

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1440

FILED OF RECORD
JAN 17 2013
K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY ROLAND B. WILSON, M.D., LICENSE NO. 23084,
2460 DERBY DRIVE, SHELBYVILLE, INDIANA 46176-9241

AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by
and through its Hearing Panel B, and Roland B. Wilson, M.D., ("the licensee"), and,
based upon their mutual desire to fully and finally resolve this pending Complaint
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, Roland B. Wilson, M.D., was licensed by the Board to practice
medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is anesthesiology.
3. At all relevant times, the licensee practiced at Commonwealth Quality Healthcare,
LLC, in Prestonsburg, Kentucky.
4. On or about April 25, 2012, Stephen C. Johnson, Pharmacist Consultant, Office of
Inspector General, Drug Enforcement and Professional Practices Branch of the
Cabinet for Health and Family Services ("Drug Enforcement"), reviewed and
analyzed the licensee's KASPER records (for the period October 1, 2011 through
April 19, 2012) and noted several concerns, including:

- Possible prescribing to employees;
- Prescribing of same or similar controlled substances to persons with similar last names;
- Use of addictive drug combinations;
- Polypharmacy;
- Concerns about the ages of some patients; and
- Atypical distances traveled

Mr. Johnson identified twenty-one (21) of the licensee's patients with prescribing patterns reflective of these concerns and recommended further investigation by the Board.

5. During the course of the investigation, the Board obtained medical records for a number of employees and/or employee family members of Commonwealth Quality Healthcare, LLC. When the Board's investigator first questioned the licensee about prescribing to these persons, the licensee stated that this was improper and he did not do that. However, when confronted with patient charts, he acknowledged that he had prescribed for one employee and could not recall whether he prescribed for another.
6. A Board Consultant reviewed twenty-one (21) of the licensee's patient charts and found that the licensee failed to conform to or departed from acceptable and prevailing medical practices and that he engaged in a pattern of acts which demonstrated gross incompetence, gross ignorance and gross negligence. The Board Consultant stated

Dr. Wilson chose to practice in a facility that mirrored a "pill mill."...

The organization of the charts was difficult at best. The charts were separated by tabs but the documentation in the tabs often did not correspond to what was contained in the tabbed section. All patient charts had some type of consents for treatment albeit many were not signed appropriately; some charts lack any signature from staff or the patient. Many of these consents had the wrong year on them. There were several records that had data covered up by using "white out"

liquid erasure... Some of the charts had forms completed in pencil. Often there was illegible writing by Dr. Wilson.

... Some charts had tracking numbers to indicate KASPER data had been obtained but this was very inconsistent. For most of the charts the KASPER data was not acknowledged. I found more often than not, patients were given numerous early refills on their prescriptions for both benzodiazepines and opioid medications. There was no explanation of documentation for the early refills.

All of the patient charts contained reports from Calloway Lab indicating regular urine drug testing was performed at each patient visit. However, the utilization of this information was questionable. Frequently, the results were ignored. There were many occurrences of abnormal results that should have been clarified by additional testing and this was not done. ... There were several incidents where the facility cancelled the confirmation of a urine drug test. ... Frequently amphetamine positive results were not clarified. There were many occasions in which a urine sample did not pass integrity testing. Again, this was not addressed. Nearly 100% of the twenty one charts reviewed had failed urine drug testing results and many failed urine drug testing numerous times.

...
... There were several patients that were given multiple controlled substance prescriptions repeatedly without being seen. None of the prescriptions written for controlled substances by Dr. Wilson were written to standard. ... There were some prescriptions with the dates that had obviously been altered.

