84-85; Dept. Ex. 4, pp. 32-35. However, the notes lack a clinical assessment and definitive diagnosis. *Id.* On March 25, 2014, Respondent saw Patient 2, whose chief complaint was that she needed Lexapro. Tr. 12/13/2021, p. 86; Dept. Ex. 4, p. 36. However, in the notes there is no history of illness and there is no physical exam denoting a diagnosis. *Id.* While there is a notation of an exam of the lungs, heart, and abdomen, there is no musculoskeletal or joint exam, no neurological or psychological exam. Tr. 12/13/2021, p. 86. Therefore, the Department sustained its burden of proof regarding the allegations contained in paragraph 5c of the Charges.

Regarding the allegations contained in paragraph 5d of the Charges, the evidence is insufficient to establish that Respondent failed to make referrals to specialized diagnostic and/or treatment care for chronic pain, lupus, arthritis, ADHD, and/or depression, or failed to document such referrals. Tr. 12/13/2021, pp. 83-84; Tr. 7/25/2022, pp. 29, 88-89, 116; Dept. Ex. 4, pp. 28, 29; Rt. Ex. B, p. 17. On September 11, 2013, Respondent referred Patient 2 to a rheumatologist consultation and tried, albeit unsuccessfully, to refer Patient 2 to other specialists. Dept. Ex. 4, p. 35. Respondent's notes show that he referred Patient 2 to a rheumatologist. Tr. 12/13/2021, p. 94. Therefore, the Department did not sustain its burden of proof regarding the allegations contained in paragraph 5d of the Charges.

Regarding the allegations contained in paragraph 5e of the Charges, the Department sustained its burden of proof that Respondent failed to coordinate care adequately with specialists in psychiatry, rheumatology, and or obstetrics, or failed to document any such communications, or failed to document such coordination. The preponderance of the evidence establishes that although Respondent referred Patient 2 to a rheumatologist, there are no other notations as to whether the patient saw the rheumatologist or had a consult, or whether there were any other successful referrals. Dept. Ex. 4; Tr 12/13/2021, p. 94. Therefore, the Department sustained its burden of proof regarding the allegations contained in paragraph 5e of the Charges.

Regarding the allegation contained in paragraph 5f of the Charges, the Department sustained its burden of proof that Respondent prescribed long-term, high dose opioids, with benzodiazepines, and other controlled medications, without baseline assessments, appropriate interval re-assessments, attempts at non-opioid therapy, urine screening, and/or adequate discussion of risks and benefits with the patient or adequate documentation of such discussions. Tr. 6/20/2022, p. 73.

Dr. Molloy testified that there has been a national and state trend of standardizing when it is appropriate to prescribe narcotics issued by the CDC and the American Academy of Family Medicine or Internal Medicine. Tr. 12/12/2021, p. 102. Beginning in 2015, the State of Connecticut has required at least one hour of education in prescribed controlled substances every six years. *Id.* The CDC provides recommendations for short-term use, long-term use, urine drug screen testing, assessing for pain, follow-up visits, criteria for stopping and starting opioids, utilization of other treatment, checking the PDMP (how patients receive medications from other practitioners), and a mechanism for determining the morphine milligram equivalent drug intake. *Id.* pp. 102-103.

Dr. Molloy testified that the standard of care requires that a physician order a urine toxicology screen at least on an annual basis, and at the beginning of treating a new patient. Tr. 12/13/2021, p. 101. Dr. Molloy testified that there was no routine urine screening ordered for drugs and controlled substances. *Id.* pp. 79-80. During the time for which Respondent treated Patient 2 between 2010 to 2018 (a period of eight years), Respondent performed a total of six urine screens. Dept. Ex. 4, 5; Tr. 12/13/2021, p. 100. During this time, Patient 2 tested positive for cocaine on one occasion. Tr. 12/13/2021, pp. 100-101. Respondent's notes lack any

documentation showing that he discussed the positive cocaine urine screen with Patient 2. *Id.* pp. 101-102. Dr. Molloy testified that Respondent failed to use other measures besides controlled substances to treat Patient 2's conditions. *Id.* Even Respondent's expert witness, Dr. Arpad S. Fejos, agreed with Dr. Molloy, Dr. Fejos testified that Respondent's notes could use more documentation. Tr. 7/25/2022, p. 32.

For example, on November 15, 2010, Respondent performed an assessment of Patient 2, who complained of neck pain. Tr. 12/13/2021, pp. 70-71; Dept. Ex. 4, pp. 1-4. However, there is no noted history of present illness describing when the neck pain started, what precipitated the neck pain, or what makes it worse or better. The chart does not detail what specifically is referred to as stress and fatigue, the cause of the neck pain, or which the part of the neck is involved (for example, whether the pain is muscular, bone-related, or neuro- or radiculopathy). *Id.* Respondent prescribed the anti-depressant, Celexa; an anti-anxiety medication; a muscle relaxant, Soma; and the narcotic, Vicodin. Tr. 12/13/2021, p. 71. Respondent failed to document any discussion with Patient 2 about the risks of these drugs, which include, among other things, lack of focusing related to driving and to taking care of children, especially in light that Patient 2 is of reproductive years. *Id.*

Therefore, the Department sustained its burden of proof regarding the allegations contained in paragraph 5f of the Charges.

