COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1458

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY ROY D. REYNOLDS, M.D., LICENSE NO. 19383, 121 MEMORIAL DRIVE, FRANKLIN, KENTUCKY 42134

AGREED ORDER OF SURRENDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel B, and Roy D. Reynolds, M.D., ("the licensee"), and, based upon their mutual desire to fully and finally resolve the grievance without an evidentiary hearing, hereby ENTER INTO the following **AGREED ORDER OF SURRENDER:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order of Surrender:

1. At all relevant times, Roy D. Reynolds, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is family medicine.
3. On or about April 30, 2012, the Board received a grievance which alleged that the licensee inappropriately prescribed controlled substances to a patient in a manner which resulted in the patient's overdose death.
4. The Simpson County Sheriff advised the Board that his office had recently been involved in two (2) other overdose death investigations and one (1) suicide investigation of persons who had been the licensee's patients. In addition, the Sheriff indicated that a significant amount of diverted drugs in the community originated from prescriptions written by the licensee.

5. The Simpson County Coroner advised the Board that, over the course of the previous eighteen (18) months, he had investigated three (3) overdose deaths and one (1) suicide death of the licensee's patients.

6. Based on concerns of several possible overdoses by the licensee's patients, the Kentucky State Police and the Board requested that the Office of Inspector General (OIG), Division of Audits and Investigations, conduct a KASPER analysis of the licensee's prescribing patterns.

7. On or around June 26, 2012, OIG Investigator, Duncan McCracken, R.Ph., reviewed and analyzed the licensee's KASPER records (for the period of June 11, 2010 through June 10, 2012) and identified twenty-two (22) of the licensee's patients based upon the prescribing of addictive drug combinations, use of multiple pharmacies, early issuance and early refills of prescriptions, and similar last names among patients. Mr. McCracken forwarded the patient names to the Board for further investigation.

8. In or around October 2012, a Board consultant reviewed the licensee's patient charts for the patients identified in the course of the investigation, the licensee's KASPER report, patient death summaries, and narrative summaries of patient care provided by the licensee during the course of the investigation, and the Board consultant concluded that the licensee departed from or failed to conform to acceptable and prevailing medical practices; and that he committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross negligence, as well as instances of gross ignorance, gross incompetence and malpractice.

Specifically, the consultant noted the following regarding quality issues:

(1) Poor charting: recordkeeping is disorganized, penmanship poor, inconsistent use of medication lists; papers in the chart are not attached to the covers.
(2) Care of chronic conditions is inadequate. For example, Hemoglobin a1c'S are sometimes ordered too frequently, and care of diabetes is limited to addressing blood sugars, while neglecting foot exams, microalbulim assessment, retinopathy screens, LDL determinations, and immunizations ([Patient A and Patient B]). High blood pressures are frequently not addressed.
(3) Some medications are prescribed inappropriately.
    a. [Patient C] was treated with digoxin for CHF, though the records do not support that diagnosis.
    b. Clitalopram was added to a patient's medications when she was on Abilify and had borderline QT prolongation one month before ([Patient D]). Both drugs are known to cause QT prolongation.
    c. One patient had a seborrheic keratosis on her face at age 37 and was prescribed Effudex ([Patient E]).
    d. He prescribed ERT for a 47 year old patient who smoked and was hypertensive ([Patient F]).
    e. He occasionally prescribes antibiotics inappropriately (e.g. [Patient G]).
    f. [Patient H] was given testosterone supplementation despite levels that were within normal range.
    g. Dr. Reynolds prescribed Ritalin to a patient who hadn't had sleep in 3 nights, diagnosed with bipolar 'going into mania.' Ritalin is contra-indicated in mania. ([Patient I])
(4) One patient reported physical abuse ([Patient C]) on 1/11/12. There is no documentation of reports of this domestic violence, which is state law.
(5) Follow up of patients seems to be more centered on refilling controlled substances than following other chronic conditions.
(6) Abnormal labs were inconsistently worked up. For example, [Patient J] had a low GFR (4/12/11) with no work up or follow up, despite having multiple elevations in blood pressure, and obesity. Lipids were never checked. [Patient H] had persistent macrocytosis without anemia. Workup was not documented. [Patient E] had an excision of a dyplastic nevus (6/14/10) that pathology recommended re-excision because of inadequate margins. That was not done.
(7) Health maintenance is not consistently addressed.

Specifically, the consultant noted the following concerns regarding the licensee's prescribing of controlled substances issues:

(1) Urine drug screens for compliance were done only in a couple of patients. Many of his patients were high risk, and it doesn't appear to be considered. In one of the few patients that had a UDS on the chart, benzodiazepines were present though Dr. Reynolds did not prescribe them ([Patient K]).