It was apparent to me that Dr. Wilson demonstrated a lack of knowledge and a level of competence that would be expected of a physician practicing pain management. He acknowledged that as an anesthesiologist of twenty-eight years, he "was not familiar" with oral pain medications. Further, he never practiced as a physician providing medical management. He demonstrated a lack of ability repeatedly in prescribing as noted by the combinations of medications and the dosing of medications. While I was concerned about his general lack of knowledge, I was disturbed by his obvious neglect to the basic fundamentals of the practice of medicine and the resulting lack of appropriate and prudent medical care. ... A nursing examination cannot be substituted for the examination by the physician. A nursing diagnosis is not a medical diagnosis. A medical diagnosis is rendered after an examination by the physician. There was no initial examination or focused physical examination results documented by Dr. Wilson. None of the 21 charts contained documentation that a history and physical examination was performed by Dr. Wilson. None of the charts had documentation that he examined the patients at follow up visits

regardless of their complaints. There were some charts that did not have a history of physical examination from anyone.

Dr. Wilson did nothing to establish a diagnosis or formulate a working diagnosis. Not only were his follow up evaluations lacking in any documentation of an examination but in general the follow up patient visit notes were incomplete and inconsistent. The notes were often two or three lines and most commonly stated the "patient satisfied with the current regiment" and "without complaints." These notes were frequently the opposite of the information the patient gave to the triage nurse/staff member. There were frequent examples of the patient complaining of new symptoms or changes in symptoms. ... Again, Dr. Wilson never documented that he physically examined the area(s) of concern. He never addressed the problem except to increase either the opioid medication or the benzodiazepine. ...

Dr. Wilson not only neglected to formulate a diagnosis, he never followed up on any diagnostic testing previously ordered by the other physicians prior to his employment with the facility. Rarely did he order a diagnostic study and when he did, he never followed up on the status of the study. It was frequently unclear whether the patient actually went for the ordered study or not.

Dr. Wilson prescribed benzodiazepines regularly to his patients regardless of age and obvious risk factors associated with the use of these medications. He frequently prescribed benzodiazepines in response to a patient's complaint of increased pain. He would increase the benzodiazepine when the patient asked for additional pain medications. There were frequent occasions that a patient did not have the prescribed benzodiazepine in their urine. This did not influence his prescribing of the medication. He not only continued the prescribing of these medications but increased the dose/frequency repeatedly. ...

...
It is my opinion that Dr. Wilson did not practice medicine that was consistent with the acceptable standards and prevailing medical practice. ...in addition, he committed a pattern of acts that I determined to be grossly negligent, grossly ignorant and grossly incompetent.

...
In summary, the pattern of acts includes:

1. Prescribing high risk medication to patients without examining the patient or determining a diagnosis.
2. Prescribing opioid medications to patients without indications for their use.
3. Prescribing benzodiazepines for patients without a diagnosis that warranted the use of these medications.

4. Prescribing benzodiazepines in combination with opioid medications without any concern for the risk associated with this combination; as though there were no consequences when combining these medications.
5. Prescribing controlled substances for patients with multiple incidents of aberrant behaviors.
6. Increasing the quantities and doses of opioids and benzodiazepines in response to the patient asking for increases rather than upon investigation of the problem.
7. Repeatedly prescribing benzodiazepines and increasing the doses in response to complaints of increased pain.
8. Never referring the patient for other therapies such as a psychiatrist, interventional pain specialist, physical therapy or surgeon. ...
9. Prescribing combinations and doses of medications that exceeded recommended doses and cautions. ...
10. Prescribing medications that may cause deleterious side effects from their use. ...
11. Continued to prescribe to patients within increasing doses while noting his intentions to decrease medications.
12. Continued prescribing of high risk opioid medications and benzodiazepines without explaining any of the aberrant behaviors to include failed urine drug testing, early refills, incidents with medications, etc. Rarely a mention was made regarding the aberrant behavior but the explanation was inadequate.

(The consultant's report, including summary reviews of each individual chart, was attached to the Complaint filed October 22, 2012, and is incorporated in its entirety by reference herein.)

