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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1938

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY CRYSTAL K. COMPTON, D.O., LICENSE NO. 03120, 1349 LEFT FORK ISLAND CREEK, PIKEVILLE, KENTUCKY 41501

ORDER OF REVOCATION

Pursuant to KRS 311.591(7) and KRS 13B.120, at its meeting on April 21, 2022, the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Hearing Panel A, took up this matter for final action. Hearing Panel A considered the Complaint; the Hearing Officer's Findings of Fact, Conclusions of Law and Recommended Order, dated March 2, 2022; and the licensee's Exceptions, filed March 15, 2022.

Having considered all the information available and being sufficiently advised, Hearing Panel A ACCEPTS AND ADOPTS the Hearing Officer's Findings of Fact and Conclusions of Law and INCORPORATES them BY REFERENCE into this Order. (Attachment) Hearing Panel A FURTHER ACCEPTS AND ADOPTS the Hearing Officer's recommended order.

Having considered all statutorily available sanctions and the nature of the violations in this case, the Hearing Panel has determined that revocation is the appropriate sanction. Accordingly, Hearing Panel A **ORDERS**:

1. The license to practice osteopathy held by Crystal K. Compton, D.O., is hereby REVOKED and she shall not perform any act which constitutes the "practice of medicine or osteopathy," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – in the Commonwealth of Kentucky;

2. The provisions of KRS 311.607 SHALL apply to any petition for reinstatement filed by the licensee;

3. Pursuant to KRS 311.604, the licensee SHALL complete a board-approved clinical skills assessment at either the Center for Personalized Education for Professionals ("CPEP") (720 South Colorado Boulevard, Suite 1100-N, Denver Colorado 80246, Tel. (303) 577-3232) or LifeGuard (400 Winding Creek Boulevard, Mechanicsburg, Pennsylvania 17050, Tel. (717) 909-2590), prior to filing any petition for reinstatement of her license to practice osteopathy in the Commonwealth of Kentucky; and

4. Pursuant to KRS 311.565(1)(v), the licensee SHALL REIMBURSE the costs of the proceedings in the amount of $ 29,461.28, prior to filing any petition for reinstatement of her license to practice osteopathy in the Commonwealth of Kentucky.

SO ORDERED on this 21st day of April, 2022.

W. Saleem

WAQAR A. SALEEM, M.D.
CHAIR, HEARING PANEL A

CERTIFICATE OF SERVICE

I certify that the original of the foregoing Order of Revocation was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed, first-class postage prepaid, to Thomas J. Hellmann, Esq., Hearing Officer, 810 Hickman Hill Road, Frankfort, Kentucky 40601; and copies were mailed, certified return-receipt requested, to the licensee Crystal K. Compton, D.O., License No. 03120, 1349 Left Fork Island Creek, Pikeville, Kentucky 41501 and her counsel, Stephen W. Owens, Esq., P.O. Box 1426, Pikeville, Kentucky 41501, on this 21st day of April, 2022.

Leanne K. Diakov

Leanne K. Diakov
General Counsel
Kentucky Board of Medical Licensure
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Louisville, Kentucky 40222
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EFFECTIVE DATE AND APPEAL RIGHTS

Pursuant to KRS 311.593(1) and 13B.120, the effective date of this Order will be thirty (30) days after this Order of Revocation is received by the licensee or the licensee's attorney, whichever shall occur first.

The licensee may appeal from this Order, pursuant to KRS 311.593 and 13B.140-.150, by filing a Petition for Judicial Review in Jefferson Circuit Court within thirty (30) days after this Order is mailed or delivered by personal service. Copies of the petition shall be served by the licensee upon the Board and its General Counsel or Assistant General Counsel. The Petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested, along with a copy of this Order.

COMMONWEALTH OF KENTUCKY
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FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDED ORDER

The Kentucky Board of Medical Licensure brought this action against the license of Crystal K. Compton, M.D., charging her with several violations of the statutes governing the practice of medicine. The hearing officer conducted the administrative hearing on October 6 and 7 and November 13, 2020; and on November 22 and 23 and December 3, 2021. Hon. Leanne K. Diakov represented the Board, and Hon. Stephen W. Owens represented Dr. Compton, who also attended the hearing.

After considering the testimony of the witnesses, the exhibits admitted into evidence, and the arguments of counsel, the hearing officer finds Dr. Compton engaged in the misconduct set forth in the *Complaint* in violation of the Board's statutes and regulations, and he recommends the Board take any appropriate action against Dr. Compton's license for those violations. In support of his recommendation the hearing officer submits the following findings of fact, conclusions of law, and recommended order.

FINDINGS OF FACT

1. On September 19, 2019, the Board issued the *Complaint* charging Dr. Compton with violating several standards contained in KRS 311.595 governing the practice of medicine.

2. The Board's allegations against Dr. Compton center on her prescribing practices for controlled substances for sixteen patients that were the subject of a review by a Board consultant, Dr. Neeraj Mahboob. *Complaint*, Paragraphs 5 and 6, pages 2-5.

3. Based upon Dr. Mahboob's findings and opinions regarding Dr. Compton's care and treatment of the sixteen patients, the Board charged Dr. Compton with violating KRS 311.595(9), as illustrated by KRS 311.597(1)(d), (3), and (4), and KRS 311.595(12). *Complaint*, Paragraph 10, page 6.

4. A physician is subject to discipline under KRS 311.595(9), as illustrated by KRS 311.597(1)(d), for knowingly prescribing excessive medications under the accepted and prevailing medical practice standards, and under KRS 311.595(9), as illustrated by KRS 311.597(3) and (4), a physician is subject to discipline for engaging in conduct deemed to be gross incompetence, gross ignorance, gross negligence or malpractice and for failing to conform to the standards of acceptable and prevailing medical practice in Kentucky.

5. Under KRS 311.595(12), a physician is subject to discipline for violating the medical practice act and any valid regulations of the Board, such as 201 KAR 9:260, which contains the professional standards for the prescribing and dispensing of controlled substances.

6. Pursuant to 201 KAR 9:260, a physician is required to follow certain standards for assessing the patient before prescribing controlled substances and for monitoring patients who have been prescribed the long-term use of controlled substances to ensure the medications are not abused or diverted. Exhibit 3.

7. In her written response to the *Complaint* Dr. Compton asserted that all patients' medical conditions justified her prescribing practices, that the prescribed dosages and combinations of medications were appropriate, that there is no evidence of diversion or abuse of medications, and that any patient whom Dr. Compton had reason to know was abusing or diverting medications "was immediately fired as a patient." Letter from Hon. Stephen W. Owens dated October 14, 2019, and received by the Board on October 15, 2019, which has been filed as part of the administrative record as her response to the *Complaint*.

8. Dr. Compton graduated in 2006 from the School of Osteopathic Medicine at Pikeville College in Pikeville, Kentucky, practices in Internal Medicine, and has had an active medical license for over thirteen years. Exhibit 4, marked page 111-112.

9. During the time period at issue in this action, which ranges generally from November 2015 to April 2019, Dr. Compton practiced at the East Kentucky Medical Group and then at her solo practice, The Good Doctor. Id, marked page 115.

10. She is not board certified in Internal Medicine. DVD of first day of the administrative hearing (hereinafter, DVD I), 10:11 a.m. (The video recording of the combined six days of the administrative hearing will be referenced sequentially in this recommendation as DVD I-VI.)

11. In the summer of 2018, Dr. Compton was involved in an automobile accident that caused a serious spinal injury and resulted in her being hospitalized and in a rehabilitation facility for an extended period of time. DVD I, 10:17-10:18 a.m.

12. In the meantime the medical practice in which she had an ownership interest filed for bankruptcy, but the majority of the patients from that practice

transferred to her new practice, The Good Doctor. DVD I, 10:22 and 10:24 a.m.

13. As part of her defense to this action Dr. Compton asserts that the computer server from her former medical practice had been repossessed during the pendency of the bankruptcy proceeding, and as a result, some of the medical records subpoenaed by the Board for the patients at issue may be missing. DVD I, 10:54-10:58 a.m.

14. At the administrative hearing, however, Dr. Compton testified that she turned over to the Board all the records in her possession, and she did not identify any missing records, which she categorized as MRIs and patient referrals, that justified her prescribing practices and would have a significant impact on the opinions of Dr. Mahboob. Id.; Exhibits 22 and 23.

15. Dr. Compton also asserted in her defense over her lack of referrals of her patients to specialists that there's a three-month waiting period for getting patients into pain management clinics or for them to obtain psychiatric or psychological counseling. DVD I, 10:58-11:00 a.m.

16. The hearing officer did not find that any of Dr. Compton's general assertions as to missing medical records called into question any of Dr. Mahboob's findings and opinions regarding the care and treatment provided by Dr. Compton or to the deficiencies he found in her practice of medicine.

17. At the administrative hearing Dr. Compton admitted that she had obtained the required continuing medical education credits for prescribing controlled substances during the time period at issue in this action and that she certified her compliance with

those requirements on her renewal applications for her license to practice medicine. DVD I, 10:32-10:34 a.m.

18. The Board initiated an investigation of Dr. Compton after receipt of the Investigative Report prepared by Ms. Paula York from the Office of Inspector General ("OIG"), Cabinet for Health and Family Services, who found "several patterns of concern" based upon her review of Dr. Compton's KASPER report for the period of January 1, 2017, through February 26, 2019. DVD I, 1:03-1:04 p.m.; Exhibit 26.

19. Ms. York is a registered pharmacist who has worked for the OIG since 1999 to enforce the state and federal drug enforcement acts, and she assists the Board and various state and federal law enforcement officials in their investigations. DVD I, 1:02-1:03 p.m.

20. In her Investigative Report Ms. York found several significant patterns in the prescriptions issued by Dr. Compton to the patients: They were being prescribed the long-term use of one or more controlled substances; the prescriptions were in combinations favored by persons who abuse or divert controlled substances; patients received high doses of opioid prescriptions; and family members were prescribed the same or similar medications. DVD I, 1:03-1:05 p.m.; Exhibit 26.

21. The report identified sixteen of Dr. Compton's patients that the OIG "recommended to be reviewed to determine if Dr. Compton provided appropriate medical care." Exhibit 26, unmarked page 2.

22. The Investigative Report also noted that "while Dr. Compton requested over 2,500 KASPER reports during the reviewed period, she is NOT in compliance with

the requirements of 201 KAR 9:260 relative to the above patients." Exhibit 26, unmarked page 3 (emphasis in original).

23. Ms. York testified at the administrative hearing and explained that she initiated the review of Dr. Compton's prescribing practices after receiving an anonymous complaint regarding her prescribing practices. DVD I, 1:03 p.m.; Exhibit 26, unmarked page 2.

24. In reviewing the KASPER report Ms. York noted that Dr. Compton prescribed patients very large quantities of controlled substances and prescribed to multiple family members, which Ms. York described as a "red flag" if family members are receiving the same or similar controlled substances. DVD I, 1:05 p.m.