(2) He prescribed Adipex then Tenuate for two women who were not obese. (Initial BMI 28 though height not documented then 26 on [Patient L]) ([Patient M])
(3) Early refills were not consistently addressed ([Patient K])
(4) Drug monitoring reports that showed high risk activity did not result in appropriate controls in Dr. Reynolds' prescribing habits.
    a. [Patient N] received duplicative prescriptions at multiple pharmacies (....)
    b. Dr. Reynolds continued to prescribe controlled substances despite KASPER reports that showed abuse/misuse (e.g. [Patient D] ....)
    c. [Patient K] had early refills on her KASPER and had benzos on her UDS on 12/27/10 when Dr. Reynolds had not prescribed them.
    d. There was a phone call from someone that their son overdosed from medicines he had received from [Patient K]. I could not find where this was addressed with the patient.
    e. Dr. Reynolds prescribed controlled substances to patients with alarming KASPER reports, worrisome for misuse or diversion (e.g. [Patient O], [Patient A]) Dr. Reynolds put the blame of his patient getting duplicative prescriptions from multiple physicians on the pharmacy that filled them ([Patient P]: Dr. Reynolds narrative report; no KASPER was done until patient died)
(5) One patient used more medicine than prescribed and ran out of benzodiazepines. She had seizures worrisome to me, as a reviewer, for drug withdrawal. When she saw Dr. Reynolds for more medicine after running out early, he used muscle relaxants instead of weaning her off the medicine, and prescribed Dilantin. ... ([Patient C]) She later was admitted to the hospital with benzodiazepine withdrawal seizures. Neurology was consulted and diagnosed benzodiazepine-withdrawal seizures. Dr. Reynolds continued to prescribe the benzodiazepines and gave her phenytoin for her seizures.
(6) Poor charting and organization does not allow for good follow up for these high risk prescriptions... Refills of narcotics, benzos and soma found on the KASPER reports were not documented in the chart ([Patient N]).
(7) 7/28/11 there was an anonymous (except for caller ID) report that [Patient C] was buying drugs off the street and taking her husband's medications. There is no record that Dr. Reynolds ever addressed this.
(8) One patient admitted to sharing his tylox ([Patient Q]) but no changes were made. Another patient admitted that her husband was taking her Xanax ([Patient I]). Dr. Reynolds continued prescribing controlled substances. Indeed, there was a phone call to the office on 3/15/12 that [patient I] was selling her medications. Another phone caller stated [Patient C] was buying medicine off the street. These calls were not addressed in the charts, and the patients continued to receive high risk medications.
(9) Dr. Reynolds states in his own review of [Patient P's] record that he was using soma until he heard an audio digest report from a neurologist that soma was only used by 'quacks.' He stated he then stopped prescribing soma, though he felt it was the best drug available for spasm.

(10) Dr. Reynolds changes medicine frequently. I do not understand the rationale. Indeed patients often report better control of their symptoms, but then were changed to lower dose of potency medicines shortly thereafter ([Patient D] 1/8/09 and on....) This practice could possibly lead to withdrawal symptoms and increase the risk of psychological addiction.
(11) Dr. Reynolds took one of his patients to a concert, but the patient had too many drugs to stay awake. The episode did not halt his prescribing of controlled substances. It is also risky to prescribe for a friend ([Patient Q]).

The suspicions of the Simpson County Sheriff ... that Dr. Reynolds could be a source for some of the drugs that were being diverted in the county appears to be consistent with some of the charts reviewed. There is no evidence that Dr. Reynolds intended for his prescriptions to be diverted or misused. However, numerous red flags were not appropriately addressed.

... Quantities of some of the prescriptions, early refills, affects of the patients, phone calls to the office by other community members, and worrisome KASPER reports were not consistently addressed, and fall below prevailing medical practice standards. Urine drug screens for compliance were not done in many of the high risk patients. I feel that his case falls at least in the zones of negligence and possibly ignorance, though there are instances of incompetence and malpractice.

Dr. Reynolds' liberal prescribing habits constitute a danger to the health of his patients, by ignoring the attendant risks of addiction and withdrawal, and occasionally prescribing when they are not indicated. ....

9. On January 17, 2013, the Board's Inquiry Panel B reviewed the investigation and the licensee appeared before and was heard by the Panel before it deliberated. The Panel and the licensee agreed to enter into an Agreed Order of Indefinite Restriction, in lieu of the issuance of a Complaint and Emergency Order of Suspension, which restricted the licensee from prescribing controlled substances until completion of certain remedial education courses and until approved to do so by the Panel or the Panel Chair. (KBML Case No. 1458) The Agreed Order of Indefinite Restriction provided that neither the Panel nor Panel Chair would consider reinstating the licensee's prescribing privileges unless and until the licensee completed the "Prescribing Controlled Drugs" course (at Vanderbilt University Medical Center or the University

of Florida) and the Patient Care Documentation Seminar (at The Center for Personalized Education for Physicians in Colorado).