7. The Board Consultant also found that "Dr. Wilson's practice of pain management constitutes a danger to the health, welfare and safety of the citizens of the Commonwealth of Kentucky. He prescribed with a level of flagrant neglect and without any obvious concern for the ramifications of his actions."
8. The licensee disputes and denies the Board consultant's findings, but acknowledges that after more than thirty years of practicing solely as an anesthesiologist, he got "in over my head" practicing pain medicine at Commonwealth Quality Healthcare, LLC.

9. On October 18, 2012, the Board's Inquiry Panel A determined that the licensee's practice constitutes a danger to the health, welfare and safety of his patients or the general public. As a result, the licensee was suspended from the practice of medicine in the Commonwealth of Kentucky. He remained suspended until entry of this Agreed Order of Indefinite Restriction.

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 medical license is subject to regulation and discipline by the Board.
2. The licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(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 the pending Complaint 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 the pending Complaint 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 Roland B. Wilson, 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 perform any act which would constitute the "practice of medicine," as that term is defined in 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, *unless and until* the Panel or its Chair has approved, in advance and in writing, the practice location at which the licensee may practice medicine. The decision whether to approve a particular practice location lies in the sole discretion of the Panel or its Chair. In determining whether to approve a particular practice location, the Panel or its Chair will particularly consider whether there will be appropriate supervision of the licensee, and may also consider the nature of the practice, including the licensee's proposed duties and hours to be worked. In approving such practice location, the Panel or its Chair may include, as it deems appropriate, specific conditions/restrictions to ensure patient safety. The licensee shall not change a practice location without first obtaining written approval by the Panel or its Chair for such change;
- b. In the event that the Panel or its Chair should approve a practice location so that the licensee may resume the practice of medicine in the Commonwealth of Kentucky, the licensee SHALL ONLY practice medicine in the specialty of anesthesiology in a perioperative practice environment.
- c. In the event that the Panel or its Chair should approve a practice location so that the licensee may resume the practice of medicine in the Commonwealth of Kentucky, the licensee SHALL NOT prescribe any controlled substances for patients' use outside of the facility of the approved practice location;
- d. The licensee SHALL NOT seek amendment of the immediately preceding ¶¶2(a)-(c) for at least four (4) years from the date of filing of this Agreed Order of Indefinite Restriction;
- e. Pursuant to KRS 311.565(1)(v), the licensee SHALL pay a FINE in the amount of ten-thousand dollars (\$10,000.00) according to the following schedule: at least \$250.00 each month for forty (40) months, with payment

due on the first day of each month beginning February 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 for the costs of the investigation and proceedings in the amount of three-thousand six hundred and seventy-five dollars (\$3,675.00), within six (6) months of the date of filing 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.

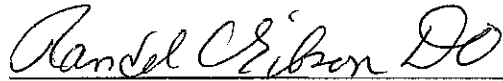
SO AGREED on this 17th day of January, 2013.

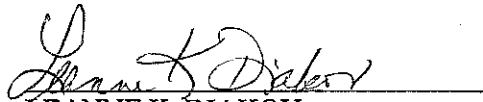
FOR THE LICENSEE:


ROLAND B. WILSON, M.D.

COUNSEL FOR LICENSEE
(IF APPLICABLE)

FOR THE BOARD:


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

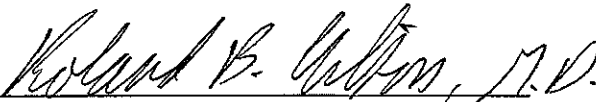

LEANNE K. DIAKOV
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Tel. (502) 429-7150

WAIVER OF RIGHTS

I, Roland B. Wilson, M.D., am presently the Respondent in Kentucky Board of Medical Licensure Case No. 1440. I understand that, under 201 KAR 9:082, I must waive certain rights if I wish to resolve this matter by informal dispensation. Accordingly, I WAIVE my right to raise any constitutional, statutory or common law objection(s) I may have to the Hearing Panel rejecting the proposed informal dispensation or to the curtailment of such a settlement by the Board's General Counsel or Assistant General Counsel.