25. Ms. York described as "quite alarming" Dr. Compton's pattern of prescribing patients high doses of the same controlled substances and in similar quantities. DVD I, 1:05 p.m.

26. Dr. Compton's prescribing pattern reminded Ms. York of the type of prescribing she had seen by physicians who operated "pill mill type operations." DVD I, 1:06 p.m.

27. Many patients were being prescribed oxycodone 30 mg, which is the highest commercially available dosage of the medication, in combination with benzodiazepines, and some patients were prescribed two different immediate release opioids along with gabapentin, which has been designated a Schedule 5 medication in Kentucky because it has been so widely abused. DVD I, 1:06-1:07 p.m.

28. Upon completing her review, Ms. York referred her findings to the Drug Enforcement Agency for investigation in the fall of 2018, and in March 2019, at the

request of the DEA, she referred the matter to the Board after updating her KASPER review and finding the same prescribing patterns. DVD I, 1:09 and 1:12 p.m.; Exhibit 25.

29. In the KASPER report for Dr. Compton covering the time period January 1, 2017 to February 26, 2019, Ms. York found prescriptions for the long-term use of controlled substances with high doses of opiates and combinations of medications used by abusers and diverters of controlled substances. DVD I, 1:12 p.m.

30. Ms. York found family members of patients at the same address who received the same or similar controlled substances from Dr. Compton. DVD I, 1:13 p.m.

31. While noting that such prescriptions by themselves were not improper, Ms. York stated they represented "red flags," were "concerning," and merited further review. DVD I, 1:35 p.m.

32. The sixteen patients referred to the Board did not represent the total number of patients who received prescriptions that were of concern to Ms. York but were only a representative sampling of Dr. Compton's pattern of prescribing. DVD I, 1:13 p.m.

33. All sixteen patients were regularly prescribed controlled substances over an extended period of time of at least two years and usually on a monthly basis. DVD I, 1:14 p.m.; Exhibit 25.

34. In addition to reviewing Dr. Compton's prescribing practices, Ms. York has access to and was able to review the dates on which Dr. Compton obtained KASPER reports for the sixteen individual patients, which a physician is required to review before initially prescribing a controlled substance and at least every three months thereafter

when prescribing controlled substances over an extended period of time. DVD I, 1:15-1:16 p.m.

35. For each of the sixteen patients, Dr. Compton failed to obtain KASPER reports every three months during the January 1, 2017, through February 26, 2019, time period of her KASPER review. DVD I, 1:18 p.m.

36. For every patient Dr. Compton had gaps in obtaining KASPER reports that ranged from four to sixteen months while the patients were being prescribed monthly doses of controlled substances. DVD I, 1:21-1:31 p.m.

37. There were also instances in which Dr. Compton stated in her progress note that she had reviewed a KASPER report but, in fact, had not. DVD I, 1:19-1:20 p.m.; Exhibit 7, page 54.

38. Ms. York also reviewed the prescribing patterns for the physicians who provided medical care to the sixteen patients after the Board suspended Dr. Compton's medical license in August 2019, and Ms. York did not see any concerns that would merit referral of those physicians to the Board for investigation of their prescribing practices. DVD I, 1:31-1:32 p.m.

39. As with her later response to the *Complaint*, in her May 20, 2019, response to the four specific areas of concern set forth in Ms. York's Investigative Report, Dr. Compton denied any misconduct and asserted that all prescriptions were supported by objective evidence and justified by the patients' medical conditions. Exhibit 22.

40. Dr. Compton did not address the specific assertion in the OIG report regarding her failure to comply with the requirement in 201 KAR 9:260 for KASPER

reviews, other than to assert she "routinely does KASPERS and drug screens." Exhibit 22, first page.

41. The Board's consultant, Dr. Mahboob, has practiced in Kentucky for twenty years, has been registered for twenty-eight years with the Drug Enforcement Agency to prescribe controlled substances, is board certified in Internal Medicine, and has practiced medicine in Manchester, Kentucky, since 2002. Exhibit 27; DVD II, 9:26 a.m.

42. At the administrative hearing, Dr. Mahboob was qualified as an expert in Internal Medicine. DVD II, 9:17 a.m.

43. At the request of the Board Dr. Mahboob reviewed the medical records of the sixteen patients identified in the Investigative Report. DVD II, 9:18 a.m.

44. Dr. Mahboob spent more than forty-five hours reviewing Dr. Compton's medical records for the patients identified in the OIG report, and he submitted a report to the Board dated July 31, 2019, in which he found patterns similar to those found by Ms. York and significant deficiencies in the care provided by Dr. Compton for each of the patients. DVD II, 9:21 a.m.; Exhibits 26 and 28.

45. For all of the patients Dr. Mahboob found Dr. Compton fell "below minimum standards" for diagnosis, treatment, and records, and for each patient his "overall opinion" was that she was "clearly below minimum standards." Exhibit 28.

46. The hearing officer notes that for Patient L, Dr. Mahboob left blank the answer to the question regarding his "overall opinion," but his findings for Patient L were consistent with his overall opinion for the other patients. Exhibit 28, marked page 56

47. Dr. Mahboob found that Patient L's care was clearly below minimum standards since Dr. Compton had prescribed "heavy quantities of narcotics pain pills," failed to address "other medical problems," didn't document a "clear plan," and didn't make a "sincere effort to keep opiates to minimum, time to time UDS [urine drug screens], and if needed referral to pain clinic & mental health counselor." Id., marked page 57.

48. In addition to providing the basis for his opinions regarding the shortcomings in Dr. Compton's care and treatment of each of the sixteen patients, Dr. Mahboob provided a "brief synopsis" of his overall opinions regarding Dr. Compton's medical care. Exhibit 28, page 1.

49. Dr. Mahboob found her prescribing habits "deviat[ed] from Standards of Practice and Constitute risk of opioids and substance abuse disorder, diversion, overdose risk, death and/or disability." Id.

50. He also found that "these patients are being brought back to Practice every month just to prescribe a combination of heavy drugs of Narcotics medicines with early refills and without following appropriate protocols of Narcotics Prescribing and addressing other underlying pathologic processes and diagnoses, including ordering appropriate work up and referring to specialties such as pain clinics, mental health counselors, and physical therapy." Id.

51. Dr. Mahboob concluded his synopsis by stating, "In my opinion, Dr. Compton does pose a threat to the health, safety, and well-being of patients at this time due to her Narcotic Prescribing habit." Id.

52. Shortly after the issuance of Dr. Mahboob's report, Dr. Compton submitted a written response for each patient to Dr. Mahboob's report and his criticism of her care and treatment, and she included MRI reports and other documents for a few patients in support of her position. Exhibit 23, marked pages 77-110.

53. Dr. Compton's response to Dr. Mahboob's report did not include for any patient a direct or detailed challenge to any of his findings or opinions, but instead, she simply provided a brief statement as to her diagnoses, time line for her care, the patient's medications, and allegedly "important subjective and/or objective findings" in support of the care she provided to the sixteen patients. Exhibit 23, pages 79-110.

54. For three patients she submitted imaging studies and other medical records from the time period after the Board subpoenaed her records that she believed Dr. Mahboob had not been able to review but which allegedly supported the care she provided to the patients. DVD I, 11:10-11:13, 11:34-11:36, and 11:52-11:53 a.m.; Exhibit 23, marked pages 88-89 for Patient L; marked pages 95-104 for Patient F; and marked pages 107-110 for Patient A.

55. She did not explain in her response, however, how or why those records called into question any of Dr. Mahboob's findings or opinions about her prescribing practices, although at the administrative hearing Dr. Compton asserted that was why she provided those records as part of her response. DVD I, 11:46-11:49 and 11:52 a.m.

56. Dr. Compton included in her response to Dr. Mahboob's report separate narratives of her care and treatment for four patients: Patients A, F, H, and L. Exhibit 23, marked pages 77-78.

57. Although those four narratives were presumably provided to support an assertion that her prescriptions for controlled substances were appropriate, the narratives did not directly address Dr. Mahboob's findings or challenge any of his findings and conclusions. Id.

58. In addition, for two of the four patients Dr. Compton stated the patients had weaned themselves off narcotics, and for the other two, she reported they were recently seen by a pain management practice. Exhibit 23, marked pages 77-78.

59. It's not clear, however, how those facts call into question Dr. Mahboob's findings or opinions.

60. Dr. Compton also acknowledged that she referred Patient F to The Pain Treatment Center after she received the Board subpoena for her medical records, which is consistent with Dr. Mahboob's opinion regarding the care that should have been provided by Dr. Compton but was not. DVD I, 11:36 a.m.; Exhibit 23, marked page 104.

61. In her response to Dr. Mahboob's report Dr. Compton also provided a copy of a sign she had posted at her medical practice notifying patients that as of August 12, 2019, she would no longer issue prescriptions for controlled substances, that patients would receive their final prescription for pain medications "today," and that patients would be provided "a referral to Pain Management of your choice" or to "any Addiction Rehab Services" or to "Mountain Comp." Exhibit 23, marked page 76.

62. Because of ongoing federal and state investigations of her prescribing practices and based upon her belief that her DEA license would be suspended, Dr. Compton voluntarily "surrendered for cause" on August 29, 2019, her DEA certificate that authorized her to prescribe controlled substances. DVD I, 11:48 a.m.; Exhibit 24.

63. Dr. Mahboob testified at the administrative hearing for over seventeen hours with the vast majority of that time spent providing a detailed review of the care and treatment provided by Dr. Compton and the basis for his opinions on that care for each of the sixteen patients whose medical records he reviewed in this action.

64. In contrast to the detailed review and analysis provided by Dr. Mahboob, Dr. Compton did not call an expert witness to challenge his findings and opinions, and in her own testimony she did not directly address or challenge any of the findings or opinions in his report.

65. Although Dr. Compton's counsel had some questions for Dr. Mahboob at the administrative hearing about the basis for his findings and opinions, none of the examination diminished the credibility of Dr. Mahboob's findings and opinions regarding the deficiencies in the care and treatment provided to the sixteen patients.

66. In his own medical practice Dr. Mahboob treats the same type of patients and the same type of medical conditions that Dr. Compton treated in her practice. DVD II, 9:10-9:12 a.m.

67. He also noted that the standards of acceptable and prevailing medical practice are no different for a person who is a doctor of medicine than for a doctor of osteopathy, and physicians with either degree engage in the same types of clinical practices, compete for admission to the same residency programs, work in the same hospitals, and have the same hospital privileges that he has. DVD II, 9:14-9:15 a.m.

68. Thus, he applied the same standards in the review of Dr. Compton's medical charts as he would in the review of any other physician's medical records. DVD II, 9:16 a.m.

69. In his testimony Dr. Mahboob summarized and reiterated his overall opinion that Dr. Compton engaged in a clear departure from the standards of acceptable and prevailing medical practice by prescribing heavy doses of controlled substances in combination with other controlled substances, such as benzodiazepines, and by providing patients with early refills of the medications, which were clear departures from the standards of medical practice. DVD II, 9:23 and 9:35 a.m.