10. On March 1-2, 2013, the licensee completed the "Prescribing Controlled Drugs" course at the University of Florida.

11. On March 8, 2013, the licensee completed the Patient Care Documentation Seminar at The Center for Personalized Education for Physicians in Colorado ("CPEP").

12. On or about March 22, 2013, the licensee's prescribing privileges were reinstated pursuant to an Amended Agreed Order of Indefinite Restriction (KBML Case No. 1458) which required that the licensee maintain a controlled substance log for all controlled substances prescribed or dispensed, subject to at least two Board consultant reviews; successfully complete the documentation seminar implementation program, "PIP"; pay a fine of $5,000 within twenty months; reimburse the Board's costs of $6,187.50 within six months; and not further violate KRS 311.595 and/or .597.

13. On or about December 13, 2013, the licensee failed CPEP's Personalized Implementation Program ("PIP"). He did not enroll in the recommended addendum.

14. The licensee paid the fine and reimbursed the Board's costs pursuant to the terms and conditions of the Amended Agreed Order of Indefinite Restriction (KBML Case No. 1458).

15. On or about November 10, 2015, information was returned against the licensee in the United States District Court, Western District of Kentucky (Bowling Green), on the following counts:

    - Count I: In or about and between February 2009 and April 2011, having knowingly and intentionally distributed and dispensed oxycodone, a Schedule II controlled substance, and Xanax, a Schedule IV controlled substance, to

Patient J.H. outside the course of professional medical practice, in violation of 21 U.S.C. §§ 841(a)(1) and 841 (b)(1)(C).

- Count II: In or about and between July 2010 and December 2011, having knowingly and intentionally distributed and dispensed hydrocodone, a Schedule III controlled substance, and clonazepam and Xanax, Schedule IV controlled substances, to Patient J.R. outside the course of professional medical practice, in violation of 21 U.S.C. §§ 841(a)(1) and 841 (b)(1)(E).

16. On or about June 1, 2016, the licensee entered into a Plea Agreement in which he waived indictment by a grand jury, entered a voluntary plea of guilty to the charges, and admitted the following facts:

- The licensee was a doctor practicing in Franklin, Kentucky, in Simpson County. J.H. was the licensee's patient for many years. J.H. had a history of illegal drug usage and psychiatric issues which was documented in his patient charts. J.H.'s KASPER report also suggested opiate abuse and diversion. Although J.H. made various somatic complaints, the licensee never objectively documented a legitimate source of pain.

  An opiate centric treatment plan was contraindicated because of risk factors inherent with a history of drug abuse. Nonetheless, the licensee placed J.H. on a regimen of chronic opiate therapy, and the licensee did not monitor or enforce patient accountability, did not perform urine screens or pill counts, and did not attempt to wean J.H. off opiates. Between February 2009 and April 2011, the licensee repeatedly prescribed oxycodone, a Schedule II controlled substance, and Xanax, a Schedule IV controlled substance, to J.H. outside the course of professional medical practice and without a legitimate medical purpose.

  On April 3, 2011, J.H. died at age 46 of a pharmaceutical overdose, and an autopsy revealed oxycodone at five (5) times the upper therapeutic concentration. Two days prior to his death, the licensee prescribed J.H. 180 oxycodone pills and 90 Xanax.

- J.R. was the licensee's patient between July 2010 and December 2011. J.R. presented vague complaints of knee, neck and shoulder pain, but MRI's and physical examinations failed to identify any significant pathologies. A legitimate pain diagnosis was never established and J.R.'s patient records reflect a history of alcohol abuse, doctor shopping, drug dependency, and non-compliance. Controlled substances were contraindicated, but the licensee repeatedly prescribed hydrocodone, a Schedule III controlled substance at the time, and Xanax and clonazepam, Schedule IV controlled substances, outside the course of professional medical practice and without a legitimate medical purpose. On December 30, 2011, J.R. died at age 41 of a pharmaceutical

overdose, and an autopsy revealed hydrocodone at thirty (30) times the upper therapeutic concentration.

17. The charges to which the licensee entered a guilty plea carry a combined maximum term of imprisonment of thirty (30) years, a combined maximum fine of $1,500,00 and supervised release of at least three (3) years. At the time of sentencing, the licensee and the United States Attorneys agreed that a sentencing range of between two (2) years imprisonment and three (3) years of probation, in addition to a $10,000 fine, to be appropriate.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order of Surrender:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(4), (9) - as illustrated by KRS 311.597(4) – and (13). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Surrender.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve the grievance without an evidentiary hearing by entering into an informal resolution such as this Agreed Order of Surrender.