Conclusion

The Department sustained its burden of proof regarding allegations in paragraphs 1, 2a, 2b, 3, 4, 5a-5c, 5e, 5f, and 6 of Count I and II of the Charges, except for the charges contained in paragraphs 2c, 2d, and 5d of the Charges. Accordingly, the Board concludes that there is an adequate basis upon which to impose discipline on Respondent's license pursuant to §§ 19a-17 and 20-13c (4) of the Statutes.

Order

Based upon the record in this case, the above findings of fact and the conclusions of law, and pursuant to the authority vested in it by §§ 19a-17 and 20-13c of the Statutes, the Board

finds that with respect to Respondent's license number 023684 for the violations alleged and proven in Petition No. 2018-1345 warrant the following disciplinary action. The Board further finds that the conduct alleged and proven is severable and the findings for Count 1 and Count 2 each warrant said discipline.

1. Respondent's license number 023684 to practice as a physician and surgeon in the State of Connecticut is hereby assessed a civil penalty of two thousand dollars ($2,000.00) for the conduct alleged and proven in each Count of the Charges. Respondent shall pay the civil penalty assessed pursuant to this paragraph by certified or cashier's check(s) payable to "Treasurer, State of Connecticut." The check(s) shall reference the Petition Number on the face of the check and shall be payable within thirty (30) days of the effective date of this Decision.
2. Respondent's license No. 023684 to practice medicine is hereby permanently restricted in that Respondent shall permanently refrain from prescribing controlled substances.
3. Respondent's license No. 023684 is hereby reprimanded.
4. Within the first six (6) months of the probationary period set forth in paragraph 4 below, Respondent shall attend and successfully complete a course in record keeping, which is to be pre-approved by the Board. Within one (1) month of the completion of such coursework, Respondent shall provide the Department with proof, to the Department's satisfaction, of the successful completion of such courses.
5. Respondent's license shall be placed on probation, commencing on the date of this Decision, for a period of two (2) years, under the following terms and conditions:
    a. No later than thirty (30) days after the effective date of this Decision, Respondent shall submit to the Department for its pre-approval, the name of a physician licensed in Connecticut ("monitor") who, at Respondent's expense, will conduct monthly random reviews of thirty (30) of Respondent's patient records, created or updated during the probationary period. Within fifteen (15) days of the Department's approval, Respondent shall provide the monitor with a copy of this Decision. Respondent shall cause the monitor to confirm receipt of this Decision within fifteen (15) days after the monitor has received the Decision. In the event Respondent has thirty (30) or fewer patients, the monitor shall review all of Respondent's patient records.

b. Respondent's monitor shall meet with Respondent not less than once every month for the entire probationary period.

c. The monitor shall have the right to monitor Respondent's practice by any other reasonable means which the monitor deems appropriate. Respondent shall fully cooperate with the monitor during the monitoring period. Respondent shall be responsible for providing written monitor's reports directly to the Department on a monthly basis for the entire probationary period. Such monitor reports shall include documentation of dates and durations of meetings with Respondent, number and a general description of the patient records and patient medication orders and prescriptions reviewed, additional monitoring techniques utilized, and statement that Respondent is practicing with reasonable skill and safety.

d. Respondent shall provide his chief of service, employer, partner. and/or associate at any hospital, clinic, partnership and/or association at which he practices, where he volunteers, is employed. or with which he is affiliated or has privileges, with a copy of this Decision within fifteen (15) days of its effective date; and, Respondent shall cause to have his chief of service, employer, partner, and/or associate provide confirmation to the Department of receipt of the Decision within fifteen (15) days thereafter. If Respondent changes employment at any time during the probationary period, Respondent shall provide any new chief of service, employer, partner, and/or associate as described herein with a copy of this Decision within fifteen (15) days of commencement of employment or contract at a new facility and shall cause the new employer to provide the Department with confirmation of his/her receipt of the Decision within fifteen days thereafter. Respondent agrees to provide reports from any and all of employers or contracting agencies for the entire period of probation, stating that Respondent is practicing with reasonable skill and safety.

6. Within ten (10) days of the effective date of this Order, Respondent shall surrender to the issuing authorities, his state and federal Controlled Substance Registrations. Respondent shall not reapply for his state or federal controlled substance registrations for the two (2) years of the

probationary period. Preceding any such effort to reapply for controlled substance registration, the Respondent shall attend and successfully complete a course in prescription of controlled substances, which is to be pre-approved by the Board.

7. Respondent shall be responsible for all costs associated with the satisfaction of the terms of this Decision.

8. Respondent shall comply with all state and federal statutes and regulations applicable to his licensure.

9. Legal notice shall be sufficient if sent to Respondent's last known address of record reported to the Office of Practitioner Licensing and Investigations of the Department.

10. This document has no bearing on any criminal liability without the written consent of the Director of the Medicaid Fraud Control Unit or the Bureau Chief of the Division of Criminal Justice's Statewide Prosecution Bureau.

11. In the event Respondent is not employed as a physician for periods of thirty (30) consecutive days or longer, or is employed as a dentist for less than twenty (20) hours per week, or is employed outside of the State of Connecticut, Respondent shall notify the Department in writing. Such periods of time shall not be counted in reducing the probationary period covered by this Decision.

12. All correspondence related to this Decision and payment of the civil penalty must be mailed to:

Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

13. This Decision is effective on the first day of the month after it is signed by the Board.

Connecticut Medical Examining Board

April _____, 2023

_____
Kathryn Emmett, Esq.
Chairperson