70. Dr. Mahboob stated further there was no clear justification in the medical records for Patients A through P to support her prescribing practices. DVD II, 9:35 a.m.

71. Such prescribing practices could not only cause cardiovascular depression and death, but they increased the risk of diversion of the medications. DVD II, 9:23-9:24 a.m.

72. Even if such prescribing practices would have been justified for an individual patient on high doses of opiates and benzodiazepines, the standards of acceptable and prevailing medical practice require the physician to have a specialist involved in the patient's care and to undertake increased monitoring of the patient with frequent drug screens, pill counts, review of lab work, and clinical and psychological evaluations of the patient on an ongoing basis. DVD II, 9:25 a.m.

73. The Board's regulation 201 KAR 9:260 contains the standards for the acceptable and prevailing medical practice for the documentation required for the prescribing controlled substances to a patient. DVD II, 9:34 a.m.

74. In addition, the standards of acceptable and prevailing medical practice require a physician to maintain an adequate record of the care and treatment provided to a patient that shall include for every patient encounter a subjective, objective,

assessment, and plan ("SOAP") format for evaluating the patient. DVD II, 9:27-9:30 a.m.

75. The SOAP format provides clear documentation for each patient visit of the care that has been provided and why, which will be available for later review by the physician or another practitioner to ensure the patient receives the best care. DVD II, 9:28-9:29 a.m.

76. Every patient encounter with a medical practice, whether in-person or by telephone, should be documented, even if the patient is just requesting to refill medications, since continuing the same care that was previously provided is an independent medical judgment. DVD II, 9:31-9:32 am.

77. The hearing officer reviewed Dr. Mahboob's findings and opinions for all sixteen patients, and Dr. Mahboob found clear and consistent patterns of misconduct in the care and treatment Dr. Compton provided for all of the patients.

78. Instead, of providing a detailed review of Dr. Mahboob's findings for each patient, the hearing officer will review Dr. Mahboob's findings and opinions for a limited number of patients that will serve as a representative sampling of the types and scope of misconduct that exists in the medical records for all sixteen patients.

79. Dr. Compton saw Patient A on a regular basis from November 24 2015, through April 22, 2019, and the patient received monthly prescriptions for methadone and Xanax for back pain and anxiety. Exhibit 6, pages 1-179; Exhibit 25, pages 472-475.

80. Patient A was a fifty-six year old female, whom Dr. Compton inherited as the patient's primary care physician from another physician in their medical practice. DVD II, 9:53-9:56 a.m.

81. On her initial appointment with Dr. Compton Patient A's chief complaints were a cough, congestion, and shortness of breath for the previous two weeks, which were treated with an antibiotic and a steroid. DVD II, 9:56 a.m.; Exhibit 6, pages 176 and 179.

82. Dr. Compton scheduled no follow-up appointment, and on that date Patient A's current medications included Xanax 2 mg, four times a day; and methadone 10 mg, five tablets every six hours. Exhibit 6, page 176 and 179.

83. On that first visit Dr. Compton's assessment for Patient A included a previous malignant growth on her larynx, a peptic ulcer, nicotine dependence, an unspecified anxiety disorder, COPD, and gastro-esophageal reflux disease. Exhibit 6, page 179.

84. At some point in the past, Patient A had a surgical procedure to implant a spinal stimulator to treat her back pain, but there were no details relating to the procedure in Dr. Compton's medical records. DVD II, 9:53-9:54 a.m.

85. Dr. Mahboob's general concern regarding Dr. Compton's care for Patient A was there was no justification for the heavy doses and combinations of narcotics that Dr. Compton began prescribing for the patient. DVD II, 9:52-9:53 a.m.

86. Dr. Mahboob's general findings regarding the deficiencies in Dr. Compton's medical practice for her patients, such as inadequate patient notes, failure to address other medical conditions, failure to order appropriate tests, and failure to refer patients to a specialist, were also present in her progress notes for Patient A. Exhibit 28, page 1.

87. On her next visit with Dr. Compton two months later, on January 21, 2016, Patient A had complaints of lower back pain for which she received an injection, but no changes to her medications were noted in her medical records. Exhibit 6, pages 170 and 174.

88. Patient A was scheduled for a three-month follow-up. Exhibit 6, page 174.

89. Patient A returned ten days later, however, on February 1, 2016, for a compression fracture of the L1 vertebrae for which she received an injection pending her scheduled appointment with a neurosurgeon, but the medical records do not indicate any changes in her medications. Exhibit 6, pages 164-169.

90. Her list of current medications for that visit, however, showed that her methadone had previously been increased from five to six tablets every six hours, even though that increase had not been included in Dr. Compton's progress note for the previous office visit on January 21, 2016. Id., pages 164 and 170-175.

91. Patient A next saw Dr. Compton on February 11, 2016, for respiratory issues, and there were no complaints of increased pain or an increase in pain medications noted in the progress notes. Id., pages 159-163.

92. Yet, on Patient A's next visit approximately a month later, on March 14, 2016, Patient A's list of current medications included six tablets of methadone 10 mg to be taken every four hours, rather than her previous scheduled every six hours, but again, that increase was not mentioned anywhere in Patient A's plan from the previous office visit. Id., pages 154 and 159-163; DVD II, 10:02-10:05 a.m.

93. Dr. Mahboob explained that Dr. Compton's medical records fell below the standards of acceptable and prevailing medical practice because the SOAP notes "must

have substance" and "detail" that justifies the care provided and the reason for the visit, and by failing to provide that necessary information for Dr. Compton's prescribing rationale and decisions for Patient A, the medical records for Patient A that he reviewed "don't mean anything." DVD II, 10:05 a.m. and 11:12 a.m.

94. Dr. Mahboob also noted that at the same time Dr. Compton was prescribing methadone, she was also prescribing Patient A Xanax, which is a dangerous combination for the patient. DVD II, 10:06 a.m.

95. Two office visits later, on May 23, 2016, Patient A sought treatment for a cough and chest congestion, but she also reported that her methadone and xanax had been stolen from her home. Exhibit 6, page 143.

96. A patient's assertion of having stolen medications is a "red flag" that should put a clinician on alert for possible diversion of medications and requires the physician to perform a baseline review, such as the patient submitting to urine drug screens and pill counts and providing evidence of theft that includes a copy of any police report the patient filed. DVD II, 10:09-10:10 a.m.

97. There was no evidence in Dr. Compton's medical records that she performed such a baseline review. DVD II, 10:10 a.m.

98. Patient A saw Dr. Compton again in June and August 2016 for various complaints, including tooth, back, and elbow pain, and on September 6, 2016, she saw Dr. Compton after a car accident from which she was experiencing low back pain. Exhibit 6, pages 126-142.

99. Patient A reported being depressed about her mother's terminal medical

condition and threatened to kill herself by taking her "stock pile" of pills. Exhibit 6, page 126.

100. In spite of her depression, Patient A assured Dr. Compton that she would never harm herself. Exhibit 6, page 126.

101. With Patient A in an "extremely depressed" state the standards of acceptable and prevailing medical practice required Dr. Compton to have Patient A evaluated by a psychologist or counselor or speak with a mental health help line, especially considering the amount of methadone and xanax she was being prescribed. DVD II, 10:13-10:15 a.m.

102. Dr. Compton never made such a referral for Patient A, but on September 6, 2016, she was to be scheduled for imaging studies of her head and neck. Exhibit 6, page 131.

103. No changes were noted in Patient A's medications on that date, and her urine drug screen was positive for the prescribed methadone and benzodiazepines. Exhibit 6, page 130.

104. Patient A next saw Dr. Compton a month later, on October 4, 2016, for right elbow pain and swelling, but Dr. Compton never followed up on the car accident, the imaging studies, or Patient A's psychiatric issues. DVD II, 10:16-10:17 a.m.; Exhibit 6, pages 131 and 120.

105. Patient A was generally scheduled for three-month follow-ups but was seen more often for acute conditions, and she received monthly refills of methadone and Xanax prescriptions. Exhibit 6, pages 42-119; Exhibit 25, pages 472-475.

106. On October 25, 2017, she saw Dr. Compton to have her Xanax prescription filled six days early since she was out of the medication. Exhibit 6, pages 60-65.

107. Patient A reported having taken her last Xanax the day before and had been to the emergency room with nausea and vomiting where she was reportedly treated for an upper respiratory infection. Exhibit 6, page 60.

108. Dr. Compton refused to refill the prescription early, but she prescribed Patient A 240 tablets of Vistaril 25 mg, which was a large amount of an anti-anxiety medication, with one or two capsules taken every six hours as needed. Exhibit 6, page 64; DVD II, 10:21-10:22 a.m.

109. Dr. Mahboob stated the patient may very well have been going into withdrawal with the vomiting, and she was either overusing or diverting her medications. DVD II, 10:20 a.m.

110. Although Patient A's conduct was a "red flag," and she needed to be referred to a specialist and have her medications adjusted and reduced, Dr. Compton took no action, except to add the Vistaril, and did not adjust the patient's dosage of Xanax. DVD II, 10:21-10:22 a.m.; Exhibit 6, page 64; Exhibit 25, pages 473-475.

111. On the next patient visit on November 16, 2017, Dr. Compton had no follow-up on the nausea and vomiting, the early refill request, or the prescription for Vistaril prescribed in the previous office visit. DVD II, 10:23 a.m.; Exhibit 6, pages 54-59.

112. Several months later, on May 8, 2018, Patient A saw Dr. Compton for low back pain and she requested an early refill of her monthly methadone prescription. Exhibit 6, page 42.

113. Dr. Compton refused, but since the patient would be without her medication for a few days, the situation presented an opportunity to adjust the methadone downward, but that was not done. DVD II, 10:26 a.m.

114. On the next patient visit a month later, on June 8, 2018, for a follow-up on Patient A's low back pain and to have her medications refilled, she also reported experiencing abdominal pain, swelling, and nausea. Exhibit 6, page 36.

115. Dr. Compton wanted to have imaging studies of Patient A's pelvis and abdomen performed and threatened to withhold the patient's controlled substances when the patient balked at the request, but Dr. Mahboob noted that withholding, instead of tapering benzodiazepines, could be life threatening. DVD II, 10:29 a.m.

116. In addition, while proper to order immediate imaging studies, Dr. Mahboob noted that the patient should have been scheduled for an immediate follow-up in the next few days after obtaining the CT scan and lab work rather than the one-month follow-up scheduled by Dr. Compton. DVD II, 10:30-10:31 a.m; Exhibit 6, page 41.

117. During the June 8, 2018, appointment, Dr. Compton did not address the patient's gap in methadone use after running out of the medication in early May or how the patient handled that situation. DVD II, 10:28 a.m.; Exhibit 6, pages 36-41.