AGREED ORDER OF SURRENDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve the grievance without an

evidentiary hearing, the parties hereby ENTER INTO the following **AGREED ORDER OF SURRENDER:**

1. The licensee, Roy D. Reynolds, M.D., HEREBY SURRENDERS, in lieu of revocation, his license to practice medicine/osteopathy within the Commonwealth of Kentucky for an indefinite period of time, with that surrender to become effective immediately upon the date of filing of this Agreed Order of Surrender;

2. Following the effective date of the surrender of his license, the licensee SHALL NOT engage in any act which would constitute 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 approved to do so by the Board;

3. The licensee SHALL NOT petition the Board for a license to again practice medicine/osteopathy in the Commonwealth until at least two (2) years have passed from the date of entry of this Agreed Order of Surrender and he has satisfied all terms and conditions of the judgment, including but not limited to any terms of imprisonment, probation and/or supervised release, entered against him in *USA v. Reynolds*, Case No. 1:15-CR-32-GNS (U.S. District Court, Western District of Kentucky);

4. If the licensee should in the future petition for a license to again practice medicine/osteopathy in the Commonwealth, he understands and agrees that the provisions of KRS 311.607 SHALL apply to said petition;

    a. The licensee understands and agrees that the burden SHALL be upon him to satisfy the Board that he is presently of good moral character and is qualified both physically and mentally to resume the practice of medicine/osteopathy, without undue risk or danger to his patients or the public;

    b. The licensee understands and agrees that the Board shall require him to successfully complete a clinical skills assessment(s) and/or evaluation(s), at his expense, prior to considering his petition to resume the practice of medicine/osteopathy and to assist the Board in its consideration of the petition;

    c. The licensee understands and agrees that the decision whether to permit him to resume the active practice of medicine/osteopathy lies within the sole discretion of the Board and that the Board shall not be required to issue a new license. However, in the event that the Board should allow the licensee to resume the active practice of medicine/osteopathy at any time in the future, the licensee

understands and agrees that (1) he shall be indefinitely and permanently restricted from the prescribing, dispensing or professional utilization of controlled substances as a condition, pursuant to 201 KAR 9:081, and (2) he shall otherwise be under probation for a period of no less than two years nor more than five years, such that any subsequent violation during the probation period shall result in automatic revocation of license;

5. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of Surrender, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order of Surrender, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Agreed Order of Surrender would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order of Surrender; and

6. The licensee understands and agrees that any violation of the terms of this Agreed Order of Surrender would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13) and may provide a legal basis for criminal prosecution for practicing medicine without a license.

SO AGREED on this 2nd day of August, 2016.

FOR THE LICENSEE:

Roy D. Reynolds MD

ROY D. REYNOLDS, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

Randel C Gibson DO

RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B

LEANNE K. DIAKOV
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AMENDED AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel B Chair, Randel C. Gibson, D.O., and Roy D. Reynolds, M.D., ("the licensee"), and, based upon their mutual desire to amend the Agreed Order of Indefinite Restriction, entered February 14, 2013, in order to reinstate the licensee's prescribing privileges, hereby ENTER INTO the following **AMENDED AGREED ORDER OF INDEFINITE RESTRICTION:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Amended Agreed Order of Indefinite Restriction:

1. At all relevant times, Roy D. Reynolds, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is family medicine.
3. On or about April 30, 2012, the Board received a grievance which alleged that the licensee inappropriately prescribed controlled substances to a patient in a manner which resulted in the patient's overdose death.
4. The Simpson County Sheriff advised the Board that his office had recently been involved in two (2) other overdose death investigations and one (1) suicide investigation of persons who had been the licensee's patients. In addition, the Sheriff

indicated that a significant amount of diverted drugs in the community originated from prescriptions written by the licensee.

5. The Simpson County Coroner advised the Board that, over the course of the previous eighteen (18) months, he had investigated three (3) overdose deaths and one (1) suicide death of the licensee's patients.

6. Based on concerns of several possible overdoses by the licensee's patients, the Kentucky State Police and the Board requested that the Office of Inspector General (OIG), Division of Audits and Investigations, conduct a KASPER analysis of the licensee's prescribing patterns.

7. On or around June 26, 2012, OIG Investigator, Duncan McCracken, R.Ph., reviewed and analyzed the licensee's KASPER records (for the period of June 11, 2010 through June 10, 2012) and identified twenty-two (22) of the licensee's patients based upon the prescribing of addictive drug combinations, use of multiple pharmacies, early issuance and early refills of prescriptions, and similar last names among patients. Mr. McCracken forwarded the patient names to the Board for further investigation.

8. In or around October 2012, a Board consultant reviewed the licensee's patient charts for the patients identified in the course of the investigation, the licensee's KASPER report, patient death summaries, and narrative summaries of patient care provided by the licensee during the course of the investigation, and the Board consultant concluded that the licensee departed from or failed to conform to acceptable and prevailing medical practices; and that he committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances,

would be deemed to be gross negligence, as well as instances of gross ignorance, gross incompetence and malpractice.