Furthermore, if the Hearing Panel accepts the proposed Agreed Order of Indefinite Restriction as submitted, I WAIVE my right to demand an evidentiary hearing or to raise additional constitutional or statutory objections in this matter. However, if the Hearing Panel should reject the proposed Agreed Order of Indefinite Restriction, I understand that further proceedings will be conducted in accordance with KRS 311.530, *et seq.*, and I will have the right to raise any objections normally available in such proceedings.

Executed this 17th day of January 2013.



ROLAND B. WILSON, M.D.
Respondent

COUNSEL FOR THE RESPONDENT
(IF APPLICABLE)



Pain Management Consultants, LLC

1169 Eastern Parkway, Suite 2211 Louisville, KY 40217

Phone (502) 635-2775 Fax (502) 371-0475

Item 9
Page 930

Jeffrey W. Berg, M.D.
Carole A. Buskirk, ARNP

RECEIVED

SEP 13 2012

K.B.M.L.

Expert Review of Roland B. Wilson, MD
Summary of Findings/Narrative Report
Consultant: Jeffrey W. Berg, MD

I have reviewed 21 patient charts of Dr. Wilson, KASPER data from January 1, 2011 thru May 1, 2012; the investigative report prepared by Doug Wilson dated 6/11/12; and the written responses by Janie Castle, Andrea Kennedy and Dr. Wilson. I also reviewed the policies and procedures for Commonwealth Quality Health Care. I understand my review is of Dr. Wilson but it is important to evaluate the facility in which he elected to practice medicine. I will occasionally make reference to a specific chart or charts to further explain and describe a particular concerning practice. However, the referenced chart is not intended to be the only example of a particular practice habit or behavior by Dr. Wilson.

I am going to begin my review with general observations and opinions of the facility, including the operating policies and procedures. The facility was problematic in regard to new patient procedures, use of MRI reports, urine drug testing and record keeping.

Dr. Wilson chose to practice in a facility that mirrored the practices of a "pill mill". To become a patient at Commonwealth Quality Healthcare, a referral from another medical provider was not required. A prospective patient had to present with a six month pharmacy printout, a copy of an MRI report, a valid Kentucky identification card or drivers license, a social security card and cash payment for an initial visit and a urine drug test. The prospective patient was questioned if they had taken suboxone, methadone, methamphetamine, fentanyl or cocaine. If these drugs were found in the patients' urine they would not be a patient. The facility indicated they would validate the MRI report brought in by the patient and obtain one from the treating facility. If this procedure was followed a patient chart should contain two MRI reports; none of the charts contained two. The policy and procedure indicated the physician would review all KASPER reports and all data obtained on the patient and then he would determine if a patient was "worthy" of treatment at the facility.

The organization of the charts was difficult at best. The charts were separated by tabs but the documentation in the tabs often did not correspond to what was contained in the tabbed section. All patient charts had some type of consents for treatment albeit many were not signed appropriately; some charts lack any signature from staff or the patient. Many of these consents had the wrong year on them. There were several records that had data covered up by using "white out" liquid erasure; an example of this is in chart summary #5. Some of the charts had forms completed in pencil. Often there was illegible writing by Dr. Wilson.



Accredited by the
Joint Commission

Page 1

Some charts had tracking numbers to indicate KASPER data had been obtained but his was very inconsistent. For most of the charts the KASPER data was not acknowledged. I found more often than not, patients were given numerous early refills on their prescriptions for both benzodiazepines and opioid medications. There was no explanation or documentation for the early refills.