118. At her next scheduled visit a month later on July 9, 2018, for a follow-up for her low back pain, Patient A reported her abdominal pain had become worse. Exhibit 6, page 30.

119. Dr. Compton attempted, but was unable, to schedule her an appointment with a specialist, who noted Patient A had cancelled several previous appointments with him, and therefore, Dr. Compton told Patient A to go to the emergency room if the pain

became worse or if other problems arose. Exhibit 6, page 30.

120. Dr. Compton scheduled Patient A for a one-month follow-up exam, and although not noted in the progress note, Patient A received refills on her monthly methadone and Xanax prescriptions. Exhibit 6, pages 30- 35; Exhibit 25, page 474.

121. Even though Dr. Compton's progress note for July 9, 2018, states she reviewed Patient A's KASPER report, that was not correct since she did not perform a KASPER review for the ten-month period between December 28, 2017, and October 17, 2018, while at the same time prescribing the patient large doses of methadone and Xanax. Exhibit 6, page 34; Exhibit 25, pages 473-474; DVD I, 1:23-1:24 p.m.

122. At her one-month follow-up on August 7, 2018, for her low back pain and to have her medications refilled, Patient A also presented with right leg pain and swelling, and Dr. Compton ordered an ultrasound of the right lower leg to rule out a deep vein thrombosis ("DVT"). Exhibit 6, page 24.

123. The progress note for this date shows that Patient A's prescriptions for methadone and Xanax were refilled, and she was scheduled for a urine drug screen. Exhibit 6, page 29.

124. There's no mention in the progress note of the previous issue with abdominal pain, and although the imaging study of the leg was performed that day, no follow-up visit was scheduled to take any appropriate action in response to the ultrasound. Exhibit 6, pages 29 and 428; DVD II, 10:36-10:39 a.m.

125. On the patient's next visit on October 17, 2018, she reported having an endoscopic procedure performed in Lexington, Kentucky, that found two large hernias and some ulcerations in her stomach. Exhibit 6, page 17.

126. Dr. Compton did not address the findings related to the DVT or take any follow-up action for the complaint of leg pain, which wasn't even mentioned in the progress note. Exhibit 6, pages 17-23; DVD II, 10:38-10:39 a.m.

127. On the next visit a month later, on November 15, 2018, Patient A reported "doing okay" but complained of being short of breath and having chest congestion for the past three to four days. Exhibit 6, page 10.

128. Patient A received a steroid injection and her regular refills of the methadone and Xanax prescriptions. Exhibit 6, pages 15-16; DVD II, 10:40 a.m.

129. On Patient A's next visit on January 15, 2019, she reported hurting her upper back after falling, but there was no follow-up to the treatment provided in November for the chest congestion. Exhibit 6, page 7.

130. During the visit, Dr. Compton discussed decreasing Patient A's methadone, and the patient requested a referral to a pain specialist. Exhibit 6, page 8; DVD II, 10:41-10:43 a.m.

131. The KASPER report indicates that Patient A's January 15, 2019, methadone prescription was reduced from 740 10 mg tablets per month to 450. Exhibit 25, page 474.

132. On her next visit three months later, on April 2, 2019, Patient A reported that she had broken her hip, knee, foot, and ankle since her last visit, and she had been weaned off methadone during her hospital admission for those injuries. Exhibit 6, page 4; DVD II, 11:22 a.m.

133. There's nothing in the medical records that provides details or substance for her broken bones and hospitalization or for the various other medical conditions that

had been previously mentioned in Dr. Compton's progress notes. DVD II, 11:14-11-16 a.m.

134. Patient A also reported during the April 2, 2019, appointment that she was to see a neurosurgeon to discuss placement of a pain pump, and Dr. Compton issued a prescription for Xanax but stopped prescribing methadone. Exhibit 6, page 6.

135. Patient A was scheduled for a one-month follow-up but saw Dr. Compton twenty days later and reported that the neurosurgeon "cannot put in a pain pump" because it "would cause more damage than good." Exhibit 6, page 1.

136. There's nothing in Dr. Compton's medical records to confirm the neurosurgeon's decision related to a pain pump, but in addition to the Xanax, Dr. Compton now prescribed Percocet 10/325 mg every six hours and oxycodone 10 mg twice a day, which Dr. Mahboob described as "a heavy dose" of medication. Exhibit 6 page 3; DVD II, 10:47 a.m.

137. Thus, after being weaned off methadone that she had been taking for years, in just a few months Dr. Compton put Patient A back on high doses of narcotics based solely on Patient A's assertion that other planned treatment was no longer an option. DVD II, 10:44-10:47 a.m.

138. Although the progress notes show that on a few occasions Dr. Compton denied requests for early refills, Dr. Mahboob reviewed the KASPER report for Patient A's prescriptions and found numerous instances not mentioned in the progress notes of early refills and large quantities of methadone and Xanax prescribed to Patient A. DVD II, 10:49-10:54; Exhibit 25, pages 472-475.

139. Dr. Mahboob noted that even though Patient A was receiving "huge quantities" of medications, Dr. Compton did not record in the patient's progress notes any rationale or justification for increasing the monthly amounts of medication or for providing early refills. Id.

140. Patient A's medical conditions did not justify the amount of controlled substances she was prescribed. DVD II, 11:30-11:32 a.m.

141. The progress notes indicate Dr. Compton performed only six urine drug screens between May 2016 and August 2019: on May 23, June 17, and September 6, 2016; February 6 and November 17, 2017; May 8 and August 7, 2018, and none in 2019, all of which were positive for benzodiazepines and methadone. Exhibit 6, pages 29 and 147.

142. Given the amount of controlled substances that were prescribed to Patient A, Dr. Compton was required to conduct three to four urine drug screens per year and random pill counts, especially considering the patient's falls and stolen medications. DVD II, 11:33-11:34 a.m.

143. Dr. Compton displayed gross ignorance in her care and treatment of Patient A by prescribing large doses of controlled substances to a patient showing a pattern of addiction and by failing to focus on the treatment of the other medical conditions for which Patient A sought treatment. DVD II, 11:08-11:09 a.m.

144. Dr. Compton also displayed gross ignorance by failing to follow-up with the care previously provided to the patient and by failing to take action in response to "red flags," such as experiencing falls, running out of controlled substances, and having medications stolen. DVD II, 11:09-11:10 a.m.

145. Dr. Mahboob described such failures by Dr. Compton as "alarming," and a physician with Dr. Compton's background and experience for prescribing controlled substances should know such amounts of medications were excessive, and Dr. Compton should have known that with Patient A's pain and psychological issues specialists should have been involved with the patient's care. DVD II, 11:09-11:11 a.m.

146. Patient F was an example of Dr. Compton's pattern of focusing on prescribing controlled substances and ignoring other health conditions extended to a person Dr. Mahboob described as a "very young patient," and her treatment of the patient also constituted gross negligence, gross ignorance, and gross incompetence. DVD III, 11:34 a.m.; Exhibit 28, marked pages 31-34.

147. Patient F first saw Dr. Compton on November 13, 2015, at age twenty-eight. Exhibit 11, page 123; Exhibit 23, marked page 93.

148. Patient F reported having a history of cerebral palsy, but doing "fairly well," and being on a weight loss program initiated by another physician that had resulted in an eighteen pound weight loss. Exhibit 11, page 123.

149. In addition to cerebral palsy, Dr. Compton's assessment of the patient included hypertension, high cholesterol, lower back pain with sciatica, anxiety disorder, tobacco use, fatigue, and other malaise. Id., pages 124-125.

150. Dr. Mahboob noted there were no justifications stated in the medical records for any of the diagnoses, and Dr. Compton apparently accepted whatever the patient told her. DVD III, 11:38 a.m.

151. Patient F also reported a history of depression, but he was taking no medications at the time of the first office visit. Exhibit 11, page 123.

152. Dr. Mahboob found that Patient F, like the other patients in the review, was treated with high doses of controlled substances for pain and anxiety over an extended period of time, and Dr. Compton acted with gross negligence, gross ignorance, and gross incompetence by providing early refills of medications with no drug screens, narcotic contract, or psychiatric referrals, and by failing to add non-opioid modalities. DVD III, 11:32-11:34 a.m.; Exhibit 25, pages 364-368; Exhibit 28, marked page 33.

153. Dr. Compton also prescribed Patient F an "unusually high dose of Adipex for [a] prolonged period" of time and through the course of her treatment failed to address the patient's complaints of 'swelling all over" and on other occasions of rectal bleeding, all of which constituted gross negligence, gross ignorance, and incompetence. Exhibit 28, marked page 33.

154. In spite of the patient being on no medications and stating that he was "doing well," on Patient F's first visit Dr. Compton started him on several medications for pain, depression, and weight loss: ibuprofen, neurontin, Prozac, Adipex, and Norco (hydrocodone). Exhibit 11, pages 123-125.

155. Two months later, on January 11, 2016, Dr. Compton changed Patient F's prescription from Norco 10/325 mg to be taken twice a day to the stronger Percocet 7.5/325 mg four times a day. Exhibit 23, marked page 93.

156. There's no explanation in Dr. Compton's medical records for the change in the medications, and in fact, there was no office visit or patient contact noted for that date. DVD III, 11:41-11:42 a.m. and 11:44-11:46 a.m.; Exhibit 11.

157. On March 25, 2016, the Percocet was increased to 10/325 four times a day, but that change is not mentioned in the progress note for that date. Exhibit 11, pages

110-113; Exhibit 23, marked page 93: DVD III, 11:45-11:46 a.m.

158. Dr. Compton had no follow-up on lab work previously ordered for the patient. DVD III, 11:46 a.m.

159. On May 23, 2018, Patient F was switched from Percocet back to Norco without explanation, and at the next office visit, he was again switched to Percocet because of uncontrolled pain while taking Norco. Exhibit 11, pages 100 and 105.

160. On that same office visit Patient F had a twenty pound weight gain with his blood pressure at 137/82 and a heart rate of 129, but they were not addressed or discussed in light of the fact they could have been caused by the patient's Adipex prescription. Exhibit 11, page 107, DVD III, 11:50-11:51 a.m.

161. Patient F continued to have similar high blood pressure readings and heart rates at later office visits, but neither the blood pressure nor the heart rate issues were addressed or the Adipex adjusted. DVD III 11:54-11:56 a.m.

162. By November 4, 2016, a year after first seeing Dr. Compton, Patient F was on a drug "cocktail" to address his pain and weight gain that included Adipex, two benzodiazepines (Klonopin and Xanax), percocet, and neurontin. Exhibit 11, page 91; DVD III, 11:57-11:58 a.m.

163. Furthermore, there was no effort to try other modalities in place of narcotics for a twenty-nine year old patient or to order tests and radiological studies to understand the source of some of his complaints, such as foot pain. DVD III, 11:59 a.m.-12:04 p.m.

164. Dr. Mahboob noted that instead of addressing Patient F's other ongoing medical issues, such as hypertension, or new issues, such as rectal bleeding, Dr.