Specifically, the consultant noted the following regarding quality issues:

(1) Poor charting: recordkeeping is disorganized, penmanship poor, inconsistent use of medication lists; papers in the chart are not attached to the covers.
(2) Care of chronic conditions is inadequate. For example, Hemoglobin a1c'S are sometimes ordered too frequently, and care of diabetes is limited to addressing blood sugars, while neglecting foot exams, microalbulim assessment, retinopathy screens, LDL determinations, and immunizations ([Patient A and Patient B]). High blood pressures are frequently not addressed.
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    a. [Patient C] was treated with digoxin for CHF, though the records do not support that diagnosis.
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    g. Dr. Reynolds prescribed Ritalin to a patient who hadn't had sleep in 3 nights, diagnosed with bipolar 'going into mania.' Ritalin is contra-indicated in mania. ([Patient I])
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(2) He prescribed Adipex then Tenuate for two women who were not obese. (Initial BMI 28 though height not documented then 26 on [Patient L]) ([Patient M])
(3) Early refills were not consistently addressed ([Patient K])
(4) Drug monitoring reports that showed high risk activity did not result in appropriate controls in Dr. Reynolds' prescribing habits.
    a. [Patient N] received duplicative prescriptions at multiple pharmacies (....)
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(6) Poor charting and organization does not allow for good follow up for these high risk prescriptions... Refills of narcotics, benzos and soma found on the KASPER reports were not documented in the chart ([Patient N]).
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(8) One patient admitted to sharing his tylox ([Patient Q]) but no changes were made. Another patient admitted that her husband was taking her Xanax ([Patient I]). Dr. Reynolds continued prescribing controlled substances. Indeed, there was a phone call to the office on 3/15/12 that [patient I] was selling her medications. Another phone caller stated [Patient C] was buying medicine off the street. These calls were not addressed in the charts, and the patients continued to receive high risk medications.

(9) Dr. Reynolds states in his own review of [Patient P's] record that he was using soma until he heard an audio digest report from a neurologist that soma was only used by 'quacks.' He stated he then stopped prescribing soma, though he felt it was the best drug available for spasm.

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The suspicions of the Simpson County Sheriff ... that Dr. Reynolds could be a source for some of the drugs that were being diverted in the county appears to be consistent with some of the charts reviewed. There is no evidence that Dr. Reynolds intended for his prescriptions to be diverted or misused. However, numerous red flags were not appropriately addressed.

... Quantities of some of the prescriptions, early refills, affects of the patients, phone calls to the office by other community members, and worrisome KASPER reports were not consistently addressed, and fall below prevailing medical practice standards. Urine drug screens for compliance were not done in many of the high risk patients. I feel that his case falls at least in the zones of negligence and possibly ignorance, though there are instances of incompetence and malpractice.

Dr. Reynolds' liberal prescribing habits constitute a danger to the health of his patients, by ignoring the attendant risks of addiction and withdrawal, and occasionally prescribing when they are not indicated. ....

9. On January 17, 2013, the Board's Inquiry Panel B reviewed the investigation and the licensee appeared before and was heard by the Panel before it deliberated. The Panel and the licensee agreed to enter into an Agreed Order of Indefinite Restriction, in lieu of the issuance of a Complaint and Emergency Order of Suspension, which restricted the licensee from prescribing controlled substance until completion of certain remedial education courses and until approved to do so by the Panel or the Panel Chair. The Agreed Order of Indefinite Restriction provided that neither the Panel nor Panel Chair would consider reinstating the licensee's prescribing privileges unless

and until the licensee completed the "Prescribing Controlled Drugs" course (at Vanderbilt University Medical Center or the University of Florida) and the Patient Care Documentation Seminar (at The Center for Personalized Education for Physicians in Colorado).

10. On March 1-2, 2013, the licensee completed the "Prescribing Controlled Drugs" course at the University of Florida.
11. On March 8, 2013, the licensee completed the Patient Care Documentation Seminar at The Center for Personalized Education for Physicians in Colorado.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Amended Agreed Order of Indefinite Restriction:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(a) and (d), (3) and (4). Accordingly, there are legal grounds for the parties to enter into this Amended Agreed Order of Indefinite Restriction.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve the grievance without an evidentiary hearing by entering into an informal resolution such as this Amended Agreed Order of Indefinite Restriction.