All of the patient charts contained reports from Calloway Lab indicating regular urine drug testing was performed at each patient visit. However, the utilization of this information was questionable. Frequently, the results were ignored. There were many occurrences of abnormal results that should have been clarified by additional testing and this was not done. One chart included test results that belonged to another patient; the patient was told of these results which were abnormal for his particular treatment plan. (See chart summary #17). There were several incidents where the facility cancelled the confirmation of a urine drug test. An example of this was when the patient tested positive for buprenorphine (suboxone), the confirmation was cancelled and there was no discussion of these results (See chart summary #3). The high levels of opiates were never confirmed. Frequently, amphetamine positive results were not clarified. There were many occasions in which a urine sample did not pass integrity testing. Again, this was not addressed. Nearly 100% of the twenty one charts reviewed had failed urine drug testing results and many failed urine drug testing numerous times.

There were occasional attempts at pill counts. Of the few successful pill counts it was difficult to determine the outcome. Several charts noted the pill count was not as it should be. Many attempts at pill counts were unsuccessful as might be expected. Two charts contained pill counts that were accepted by Dr. Wilson to be okay but these were questionable. These charts had documentation of a phoned in pill count from an individual named "Tony" who was employed at the local pharmacy. "Tony" reported by phone that the patient had the correct number of pain pill remaining from their prescription. This is not an acceptable practice. Particularly concerning is the lack of the full name and title of the individual calling to report the pill count (See chart summary #5 and #6 for detail).

Most patients had regular, monthly office visits. There were several patients that were given multiple controlled substance prescriptions repeatedly without being seen. None of the prescriptions written for controlled substances by Dr. Wilson were written to standard. None of his prescriptions contained the patients address. Some of the prescriptions lacked the numerical quantity written out and some lacked dates. There were some prescriptions with the dates that had obviously been altered.

It was apparent to me that Dr. Wilson demonstrated a lack of knowledge and a level of competence that would be expected of a physician practicing pain management. He acknowledged that as an anesthesiologist of twenty eight years, he "was not familiar" with oral pain medications. Further, he never practiced as a physician providing medical management. He demonstrated his lack of ability repeatedly in prescribing as noted by the combinations of medications and the dosing of medications. While I was concerned about his general lack of knowledge, I was disturbed by his obvious neglect to the basic fundamentals of the practice of

medicine and resulting lack of appropriate and prudent medical care. Fundamental to the practice of medicine, the physician not only obtains verbal information from the patient to explore the chief complaint and history of present illness but performs an examination of the patient. Dr. Wilson informed the investigator that he examined his patients. It was specifically reported to the investigator that "all new patients are required to have a physical examination". There were physical examinations by L. Kidd, RN as documented on a new patient form that also resulted in a nursing diagnosis. (See chart summary #9 and #21). A nursing examination cannot be substituted for the examination by the physician. A nursing diagnosis is not a medical diagnosis. A medical diagnosis is rendered after evaluation by the physician. There was no initial examination or focused physical examination results documented by Dr. Wilson. None of the 21 charts contained documentation that a history and physical examination was performed by Dr. Wilson. None of the charts had documentation that he examined the patients at follow up visits regardless of their complaints. There were some charts that did not have a history or physical examination from anyone.

Dr. Wilson did nothing to establish a diagnosis or formulate a working diagnosis. Not only were his follow up evaluations lacking in any documentation of an examination but in general the follow up patient visit notes were incomplete and inconsistent. The notes often were two or three lines and most commonly stated the "patient satisfied with the current regimen" and "without complaints". These notes were frequently the opposite of the information the patient gave to the triage nurse/staff member. There were frequent examples of the patient complaining of new symptoms or changes in symptoms. For example, some of these symptoms included neck pain which was new, radicular pain which was new and new complaints of joint pain i.e., knee pain. Again, Dr. Wilson never documented that he physically examined the area(s) of concern. He never addressed the problem except to increase either the opioid medication or the benzodiazepine. A particularly concerning example is chart summary #19. This young man had an acute injury but was expected to recover. He continued with severe pain and he requested opioid medications. Dr. Wilson did nothing to investigate the cause of the continued pain. He rapidly transitioned this patient from a mild analgesic to more than three high dose opioid and benzodiazepine medications without justification or any investigation of the problem.