Compton's focus was on "pain, pain, and pain" with multiple early refills of his pain medications and no discussion of other modalities, referral to specialists, or ordering additional lab work. DVD III, 12:05-12:10 p.m., 12:13 p.m., 12:21-12:23 p.m.

165. Yet, during this same time period, Dr. Compton had performed only a limited number of urine drug screens and had an eight-month gap in obtaining KASPER reports for the patient. DVD I, 1:26 p.m.; DVD III, 12:32 p.m.; Exhibit 11, page 46.

166. Although Patient F's blood pressure readings on November 4, 2016, were 163/93 and 142/95, and he weighed twenty-four pounds more than when he first saw Dr. Compton a year earlier, she still took no action to address the patient's continuing prescriptions for Adipex or to increase monitoring of his blood pressure, weight, and diet. Exhibit 11, page 93; DVD III, 11:59 a.m.

167. Dr. Mahboob noted that generally there was no plan, train of thought, or any follow-up from one office visit to the next related to non-pain issues, and there was no review of any reports from specialists to whom Patient F had been referred or review of tests that had been ordered. DVD III, 12:28-12:29 p.m.

168. Dr. Mahboob noted that making a patient referral to a specialist by itself is not sufficient, but instead, a physician has a duty to make sure she gets the report from the specialist and reviews it with the patient in order to understand and resolve the medical problem. DVD III, 12:54 p.m. and 12:58-12:59 p.m.

169. In each of Patient F's last four visits with Dr. Compton he had complaints of ongoing, and at times, debilitating depression, and reported on one occasion having run out of medications ten days early, but she did not make a referral for counseling and refilled all his prescriptions for controlled substances. Exhibits 11, pages 1-18.

170. She did refer him to pain management in April 2019, which was more than three years after she first saw him and which was after the Board began investigating Dr. Compton, and she provided the Board with imaging studies that were performed after the time period at issue in this action. Exhibit 11, page 1; Exhibit 23, marked pages 98-103; Exhibits 26 and 30.

171. Dr. Compton failed to display the level of medical knowledge that would be expected from someone in her position by her failure to address Patient F's pain issues and by her failure to address his use of Adipex while having high blood pressure and a high heart rate, and by her failure to address his depression and other health complaints. DVD III, 12:49-12:50 p.m.

172. Dr. Compton displayed gross negligence, gross ignorance, and gross incompetence by failing to have a plan to address the patient's rectal bleeding, by failing to review labs, perform regular urine drug screens, have a narcotic contract or a psychiatric referral, and by failing to use nonopioid modalities. Exhibit 28, marked page 33.

173. Thus, Dr. Compton displayed the same pattern with Patient F that she displayed with Patient A and the other fourteen patients by focusing almost exclusively on prescribing pain medications without addressing or giving equal attention to the patients' other medical complaints and issues that as the patient's primary care physician she was required to address.

174. Patient N was another very young patient who first saw Dr. Compton at age nineteen for pain resulting from a motor vehicle accident nine months earlier, and for a two year period of time Dr. Compton prescribed large quantities of narcotic

medications with early refills while Patient N was also suffering from depression and anxiety. DVD IV, 3:21-3:22 p.m.; Exhibit 19, pages 2, 25, 39; Exhibit 25, pages 22-23; Exhibit 28, marked pages 63-66.

175. Dr. Mahboob stated that as a very young patient with anxiety and depression, Patient N had a high risk of overdosing on Dr. Compton's prescriptions of oxycodone 10 mg, 120 pills per month, that were later increased to oxycodone 30 mg, 180 pills per month. DVD IV, 3:22 p.m.; Exhibit 25, pages 21-22

176. Dr. Compton's focus upon prescribing high doses of narcotic pain medications while ignoring other health issues extended to the care she provided to her own father, Patient K. Exhibit 16, page 3; Exhibit 28, marked pages 51-54.

177. Initially, Patient K had been seen by another physician in the same medical practice as Dr. Compton. DVD IV, 9:10-9:11 a.m.

178. That physician treated Patient K's Type II diabetes that was not well controlled with standard diabetes medications and recommended diet and exercise. DVD IV, 9:11-9:14 a.m.; Exhibit 16, pages 60-68.

179. Dr. Compton first saw her father as a patient on November 24, 2015, when he presented with worsening "right elbow pain that radiates to shoulder" that had been present for the previous six months but was never mentioned or addressed in any previous office visit with the other physician. Exhibit 16, page 53; DVD IV, 9:16 a.m.

180. She provided her father with an trigger point injection and didn't schedule a follow-up examination. Exhibit 16, page 55.

181. Patient K returned approximately two weeks later, on December 11, 2015,

and Dr. Compton began providing medications for the treatment of his diabetes. Exhibit 16, page 50-52.

182. Dr. Compton reported that several weeks later, on January 25, 2016, she started him on Norco 7.5/325 mg three times per day, but there's no progress note for that date or any documentation of a rationale or medical necessity for the medication. DVD IV, 9:20 a.m.; Exhibit 23, marked page 86.

183. While reviewing the care and treatment provided to Patient K, Dr. Mahboob stated that the standard of care for prescribing a controlled substance requires a physician first to obtain a patient history, a good physical exam, x-rays, and MRIs, and to start treatment for the pain with physical therapy, exercises, and non-steroidal medications, after which the physician should reevaluate the condition and possibly refer the patient to an orthopedic surgeon before starting the long-term use of a controlled substances. DVD IV, 9:21-9:22 a.m.

184. There's no evidence Dr. Compton conducted such a review for Patient K.

185. Patient K next saw Dr. Compton for an annual physical on June 3, 2016, which was almost six months after his last appointment, and her progress note makes no mention of the elbow and shoulder pain but lists as one of his current medications Norco 7.5/325, three times per day. Exhibit 16, pages 40-44; DVD IV, 9:23 a.m.

186. Five months later, on November 17, 2016, Dr. Compton changed Patient K's Norco prescription to the stronger Percocet 10/325 mg, every four hours, but there is no progress note or other notation in the patient's medical record that provides any rationale for the change. Exhibit 23, marked page 86; DVD IV, 9:27-9:28 a.m.

187. On October 16, 2017, Dr. Compton added oxycodone 30 mg, every four hours, and on June 14, 2018 she added neurontin 800 mg, four times a day, without recording in Patient K's medical record a progress note with any reason or medical necessity for the medications. Exhibit 23, marked page 86; DVD IV, 9:34 and 9:39 a.m.

188. Dr. Mahboob noted a pattern over the course of Dr. Compton's treatment of Patient K of her ordering tests and lab work without follow-up with the patient and without any clarity in Dr. Compton notes for the treatment of the patient's hypertension and diabetes. DVD IV, 9:31-9:34 and 9:41 a.m.

189. Dr. Compton's progress notes for Patient K were of a "very low quality," "haphazard," and a "gross deviation" from the standard of care due to the lack of a correlation between previous and current visits and between the subjective complaints and the objective findings and due to a lack of thought process in prioritizing the patient's medical problems. DVD IV, 10:00-10:01 a.m.

190. Dr. Mahboob noted that Dr. Compton's progress notes state Patient K has black lung disease, but there were no chest x-rays, history, chief complaint, or treatment related to that condition in the record. Exhibit 16, page 45; DVD IV, 10:01-10:04 a.m.

191. In the last few progress notes, Patient K's back pain took over as his main complaint. DVD IV, 9:44 a.m. Exhibit 16, pages 4-24.

192. By the end of the care provided by Dr. Compton, Dr. Mahboob described Patient K as "an extremely sick patient" who had bilateral pneumonia, wasn't taking his diabetic medications regularly, and refused to get requested x-rays, but who was being prescribed very high doses of pain medications. DVD IV, 9:50-9:52 a.m.

193. In addition, through the course of treatment by Dr. Compton, Patient K was often provided with early refills of his medications with no medical necessity, which was also a gross deviation from the standard of care. DVD IV, 9:55-10:01 a.m.; Exhibit 25, pages 147-148.

194. As another example of the pattern of misconduct, Dr. Mahboob noted that Patient H was also a patient for whom Dr. Compton, before prescribing the long-term use of controlled substances, failed to obtain a patient history, x-rays, and MRIs, or start treatment of pain with physical therapy, exercises, and non-steroidal medications. DVD IV, 8:55-8:57 a.m.; Exhibit 25, pages 100-101; Exhibit 28, marked page 41.

195. Patient C was another example of a patient for whom Dr. Compton failed to address adequately a serious health condition.

196. Patient C was a fifty-six year old patient who reported having been to the emergency room twice in the past six months for syncope, a fainting condition, that was getting worse with each episode, which is a very serious condition that should have been given priority and treated aggressively but which was not adequately addressed by Dr. Compton. DVD II, 2:59-3:01 p.m. and 3:06-3:07 p.m.

197. At one point Patient C reported that she had passed out three times in the past week, but the cardiac evaluation that had been scheduled previously for Patient C was not discussed in Dr. Compton's progress note to understand whether the patient had even been evaluated by a cardiologist. DVD II, 3:11-3:13 p.m.; Exhibit 8, marked page 62.

198. Dr. Compton failed to address adequately the patient's complaints of chest pain in light of his history of blood clots, a low INR of 1.9, and high blood pressure. DVD III, 3:00 p.m.; Exhibit 12, page 1.

199. Dr. Mahboob described Patient G as a "sick patient" with a "life-threatening" condition and stated that it was a deviation from the standard of care for Dr. Compton to schedule the patient for a follow-up appointment in one month instead of having the patient go to the emergency room for treatment. DVD III, 3:00-3:03 p.m., Exhibit 12, page 2.

200. For all of the patients at issue in this action,, Dr. Compton failed to obtain KASPER reports every three months between January 1, 2017, and February 26, 2019, with some patients having gaps of up to fifteen months without a KASPER review, in spite of the fact that she was issuing the patients monthly prescriptions for controlled substances. DVD I, 1:18-1:31 p.m.; Exhibit 25.

201. Dr. Compton did not take issue with the substance of Dr. Mahboob's findings and opinions regarding her care and treatment of individual patients, except to assert that some of her patients had legitimate complaints of pain.

202. At the close of the administrative hearing Dr. Compton's counsel summarized her defense to the Board's allegations with the assertions that her patients had serious medical issues that justified her prescription practices, that she is not a "pill mill doctor," and has referred patients to specialists.

203. Counsel also stated that no evidence had been presented that any patient had been hospitalized or encounters with law enforcement, which are often associated with over-prescribing of controlled substances.

204. In addition, while conceding that Dr. Compton's medical records were not entirely adequate, Dr. Compton's counsel argued the Board should follow Dr. Mahboob's recommendations in his report for her to receive remedial education, training, and monitoring so that Dr. Compton can continue to practice medicine and recover from her financial problems. See Exhibit 28 (for example, marked page 14.)