AMENDED AGREED ORDER OF INDEFINITE RESTRICTION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to amend the Agreed Order of Indefinite Restriction, entered February 14, 2013, in order to reinstate the licensee's prescribing privileges, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER OF INDEFINITE RESTRICTION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Roy D. Reynolds, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order.
2. During the effective period of this Amended Agreed Order of Indefinite Restriction, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term, or until further order of the Board:

    a. The licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed. The controlled substances log must include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions should be maintained in the following manner: 1) patient; 2) chart; and 3) log;

    b. The licensee SHALL permit the Board's agents to inspect, copy and/or obtain the controlled substance log and other relevant records, upon request, for review by the Board's agents and/or consultants;

    c. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Amended Agreed Order of Indefinite Restriction. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted

copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Amended Agreed Order of Indefinite Restriction;

d. The licensee understands and agrees that at least two (2) favorable consultant reviews must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Amended Agreed Order of Indefinite Restriction;

e. If the licensee has not already done so, the licensee SHALL immediately take all necessary steps to enroll in the CPEP Personalized Implementation Program (PIP). The licensee SHALL complete the PIP, at his expense, as directed by CPEP's staff. The licensee SHALL provide the Board's staff with written verification that he has successfully completed the PIP, promptly after completing that program. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of any evaluations from the Documentation Seminar and PIP to the Board's Legal Department promptly after their completion;

f. Pursuant to KRS 311.565(1)(v), the licensee SHALL pay a FINE in the amount of five-thousand dollars ($5,000.00) according to the following schedule: at least $250.00 each month for twenty (20) months, with payment due on the first day of each month beginning March 1, 2013, and continuing until such time as the fine is paid in full;

a. Pursuant to KRS 311.565(1)(v), the licensee SHALL REIMBURSE the Board the costs of the proceedings in the amount of six-thousand one-hundred and eighty-seven dollars and fifty cents ($6,187.50), within six (6) months from the date of February 14, 2013; and

b. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Amended Agreed Order of Indefinite Restriction, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of

this Amended Agreed Order of Indefinite Restriction, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Amended Agreed Order of Indefinite Restriction would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Amended Agreed Order of Indefinite Restriction.

4. The licensee understands and agrees that any violation of the terms of this Amended Agreed Order of Indefinite Restriction would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 20 day of March, 2013.

FOR THE LICENSEE:

Roy D Reynolds, MD

ROY D. REYNOLDS, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

Randel C Gibson DO

RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B

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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1458

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY ROY D. REYNOLDS, M.D., LICENSE NO. 19383, 121 MEMORIAL DRIVE, FRANKLIN, KENTUCKY 42134

AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel B, and Roy D. Reynolds, M.D., ("the licensee"), and, based upon their mutual desire to fully and finally resolve this pending grievance without an evidentiary hearing, hereby ENTER INTO the following **AGREED ORDER OF INDEFINITE RESTRICTION**:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order of Indefinite Restriction:

1. At all relevant times, Roy D. Reynolds, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is family medicine.
3. On or about April 30, 2012, the Board received a grievance which alleged that the licensee inappropriately prescribed controlled substances to a patient in a manner which resulted in the patient's overdose death.
4. The Simpson County Sheriff advised the Board that his office had recently been involved in two (2) other overdose death investigations and one (1) suicide investigation of persons who had been the licensee's patients. In addition, the Sheriff

indicated that a significant amount of diverted drugs in the community originated from prescriptions written by the licensee.

5. The Simpson County Coroner advised the Board that, over the course of the previous eighteen (18) months, he had investigated three (3) overdose deaths and one (1) suicide death of the licensee's patients.

6. Based on concerns of several possible overdoses by the licensee's patients, the Kentucky State Police and the Board requested that the Office of Inspector General (OIG), Division of Audits and Investigations, conduct a KASPER analysis of the licensee's prescribing patterns.

7. On or around June 26, 2012, OIG Investigator, Duncan McCracken, R.Ph., reviewed and analyzed the licensee's KASPER records (for the period of June 11, 2010 through June 10, 2012) and identified twenty-two (22) of the licensee's patients based upon the prescribing of addictive drug combinations, use of multiple pharmacies, early issuance and early refills of prescriptions, and similar last names among patients. Mr. McCracken forwarded the patient names to the Board for further investigation.

8. In or around October 2012, a Board consultant reviewed the licensee's patient charts for the patients identified in the course of the investigation, the licensee's KASPER report, patient death summaries, and narrative summaries of patient care provided by the licensee during the course of the investigation, and the Board consultant concluded that the licensee departed from or failed to conform to acceptable and prevailing medical practices; and that he committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances,

would be deemed to be gross negligence, as well as instances of gross ignorance, gross incompetence and malpractice.