Dr. Wilson not only neglected to formulate a diagnosis, he never followed up on any diagnostic testing previously ordered by the other physicians prior to his employment with the facility. Rarely did he order a diagnostic study and when he did, he never followed up on the status of the study. It was frequently unclear whether the patient actually went for the ordered study or not.

Dr. Wilson prescribed benzodiazepines regularly to his patients regardless of age and obvious risk factors associated with the use of these medications. He frequently prescribed benzodiazepines in response to a patient's complaint of increased pain. He would increase the benzodiazepine when the patient asked for additional pain medications. There were frequent occasions that a patient did not have the prescribed benzodiazepine in their urine. This did not influence his prescribing of the medication. He not only continued the prescribing of these

medications but increased the dose/frequency repeatedly. In one particular patient he diagnosed the patient with multiple psychiatric disorders; acrophobia, agoraphobia and claustrophobia etc. There was no documentation as to how he made these diagnoses. He never referred the patient to a psychiatrist or psychologist despite multiple patient complaints and behaviors of anxiety and depression. He prescribed multiple sedating and high risk medications. (See chart summary #6). This patient also presented with multiple aberrant behaviors.

An example of Dr. Wilson's medical care is noted in chart summary #5. This 21 year old male patient did not have a diagnosis that warranted the prescribing of high dose opioid medications. His diagnostic studies were essentially normal. He did have some type of leg and ankle surgery in the past following a motor vehicle accident. This patient was sent for psychological evaluations per Dr. Argotte and these evaluations suggested he should be referred to a substance abuse professional. His medical history was also positive for seizures. He was prescribed high dose opioid medications in combination with benzodiazepines without justification for their use and in spite of multiple failed urine drug screens and aberrant behaviors. This patient's urine drug testing was repeatedly negative for benzodiazepines. Another example of this type of medical care by Dr. Wilson is in chart summary #6. There were times Dr. Wilson issued controlled substance prescriptions without any documentation that the patient had been seen. (See chart summary #8).

It is my opinion that Dr. Wilson did not practice medicine that was consistent with the acceptable standards and prevailing medical practice. His general prescribing of medications which includes both controlled and noncontrolled medications appeared to be disconnected. In addition, he committed a pattern of acts that I determined to be grossly negligent, grossly ignorant and grossly incompetent.

Dr. Wilson also violated ethical principles established by the American Medical Association's Code of Medical Ethics and the KRS Medical Practice Act by prescribing controlled substances to at least two of his fellow employees; Lavonda Lazar and Andrea Kennedy.

In summary, the pattern of acts includes:

1. Prescribing high risk medications to patients without examining the patient or determining a diagnosis.
2. Prescribing opioid medications to patients without indications for their use.
3. Prescribing benzodiazepines for patients without a diagnosis that warranted the use of these medications.
4. Prescribing benzodiazepines in combination with opioid medications without any concern for the risk associated with this combination; as though there were no consequences when combining these medications.
5. Prescribing controlled substances for patients with multiple incidents of aberrant behaviors.

6. Increasing the quantities and doses of opioids and benzodiazepines in response to the patient asking for increases rather than upon investigation of the problem.
7. Repeatedly prescribing benzodiazepines and increasing the doses in response to complaints of increased pain.
8. Never referring the patient for other therapies such as a psychiatrist, interventional pain specialist, physical therapy or surgeon. Dr. Wilson reported to the investigator that he referred to others when indicated. Review of the charts did not reveal this. In fact he neglected to refer.
9. Prescribing combinations and doses of medications that exceeded recommended doses and cautions. For example, high doses of acetaminophen and tramadol. High doses of tramadol; more than 400mg per day in combination with other SSRI/SNRI medications without any apparent concern for the risk of serotonin syndrome and seizure. He prescribed in this manner to a patient with a documented history of seizures.
10. Prescribing medications that may cause deleterious side effects from their use. An example includes prescribing Stadol to a patient on high dose opioid medications. The use of this medication could precipitate opioid withdrawal.
11. Continued to prescribe to patients with increasing doses while noting his intentions to decrease medications.
12. Continued prescribing of high risk opioid medications and benzodiazepines without explaining any of the aberrant behaviors to include failed urine drug testing, early refills, incidents with medications etc. Rarely a mention was made regarding the aberrant behavior but the explanation was inadequate.