205. The hearing officer found, however, that the preponderance of the evidence supports the findings and opinions of Dr. Mahboob that the care and treatment provided by Dr. Compton to the sixteen patients at issue in this action fell below the standards of acceptable and prevailing medical practice in Kentucky and constituted gross incompetence, gross ignorance, and gross negligence.

206. As stated earlier in this recommendation, the review of the deficiencies found in the care and treatment for a few of Dr. Compton's patients is not intended as an exhaustive review of all of deficiencies found for the sixteen patients but represents only a sample of the deficiencies that highlight the patterns that were present in her care and treatment of each patient.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over this action pursuant to KRS 311.591 and KRS 311.595.

2. The administrative hearing was conducted in accordance with the provisions of KRS Chapter 13B and KRS 311.591.

3. Under KRS 13B.090(7), the Board had the burden to prove by a preponderance of the evidence the allegations against Dr. Compton.

4. The Board has met its burden to prove Dr. Compton violated KRS 311.595(9), as illustrated by KRS 311.597(1)(d), (3) and (4), and KRS 311.595(12).

5. Under KRS 311.595(9), a physician is subject to discipline if she has "engaged in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public or any member thereof."

6. Pursuant to KRS 311.597(1)(d), the term "dishonorable, unethical, or unprofessional conduct" is defined to include a physician who "prescribes or dispenses any medication in such amounts that the licensee knows or has reason to know, under the attendant circumstances, that the amounts so prescribed or dispensed are excessive under accepted and prevailing medical practice standards."

7. As set forth above as examples of Dr. Compton's misconduct, and as more fully set forth in Dr. Mahboob's report and testimony for all patients, Dr. Compton violated KRS 311.595(9), as illustrated by 311.597(1)(d), by prescribing controlled substances without providing adequate reasoning or support in the medical record either for initially prescribing or for continuing to prescribe controlled substances and by failing to provide justification in the patient's medical record for an increase in the dosage or quantity of medication and by failing to provide any justification or reasoning to support an early refill of a controlled substance.

8. Pursuant to KRS 311.597(4), the term "dishonorable, unethical, or unprofessional conduct" as set forth in KRS 311.595(9) is also defined to include "any departure from, or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky . . . ."

9. Dr. Compton violated KRS 311.595(9), as illustrated by KRS 311.597(4), by failing to have adequate progress notes describing the care and treatment provided to patients and the reasoning behind many decisions she made regarding that care, especially for the prescribing of controlled substances. She violated that standard in her diagnosis and treatment of patients by prescribing high doses and quantities of controlled substances on a regular basis before attempting to treat their pain with non-narcotic medications and other treatment modalities. She violated that standard by prescribing high doses and large quantities of controlled substances without justification and without adjusting the medication or dosage based upon information suggesting addiction or misuse of the medication by the patient. She violated that standard by combining methadone with the long-term use of Xanax and by prescribing Adipex to patients over a long period of time when the medication was not effectively managing the patient's weight and was causing or contributing to other health concerns, such as high blood pressure and high heart rate. Dr. Compton violated that standard in her diagnosis and treatment of the patients by failing to have necessary lab work performed, by failing to require regular urine drug screens, by failing to review with the patient lab work that was performed, and by failing to treat adequately patients' medical conditions and complaints even when they were life-threatening. She also violated that standard by failing to follow-up in her treatment of patients for medical conditions and complaints unrelated to pain while focusing her care mainly on treating patients' pain. She violated that standard by failing to refer patients to psychiatrists, counseling, and pain clinics when patients showed signs of addiction and dependence and the need for such intervention by specialists to control and treat patients' addiction.

10. Dr. Compton violated KRS 311.595(9), as illustrated by KRS 311.597(4), by violating the AMA Code of Medical Ethics Opinion 1.2.1. She treated an immediate family member, her father, for diabetes and pain over a long period of time in circumstances that were not an emergency or an isolated setting and when there was no dispute that other qualified physicians was available to treat him. Exhibits 1 and 2.

11. Pursuant to KRS 311.597(3), the term "dishonorable, unethical, or unprofessional conduct" is defined to include "a serious act, or a pattern of acts committed during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice."

12. The term "gross negligence" has been defined as "a wanton or reckless disregard for the lives, safety or property of other persons." *Horton v. Union Light, Heat & Power Co.*, 690 S.W.2d 382, 389 (Ky. 1985). A personal injury is a necessary component for a finding of gross negligence. *Childers v. Geile*, 367 S.W.3d 578, 580-581 (Ky. 2012).

13. The preponderance of the evidence supports the conclusion that Dr. Compton violated KRS 311.595(9), as illustrated by KRS 311.597(3), by displaying gross incompetence, gross ignorance, and gross negligence in her care and treatment of the patients at issue in this action.

14. Dr. Mahboob's report to the Board, Exhibit 28, catalogs the numerous instances in which Dr. Compton failed to have adequate progress notes, over prescribed controlled substances, gave early refills, ignored signs of addiction, ignored other serious medical conditions, and failed to refer patients to specialists, all of which was to

the detriment to the health of the patients and in a few instances placed their lives in jeopardy. The fact that these deficiencies were found in all of the patients at issue in this action and considering Dr. Compton's years of experience as a physician and the knowledge she should have through her education and work, her misconduct was beyond simple or isolated instances of incompetence, ignorance, or negligence.

15. Under KRS 311.595(12), a physician is subject to discipline if she has violated or attempted to violate "any other valid regulation of the board." Pursuant to Section 10 of 201 KAR 9:260, a violation of the regulation shall constitute a violation of KRS 311:595(9) and (12). Dr. Compton violated 201 KAR 9:260, Section (5)(2)(i)(1) and Section (9)(3)(b)(1) by failing to obtain KASPER reports every three months for the patients who were issued monthly prescriptions for the long-term use of controlled substances for the treatment of pain. She violated 201 KAR 9:260, Section (5)(2)(k), by failing to require frequent urine drug screens and random pill counts on patients who were prescribed high doses of controlled substances. Dr. Compton violated 201 KAR 9:260, Sections 5, 7, and 9 generally by failing to maintain adequate oversight of the prescribing of controlled substances for her patients to ensure they were being taken appropriately and by failing to taper or discontinue medications and to refer patients to specialists when her prescribing practices were not effectively treating the patients' medical conditions. Therefore, Dr. Compton was subject to discipline under KRS 311.595(9) and (12) by her violations of 201 KAR 9:260.

RECOMMENDED ORDER

Based upon the foregoing findings of fact and conclusions of law, the hearing officer recommends the Board find Dr. Crystal K. Compton guilty of violating KRS

311.595(9), as illustrated by KRS 311.597(1)(d), (3) and (4), and KRS 311.595(12) and take any appropriate action against her license for the misconduct.

NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13B.110(4) a party has the right to file exceptions to this recommended decision:

> A copy of the hearing officer's recommended order shall also be sent to each party in the hearing and each party shall have fifteen (15) days from the date the recommended order is mailed within which to file exceptions to the recommendations with the agency head.

A party also has a right to appeal the Final Order of the agency pursuant to KRS 13B.140(1) which states:

> All final orders of an agency shall be subject to judicial review in accordance with the provisions of this chapter. A party shall institute an appeal by filing a petition in the Circuit Court of venue, as provided in the agency's enabling statutes, within thirty (30) days after the final order of the agency is mailed or delivered by personal service. If venue for appeal is not stated in the enabling statutes, a party may appeal to Franklin Circuit Court or the Circuit Court of the county in which the appealing party resides or operates a place of business. Copies of the petition shall be served by the petitioner upon the agency and all parties of record. The petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested. The petition shall be accompanied by a copy of the final order.

Pursuant to KRS 23A.010(4), "Such review [by the circuit court] shall not constitute an appeal but an original action." Some courts have interpreted this language to mean that summons must be served upon filing an appeal in circuit court.

SO RECOMMENDED this 2nd day of March, 2022.

THOMAS J. HELLMANN
HEARING OFFICER
810 HICKMAN HILL RD
FRANKFORT KY 40601
(502) 330-7338
thellmann@mac.com

CERTIFICATE OF SERVICE

I hereby certify that the original of this RECOMMENDATION was mailed this 22nd day of March, 2022, by first-class mail, postage prepaid, to:

JILL LUN
KY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK STE 1B
310 WHITTINGTON PKWY
LOUISVILLE KY 40222

for filing; and a true copy was sent by first-class mail, postage prepaid, to:

LEANNE K DIAKOV
GENERAL COUNSEL
KY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK STE 1B
310 WHITTINGTON PKWY
LOUISVILLE KY 40222

STEPHEN W OWENS ESQ
PO BOX 1426
PIKEVILLE KY 41501

THOMAS J. HEILMANN

1938FC

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1938

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY CRYSTAL K. COMPTON, D.O., LICENSE NO. 03120, 1349 LEFT FORK ISLAND CREEK, PIKEVILLE, KENTUCKY 41501

COMPLAINT

Comes now the Complainant, Chair of the Kentucky Board of Medical Licensure's Inquiry Panel B, and on behalf of the Panel which met on September 19, 2019, states for its Complaint against the licensee, Crystal K. Compton, D.O., as follows:

1. At all relevant times, Crystal K. Compton, D.O. ("the licensee"), was licensed by the Board to practice osteopathy in the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is internal medicine.
3. On or about August 6, 2018, the Cabinet for Health and Family Services, Office of Inspector General ("OIG"), received an anonymous complaint relaying concerns regarding the licensee's prescribing of controlled substances. According to OIG, the caller advised that the licensee was issuing prescriptions for controlled substances in quantities and combinations which may not be appropriate.
4. On or around March 4, 2019, OIG Investigator, Paula York, R. Ph., reviewed and analyzed the licensee's KASPER records (for the period of January 1, 2017 through February 26, 2019) and noted several patterns of concern, including:

    - Long-term use of one or more controlled substances;
    - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
    - Prescribing opiates in high doses; and
    - Family members obtaining the same or similar medications

    Ms. York identified sixteen (16) patients illustrative of these concerns and recommended further review to determine if the licensee rendered appropriate medical

care. Ms. York also stated that although the licensee had requested over 2500 KASPER reports on patients during the reviewed period, she was not in compliance with 201 KAR 9:260 KASPER requirements relative to the sixteen (16) identified patients.

5. In or around July 2019, a Board consultant completed review of the sixteen (16) patient charts and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices within the Commonwealth of Kentucky; prescribed controlled substances to an immediate family member; prescribed medications in such amounts that the licensee knew or should have known, under the attendant circumstances, to be excessive under acceptable and prevailing medical practice standards; and demonstrated gross ignorance, gross incompetence or gross negligence. Overall, the Board Consultant stated

> After reviewing multiple patient charts on Dr. Compton, I have found an evidence of Physician Prescribing habits deviating from Standards of Practice and Constitute risk of opioids and substance abuse disorder, diversion, overdose risk, death and/or disability. I have found that these patients are being brought back to Practice every month just to prescribe a combination of heavy drugs of Narcotics medicines with early refills and without following appropriate protocols of Narcotics Prescribing and addressing other underlying pathologic processes and diagnoses, including ordering appropriate work up and referring to specialties such as pain clinics, mental health counselors, and physical therapy.
>
> In my opinion, Dr. Compton does pose a threat to the health, safety and wellbeing of patients at this time due to her Narcotic Prescribing habit.