Specifically, the consultant noted the following regarding quality issues:

(1) Poor charting: recordkeeping is disorganized, penmanship poor, inconsistent use of medication lists; papers in the chart are not attached to the covers.
(2) Care of chronic conditions is inadequate. For example, Hemoglobin a1c'S are sometimes ordered too frequently, and care of diabetes is limited to addressing blood sugars, while neglecting foot exams, microalbulim assessment, retinopathy screens, LDL determinations, and immunizations ([Patient A and Patient B]). High blood pressures are frequently not addressed.
(3) Some medications are prescribed inappropriately.
    a. [Patient C] was treated with digoxin for CHF, though the records do not support that diagnosis.
    b. Clitalopram was added to a patient's medications when she was on Abilify and had borderline QT prolongation one month before ([Patient D]). Both drugs are known to cause QT prolongation.
    c. One patient had a seborrheic keratosis on her face at age 37 and was prescribed Effudex ([Patient E]).
    d. He prescribed ERT for a 47 year old patient who smoked and was hypertensive ([Patient F]).
    e. He occasionally prescribes antibiotics inappropriately (e.g. [Patient G]).
    f. [Patient H] was given testosterone supplementation despite levels that were within normal range.
    g. Dr. Reynolds prescribed Ritalin to a patient who hadn't had sleep in 3 nights, diagnosed with bipolar 'going into mania.' Ritalin is contra-indicated in mania. ([Patient I])
(4) One patient reported physical abuse ([Patient C]) on 1/11/12. There is no documentation of reports of this domestic violence, which is state law.
(5) Follow up of patients seems to be more centered on refilling controlled substances than following other chronic conditions.
(6) Abnormal labs were inconsistently worked up. For example, [Patient J] had a low GFR (4/12/11) with no work up or follow up, despite having multiple elevations in blood pressure, and obesity. Lipids were never checked. [Patient H] had persistent macrocytosis without anemia. Workup was not documented. [Patient E] had an excision of a dyplastic nevus (6/14/10) that pathology recommended re-excision because of inadequate margins. That was not done.
(7) Health maintenance is not consistently addressed.

Specifically, the consultant noted the following concerns regarding the licensee's prescribing of controlled substances issues:

(1) Urine drug screens for compliance were done only in a couple of patients. Many of his patients were high risk, and it doesn't appear to be considered. In one of the few patients that had a UDS on the chart, benzodiazepines were present though Dr. Reynolds did not prescribe them ([Patient K]).
(2) He prescribed Adipex then Tenuate for two women who were not obese. (Initial BMI 28 though height not documented then 26 on [Patient L]) ([Patient M])
(3) Early refills were not consistently addressed ([Patient K])
(4) Drug monitoring reports that showed high risk activity did not result in appropriate controls in Dr. Reynolds' prescribing habits.
    a. [Patient N] received duplicative prescriptions at multiple pharmacies (....)
    b. Dr. Reynolds continued to prescribe controlled substances despite KASPER reports that showed abuse/misuse (e.g. [Patient D] ....)
    c. [Patient K] had early refills on her KASPER and had benzos on her UDS on 12/27/10 when Dr. Reynolds had not prescribed them.
    d. There was a phone call from someone that their son overdosed from medicines he had received from [Patient K]. I could not find where this was addressed with the patient.
    e. Dr. Reynolds prescribed controlled substances to patients with alarming KASPER reports, worrisome for misuse or diversion (e.g. [Patient O], [Patient A]) Dr. Reynolds put the blame of his patient getting duplicative prescriptions from multiple physicians on the pharmacy that filled them ([Patient P]: Dr. Reynolds narrative report; no KASPER was done until patient died)
(5) One patient used more medicine than prescribed and ran out of benzodiazepines. She had seizures worrisome to me, as a reviewer, for drug withdrawal. When she saw Dr. Reynolds for more medicine after running out early, he used muscle relaxants instead of weaning her off the medicine, and prescribed Dilantin. ... ([Patient C]) She later was admitted to the hospital with benzodiazepine withdrawal seizures. Neurology was consulted and diagnosed benzodiazepine-withdrawal seizures. Dr. Reynolds continued to prescribe the benzodiazepines and gave her phenytoin for her seizures.
(6) Poor charting and organization does not allow for good follow up for these high risk prescriptions... Refills of narcotics, benzos and soma found on the KASPER reports were not documented in the chart ([Patient N]).
(7) 7/28/11 there was an anonymous (except for caller ID) report that [Patient C] was buying drugs off the street and taking her husband's medications. There is no record that Dr. Reynolds ever addressed this.
(8) One patient admitted to sharing his tylox ([Patient Q]) but no changes were made. Another patient admitted that her husband was taking her Xanax ([Patient I]). Dr. Reynolds continued prescribing controlled substances. Indeed, there was a phone call to the office on 3/15/12 that [patient I] was selling her medications. Another phone caller stated [Patient C] was buying medicine off the street. These calls were not addressed in the charts, and the patients continued to receive high risk medications.

(9) Dr. Reynolds states in his own review of [Patient P's] record that he was using soma until he heard an audio digest report from a neurologist that soma was only used by 'quacks.' He stated he then stopped prescribing soma, though he felt it was the best drug available for spasm.