6. In each patient chart, the Board Consultant found that the licensee fell below minimum practice standards concerning diagnoses, treatment, records keeping and overall. Specific to each patient, the Board Consultant noted the following

Patient A	This physician prescribing habits for controlled substances pose and constitute gross negligence/ignorance – patient being prescribed heavy doses of Xanax with early refills and being mixed with methadone. No referral to psychiatrist and counselor. … [I]t appears patient behavior of addiction being reinforced by heavy prescription of controlled substances.

Patient B	Essentially patient being given multiple pain meds, including early refills. Also Adipex being given on long term basis despite the fact on occasions his blood pressure was suboptimal…. Anybody with chronic pain and underlying depression with history of alcohol use should be evaluated by mental health provider and patients who would require heavy doses of pain medications at least need to have been referred to pain clinic. I didn't see any narcotic contract and opioid risk tool.
Patient C	Pain meds in quantity being given outweigh the benefits and pose risk for opioid dependence and overdose/death. Also Percocets and Gabapentin being filled early. … I didn't see any routine labs. This patient also seems behind in her HED1S measures. Also there's a mass in right lung that's not being mentioned in recent notes and no referral to pulmonologist for that either in the past.
Patient D	Again, there's a pattern of heavy doses of controlled medicines as well as combinations of controlled like Oxycodone, Methadone, Klonopin, Soma, Ambien seen. This could very easily cause overdose and death. Also leading to chronic opioid dependence and addiction problems. Patient has on multiple occasions high blood pressure readings without being addressed/counseled. NO mention of patient referral [to specialists]… No labs or urine drug screens seen. No narcotic contract. Patient just begin handed over combination of controlled medicine, leading to vicious cycle of dependence/tolerance and addiction.
Patient E	Only back pain and anxiety being addressed by giving heavy doses of pain pills, benzodiazepines and Gabapentin. No mention of pain meds tapered down and utilizing nonopioids. No physical therapy, no mental health provider referral. No urine drug screen, no narcotic contract seen. Patient has history of hypertension and hyperlipidemia. No mention of control or medicine being given for that purpose. On many occasions blood pressure found to be elevated and no meaningful action taken. Only pain pills being refilled along with Klonopin and also noted to have early refills without keeping track when the controlled meds are due.
Patient F	Patient being treated primarily for back/ankle/foot pain/anxiety with mega doses of opioids, benzodiazpines and unusually high dose of Adipex for prolonged period. This patient at one point on August 23, 2017 complained of swelling all over and physician failed to even address the issue and just refilled the pain pills and Xanax. Also found a pattern fo early refills without any tracking/pill count. At one point, February 7, 2017, patient complained of rectal bleeding too but no plan for follow up on rectal bleeding seen. Again, no routine labs, urine drug screens, narcotic contract, psych referrals, etc. No effort to add nonopioid

	modalities. All this constituted gross negligence/ignorance and incompetence.
Patient G	Just an example, patient seen April 9, 2019, BP 150/100, complained of chest pain, no stat labs or EKG done. Patient given 1 month follow up instead and narcotics refilled. Again, April 24, 2017, BP 169/114, no mention of BP control. Examples like these showing provider showing pattern of ignorance and negligence and merely bringing patient back to reinforce his habit of opioid/benzos dependence.
Patient H	Pattern of prescribing heavy doses of narcotics pain pills and Adipex constitute negligence/ignorance/incompetence. Patient with no clear cut indication for above meds being brought in regularly just to be given those meds. No referral for physical therapy, counseling. No effort on part of provider to taper off the pain meds using nonopioid modalities in this young patient. This pattern increases incidence of substance use disorder.
Patient I	Just being brought every month and given pain pills and benzodiazepines in heavy doses. Also noticed early refills. NO attention to other problems. On few occasions, blood pressure noticed high, no counseling provided or any plan to address. Only thing is opioids and benzos being refilled.
Patient J	Physician showing pattern of ignorance, negligence and incompetence by not addressing all other medical problems but only pain by giving heavy doses and quantities of opioids along with benzos, putting patient at risk of overdose/death. No evidence of any labs, UDS, imaging studies, physical therapy, counseling. No sincere effort of keeping pain pills to minimum along with taking patient off the benzos.
Patient K	Provider prescribing heavy doses of narcotics with early refills noted too. Also noted this patient to be provider (immediate) family member. No other medical problems being addressed appropriately. Just an example, COPD/CWP – no evidence of nebulizers and inhalers seen when patient's meds reviewed.
Patient L	Provider giving heavy quantities of narcotic pain pills. I couldn't see any narcotic contract, urine drug screen. Other medical problems not being addressed, e.g., July 27, 2018 – seen for pneumonia and bronchitis, no follow up visit; June 20, 2018, seen for dehydration/passing out, no labs/EKG done (fluids given and advised to follow up prn).
Patient M	No labs/recent imaging studies. Past CT chest on June 8, 2016 showing right middle lobe nodule, no mention in the patient notes

	and/or follow up CT chest done. Only pain being addressed with narcotic pain pills. Also heavy doses of long term Adipex noted. Also noted patient being given early refills. … No narcotic contract, no urine drug screens.
Patient N	Young patient being given heavy doses of opioids with early refills causing an addiction pattern. No evidence of any physical therapy, rpt imaging of back. No sincere effort to taper off opioids and using nonopioid modalities too. No evaluation by mental health counselor. I have not seen any evidence of urine drug screens either.
Patient O	This provider giving heavy doses of opioids with early refills without any clear cut goal of tapering and using nonopioid modalities. This pattern of prescribing case patients to become opioid addicted. No referral to pain clinic or mental health counselor. No UDS/narcotic contract noted in the chart. I didn't see any labs either.
Patient P	Provider is treating pain and anxiety with combination of heavy opioids and benzodiazepines. Early refills, no labs, UDS. No effort to use nonopioids/PT. No referral to mental health provider and/or pain clinic. Her narcotic prescribing habits deviate from standards of practice and cause opioid use disorder. Patient has other medical conditions, like DM, HTN and hyperlipidemia, not being addressed. No recent A1C, lipid panel seen in the chart. All focus on pain meds and Xanax.

The Board Consultant's report, including review worksheets, is adopted and incorporated herewith in its entirety by reference.

7. On or about August 16, 2019, the licensee provided a written response to the Board Consultant's report through counsel, which included a copy of a notice purportedly placed in her office stating in part

> As of Monday, August 12th, 2019, Dr. Compton will no longer be writing any controlled narcotics. You will receive a final prescription for your pain medications today and a referral to pain management of your choice. … We can also refer you to any addiction rehab services if you feel they would be more beneficial to you. … If you are on any nerve medications, you will receive a final taper prescription today and a referral to Mountain Comp. …[or] to any psychiatrist of your choice. …

In addition, the licensee indicated that she had since referred Patients H, F and A to pain management and that Patient L had not been prescribed to since December 2018.

8. The Board Consultant reviewed the licensee's response and stated that the information in the licensee's response did not change his original report.

9. On or about August 23, 2019, an Emergency Order of Suspension was issued against the licensee's license to practice osteopathy in the Commonwealth of Kentucky.

10. By her conduct, the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(1)(d), (3) and (4), and KRS 311.595(12). Accordingly, legal grounds exist for disciplinary action against her license to practice osteopathy in the Commonwealth of Kentucky.

11. The licensee is directed to respond to the allegations delineated in the Complaint within thirty (30) days of service thereof and is further given notice that:

    (a) Her failure to respond may be taken as an admission of the charges;

    (b) She may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in her defense.

12. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for March 10 & 11, 2020, at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure and pursuant to KRS Chapter 13B. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice osteopathy in the Commonwealth of Kentucky held by Crystal K. Compton, D.O.

This 19th day of September, 2019.

CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Theresa Gargan, Docket Clerk, Administrative Hearings Branch, Office of the Attorney General, 1024 Capital Center Drive, Frankfort, Kentucky 40601 and copies were mailed via certified mail return-receipt requested to the licensee, Crystal K. Compton, D.O., License No. 03120, 1349 Left Fork Island Creek, Pikeville, Kentucky 41501, and to her counsel, Stephen W. Owens, Esq., P.O. Box 1426, Pikeville, Kentucky 41501 on this 19th day of September, 2019.

Leanne K. Diakov
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1938

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY CRYSTAL K. COMPTON, D.O., LICENSE NO. 03120, 1349 LEFT FORK ISLAND CREEK, PIKEVILLE, KENTUCKY 41501

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure ("the Board"), acting by and through the Chair of its Inquiry Panel B, considered a memorandum by Billy Madden, Medical Investigator, dated August 22, 2019; an Investigative Report from the Cabinet for Health and Family Services, Office of Inspector General, written by Paula York, R. Ph., dated March 4, 2019; correspondence from Stephen W. Owens, Esq., on behalf of the licensee, dated May 20, 2019; a Board Consultant Report (and Expert Review Worksheets), dated July 31, 2019; and correspondence from Stephen W. Owens, Esq., on behalf of the licensee, dated August 16, 2019.

Having considered this information and being sufficiently advised, the Chair of Inquiry Panel B ENTERS the following EMERGENCY ORDER OF SUSPENSION, in accordance with KRS 311.592(1) and 13B.125(1):

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available to her, the Chair of Inquiry Panel B concludes there is probable cause to make the following Findings of Fact, which support this Emergency Order of Suspension:

1. At all relevant times, Crystal K. Compton, D.O. ("the licensee"), was licensed by the Board to practice osteopathy in the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is internal medicine.

3. On or about August 6, 2018, the Cabinet for Health and Family Services, Office of Inspector General ("OIG"), received an anonymous complaint relaying concerns regarding the licensee's prescribing of controlled substances. According to OIG, the caller advised that the licensee was issuing prescriptions for controlled substances in quantities and combinations which may not be appropriate.

4. On or around March 4, 2019, OIG Investigator, Paula York, R. Ph., reviewed and analyzed the licensee's KASPER records (for the period of January 1, 2017 through February 26, 2019) and noted several patterns of concern, including:

    - Long-term use of one or more controlled substances;
    - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
    - Prescribing opiates in high doses; and
    - Family members obtaining the same or similar medications

    Ms. York identified sixteen (16) patients illustrative of these concerns and recommended further review to determine if the licensee rendered appropriate medical care. Ms. York also stated that although the licensee had requested over 2500 KASPER reports on patients during the reviewed period, she was not in compliance with 201 KAR 9:260 KASPER requirements relative to the sixteen (16) identified patients.