(10) Dr. Reynolds changes medicine frequently. I do not understand the rationale. Indeed patients often report better control of their symptoms, but then were changed to lower dose of potency medicines shortly thereafter ([Patient D] 1/8/09 and on....) This practice could possibly lead to withdrawal symptoms and increase the risk of psychological addiction.

(11) Dr. Reynolds took one of his patients to a concert, but the patient had too many drugs to stay awake. The episode did not halt his prescribing of controlled substances. It is also risky to prescribe for a friend ([Patient Q]).

The suspicions of the Simpson County Sheriff ... that Dr. Reynolds could be a source for some of the drugs that were being diverted in the county appears to be consistent with some of the charts reviewed. There is no evidence that Dr. Reynolds intended for his prescriptions to be diverted or misused. However, numerous red flags were not appropriately addressed.

... Quantities of some of the prescriptions, early refills, affects of the patients, phone calls to the office by other community members, and worrisome KASPER reports were not consistently addressed, and fall below prevailing medical practice standards. Urine drug screens for compliance were not done in many of the high risk patients. I feel that his case falls at least in the zones of negligence and possibly ignorance, though there are instances of incompetence and malpractice.

Dr. Reynolds' liberal prescribing habits constitute a danger to the health of his patients, by ignoring the attendant risks of addiction and withdrawal, and occasionally prescribing when they are not indicated. ....

9. On January 17, 2013, the Board's Inquiry Panel B reviewed the investigation and the licensee appeared before and was heard by the Panel before it deliberated. The Panel and the licensee agreed to enter into this Agreed Order of Indefinite Restriction, in lieu of the issuance of a Complaint and Emergency Order of Suspension.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order of Indefinite Restriction:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(a) and (d), (3) and (4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Indefinite Restriction.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending grievance without an evidentiary hearing by entering into an informal resolution such as this Agreed Order of Indefinite Restriction.

AGREED ORDER OF INDEFINITE RESTRICTION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve this pending grievance without an evidentiary hearing, the parties hereby ENTER INTO the following **AGREED ORDER OF INDEFINITE RESTRICTION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Roy D. Reynolds, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order.
2. During the effective period of this Agreed Order of Indefinite Restriction, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term, or until further order of the Board:
    a. The licensee SHALL NOT prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to do so by the Panel or the Panel Chair;

b. The Panel or Panel Chair will not consider a request by the licensee to resume the professional utilization of controlled substances unless and until the following conditions have been satisfied and verification provided:
    i. The licensee has successfully completed the "Prescribing Controlled Drugs" course at The Center for Professional Health at Vanderbilt University Medical Center, Nashville, TN, Tel. (615) 936-0678 or the University of Florida, 8491 N.W. 39th Avenue, Gainesville, Florida , Tel. (352) 265-5549, at his expense; and
    ii. The licensee has successfully completed the Documentation Seminar at the Center for Personalized Education for Physicians (CPEP), 7351 Lowry Boulevard, Suite 100, Denver, Colorado 80230, Tel. (303) 577-3232.

c. Immediately upon completion of the Documentation Seminar at the Center for Personalized Education for Physicians (CPEP), the licensee SHALL also take all necessary steps to enroll in the CPEP Personalized Implementation Program (PIP). The licensee shall complete the PIP, at his expense, as directed by CPEP's staff. The licensee SHALL provide the Board's staff with written verification that he has successfully completed the PIP promptly after completing that program. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of any evaluations from the Documentation Seminar and PIP to the Board's Legal Department promptly after their completion;

d. If the Panel or Panel Chair should grant the licensee's request to resume the professional utilization of controlled substances, it will do so by an Amended Agreed Order of Indefinite Restriction, which shall provide for the licensee to maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized and shall provide for periodic review of the log and relevant records by Board agents upon request, at least two (2) favorable consultant reviews, and any other conditions deemed necessary by the Panel or Panel Chair at that time;

e. Pursuant to KRS 311.565(1)(v), the licensee SHALL pay a FINE in the amount of five-thousand dollars ($5,000.00) according to the following schedule: at least $250.00 each month for twenty (20) months, with payment due on the first day of each month beginning March 1, 2013, and continuing until such time as the fine is paid in full;

f. Pursuant to KRS 311.565(1)(v), the licensee SHALL REIMBURSE the Board the costs of the proceedings in the amount of six-thousand one-hundred and eighty-seven dollars and fifty cents ($6,187.50), within six (6) months from entry of this Agreed Order of Indefinite Restriction; and

g. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of Indefinite Restriction, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order of Indefinite Restriction, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Agreed Order of Indefinite Restriction would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order of Indefinite Restriction.

4. The licensee understands and agrees that any violation of the terms of this Agreed Order of Indefinite Restriction would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 14th day of February, 2013.

FOR THE LICENSEE:

ROY D. REYNOLDS, M.D.
2-2-13
1130 # CST

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

RANDEL C. GIBSON, D.O.
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