5. In or around July 2019, a Board consultant completed review of the sixteen (16) patient charts and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices within the Commonwealth of Kentucky; prescribed controlled substances to an immediate family member; prescribed medications in such amounts that the licensee knew or should have known, under the attendant circumstances, to be excessive under acceptable and prevailing medical practice standards; and demonstrated gross ignorance, gross incompetence or gross negligence. Overall, the Board Consultant stated

After reviewing multiple patient charts on Dr. Compton, I have found an evidence of Physician Prescribing habits deviating from Standards of Practice and Constitute risk of opioids and substance abuse disorder, diversion, overdose risk, death and/or disability. I have found that these patients are being brought back to Practice every month just to prescribe a combination of heavy drugs of Narcotics medicines with early refills and without following appropriate protocols of Narcotics Prescribing and addressing other underlying pathologic processes and diagnoses, including ordering appropriate work up and referring to specialties such as pain clinics, mental health counselors, and physical therapy.

In my opinion, Dr. Compton does pose a threat to the health, safety and wellbeing of patients at this time due to her Narcotic Prescribing habit.

6. In each patient chart, the Board Consultant found that the licensee fell below minimum practice standards concerning diagnoses, treatment, records keeping and overall. Specific to each patient, the Board Consultant noted the following

Patient A	This physician prescribing habits for controlled substances pose and constitute gross negligence/ignorance – patient being prescribed heavy doses of Xanax with early refills and being mixed with methadone. No referral to psychiatrist and counselor. … [I]t appears patient behavior of addiction being reinforced by heavy prescription of controlled substances.
Patient B	Essentially patient being given multiple pain meds, including early refills. Also Adipex being given on long term basis despite the fact on occasions his blood pressure was suboptimal…. Anybody with chronic pain and underlying depression with history of alcohol use should be evaluated by mental health provider and patients who would require heavy doses of pain medications at least need to have been referred to pain clinic. I didn't see any narcotic contract and opioid risk tool.
Patient C	Pain meds in quantity being given outweigh the benefits and pose risk for opioid dependence and overdose/death. Also Percocets and Gabapentin being filled early. … I didn't see any routine labs. This patient also seems behind in her HED1S measures. Also there's a mass in right lung that's not being mentioned in recent notes and no referral to pulmonologist for that either in the past.
Patient D	Again, there's a pattern of heavy doses of controlled medicines as well as combinations of controlled like Oxycodone, Methadone, Klonopin, Soma, Ambien seen. This could very easily cause overdose and death. Also leading to chronic opioid dependence and addiction problems. Patient has on multiple occasions high blood pressure readings without being addressed/counseled. NO

	mention of patient referral [to specialists]… No labs or urine drug screens seen. No narcotic contract. Patient just begin handed over combination of controlled medicine, leading to vicious cycle of dependence/tolerance and addiction.
Patient E	Only back pain and anxiety being addressed by giving heavy doses of pain pills, benzodiazepines and Gabapentin. No mention of pain meds tapered down and utilizing nonopioids. No physical therapy, no mental health provider referral. No urine drug screen, no narcotic contract seen. Patient has history of hypertension and hyperlipidemia. No mention of control or medicine being given for that purpose. On many occasions blood pressure found to be elevated and no meaningful action taken. Only pain pills being refilled along with Klonopin and also noted to have early refills without keeping track when the controlled meds are due.
Patient F	Patient being treated primarily for back/ankle/foot pain/anxiety with mega doses of opioids, benzodiazpines and unusually high dose of Adipex for prolonged period. This patient at one point on August 23, 2017 complained of swelling all over and physician failed to even address the issue and just refilled the pain pills and Xanax. Also found a pattern fo early refills without any tracking/pill count. At one point, February 7, 2017, patient complained of rectal bleeding too but no plan for follow up on rectal bleeding seen. Again, no routine labs, urine drug screens, narcotic contract, psych referrals, etc. No effort to add nonopioid modalities. All this consituted gross negligence/ignorance and incompetence.
Patient G	Just an example, patient seen April 9, 2019, BP 150/100, complained of chest pain, no stat labs or EKG done. Patient given 1 month follow up instead and narcotics refilled. Again, April 24, 2017, BP 169/114, no mention of BP control. Examples like these showing provider showing pattern of ignorance and negligence and merely bringing patient back to reinforce his habit of opioid/benzos dependence.
Patient H	Pattern of prescribing heavy doses of narcotics pain pills and Adipex constitute negligence/ignorance/incompetence. Patient with no clear cut indication for above meds being brought in regularly just to be given those meds. No referral for physical therapy, counseling. No effort on part of provider to taper off the pain meds using nonopioid modalities in this young patient. This pattern increases incidence of substance use disorder.
Patient I	Just being brought every month and given pain pills and benzodiazepines in heavy doses. Also noticed early refills. NO attention to other problems. On few occasions, blood pressure

	noticed high, no counseling provided or any plan to address. Only thing is opioids and benzos being refilled.
Patient J	Physician showing pattern of ignorance, negligence and incompetence by not addressing all other medical problems but only pain by giving heavy doses and quantities of opioids along with benzos, putting patient at risk of overdose/death. No evidence of any labs, UDS, imaging studies, physical therapy, counseling. No sincere effort of keeping pain pills to minimum along with taking patient off the benzos.
Patient K	Provider prescribing heavy doses of narcotics with early refills noted too. Also noted this patient to be provider (immediate) family member. No other medical problems being addressed appropriately. Just an example, COPD/CWP – no evidence of nebulizers and inhalers seen when patient's meds reviewed.
Patient L	Provider giving heavy quantities of narcotic pain pills. I couldn't see any narcotic contract, urine drug screen. Other medical problems not being addressed, e.g., July 27, 2018 – seen for pneumonia and bronchitis, no follow up visit; June 20, 2018, seen for dehydration/passing out, no labs/EKG done (fluids given and advised to follow up prn).
Patient M	No labs/recent imaging studies. Past CT chest on June 8, 2016 showing right middle lobe nodule, no mention in the patient notes and/or follow up CT chest done. Only pain being addressed with narcotic pain pills. Also heavy doses of long term Adipex noted. Also noted patient being given early refills. … No narcotic contract, no urine drug screens.
Patient N	Young patient being given heavy doses of opioids with early refills causing an addiction pattern. No evidence of any physical therapy, rpt imaging of back. No sincere effort to taper off opioids and using nonopioid modalities too. No evaluation by mental health counselor. I have not seen any evidence of urine drug screens either.
Patient O	This provider giving heavy doses of opioids with early refills without any clear cut goal of tapering and using nonopioid modalities. This pattern of prescribing case patients to become opioid addicted. No referral to pain clinic or mental health counselor. No UDS/narcotic contract noted in the chart. I didn't see any labs either.
Patient P	Provider is treating pain and anxiety with combination of heavy opioids and benzodiazepines. Early refills, no labs, UDS. No effort to use nonopioids/PT. No referral to mental health provider and/or

	pain clinic. Her narcotic prescribing habits deviate from standards of practice and cause opioid use disorder. Patient has other medical conditions, like DM, HTN and hyperlipidemia, not being addressed. No recent A1C, lipid panel seen in the chart. All focus on pain meds and Xanax.

The Board Consultant's report, including review worksheets, is adopted and incorporated herewith in its entirety by reference.

7. On or about August 16, 2019, the licensee provided a written response to the Board Consultant's report through counsel, which included a copy of a notice purportedly placed in her office stating in part

> As of Monday, August 12th, 2019, Dr. Compton will no longer be writing any controlled narcotics. You will receive a final prescription for your pain medications today and a referral to pain management of your choice. … We can also refer you to any addiction rehab services if you feel they would be more beneficial to you. … If you are on any nerve medications, you will receive a final taper prescription today and a referral to Mountain Comp. …[or] to any psychiatrist of your choice. …

In addition, the licensee indicated that she had since referred Patients H, F and A to pain management and that Patient L had not been prescribed to since December 2018.

8. The Board Consultant reviewed the licensee's response and stated that the information in the licensee's response did not change his original report.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to her, the Chair of Inquiry Panel B finds there is probable cause to support the following Conclusions of Law, which serve as the legal bases for this Emergency Order of Suspension:

1. The licensee's Kentucky osteopathic license is subject to regulation and discipline by this Board.

2. KRS 311.592(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician's license at any time an inquiry panel has probable cause to believe that a physician's practice constitutes a danger to the health, welfare and safety of patients or the general public.

3. There is probable cause to believe that the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(1)(d), (3) and (4), and KRS 311.595(12).

4. 201 KAR 9:240 §1 provides,

   (1) An inquiry panel or the panel's chair, acting on behalf of the inquiry panel, may issue an emergency order restricting or suspending a physician's license to practice medicine or osteopathy within the Commonwealth of Kentucky in accordance with KRS 311.592 and 13B.125.
   (2) ...
   (3) (a) An inquiry panel's chair may act on behalf of the inquiry panel and issue an emergency order restricting or suspending a physician's license to practice medicine or osteopathy within the Commonwealth of Kentucky if the panel chair determines that a basis for an emergency order as established in subsection (1) of this section exists and the circumstances of the specific case warrant emergency action prior to the next regularly scheduled meeting of the inquiry panel.

5. The Inquiry Panel Chair concludes there is probable cause to believe this licensee's practice constitutes a danger to the health, welfare and safety of her patients or the general public.

6. The Board may draw logical and reasonable inferences about a licensee's practice by considering certain facts about a licensee's practice. If there is proof that a licensee has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the licensee will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a licensee's practice presents representative proof of the nature of that licensee's practice in general. Accordingly, probable cause to believe that the licensee has committed certain violations in the recent past presents probable

cause to believe that the licensee will commit similar violations in the near future, during the course of the licensee's osteopathic practice.

7. The United States Supreme Court has ruled that it is no violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and, 2) the statute provides for a prompt post-deprivation hearing. Barry v. Barchi, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); FDIC v. Mallen, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and Gilbert v. Homar, 520 U.S. 924 (1997), 117 S.Ct. 1807 (1997). Cf. KRS 13B.125(1).

KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by the licensee. The licensee has been advised of her right to a prompt post-deprivation hearing under this statute.

EMERGENCY ORDER OF SUSPENSION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Chair of Inquiry Panel B hereby ORDERS that the license to practice osteopathy in the Commonwealth of Kentucky held by Crystal K. Compton, D.O., is SUSPENDED and Dr. Compton is prohibited from performing any act which constitutes the "practice of medicine or osteopathy," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – until the resolution of the Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

The Chair of Inquiry Panel B further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee.

SO ORDERED this 23rd day of August, 2019.

SANDRA R. SHUFFETT, M.D.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Suspension was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and copies were mailed via certified mail return-receipt requested to the licensee, Crystal K. Compton, D.O., License No. 03120, 1349 Left Fork Island Creek, Pikeville, Kentucky 41501, and to her counsel, Stephen W. Owens, Esq., P.O. Box 1426, Pikeville, Kentucky 41501 on this 23rd day of August, 2019.

Leanne K. Diakov
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Kentucky Board of Medical Licensure
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