Dr. Wilson's practice of pain management constitutes a danger to the health, welfare and safety of the citizens of the Commonwealth of Kentucky. He prescribed with a level of flagrant neglect and without any obvious concern for the ramifications of his actions.

Submitted: _____

Jeffrey W. Berg, MD

CHART REVIEWS

RE: Roland B. Wilson, MD

1. [REDACTED] Dr. Argotte initially evaluated this patient on 4/13/11. She reported a 20 year history of chronic pain in the back, neck and most joints; anxiety and depression. She reported that she had been under the care of a pain specialist prior but left because she did not like the doctor. She reportedly had physical therapy and injections but did not benefit from these therapies. She also reported a prior evaluation from a neurosurgeon. She was diagnosed with uncontrolled pain as a result of cervical, thoracic and lumbar pain, arthritis, anxiety and fibromyalgia. Dr. Argotte reviewed radiology studies from 3/2009 and indicated the following results; cervical degenerative disc disease with disc bulging and herniation, facet arthropathy and spinal stenosis; lumbar degenerative disc disease with herniation, facet hypertrophy and stenosis. She was prescribed an opioid analgesic for pain- Percocet 10/650 4/day; a muscle relaxer-baclofen 10mg 3/day; an AED-lyrica 75mg 3/d; an NSAID-diclofenac 50mg daily and an antidepressant-Paxil 10mg daily. The lyrica and Paxil were increased at the next visits. The last visit with Dr. Argotte appeared to be 6/9/11. The patient returned on 7/13/11 and saw Dr. Greenlaw who was now the physician for the facility. He referred the patient for a surgical consult and prescribed the following medications: Ultram 50mg 3/day, oxycodone 15mg 4/day, Xanax 1mg 2/day, diclofenac 100mg per day, lyrica 100mg 3/d, baclofen 20mg 3/day and celexa 20mg per day. This appeared to be the only visit with Dr. Greenlaw and on 8/10/11 the patient returned for follow up and was seen by Dr. Dehaven. She reported to him that she needed stronger pain medications. She was prescribed Xanax 1mg 2/d, Lorcet 10/325 2/day, oxycodone 15mg 4/day, lyrica 100mg 3/day, baclofen 20mg 3/day and celexa 20mg daily. She returned on 9/8/11 and all medications remained the same except baclofen was discontinued and soma 350mg 3/d was prescribed; Lorcet was discontinued and Percocet 10/325 3/day was initiated. Dr. Wilson began treating the patient on 10/12/11. The patient reported pain but stated meds were helping. A urine drug test was performed and negative for benzodiazepines and oxycodone but positive for amphetamine and opiates. The specimen was sent for confirmation of oxycodone which was negative. She was given the same medication prescriptions as per the previous visit prescribed by Dr. Dehaven. 11/9/11 she returned and reported she was out of soma and the other medications were not working for her. The confirmation report for the urine test of 10/12/11 was negative for oxycodone. The specimen was screened again by the confirmation lab and resulted positive for benzodiazepines and opiates but not confirmed. The level of amphetamine was not conclusive. A notation was made on the follow up triage form, "med may need to be reevaluated". She was given the following prescriptions: Percocet 10/325 #45 to take 1 every 8 hrs, oxycodone 15mg #60 to take 1 every 6 hrs, lyrica #102 to take 1 every 8 hrs, Xanax 1mg #30 to take 1 twice per day, soma 350mg #102 to take 1 every 8 hrs and celexa 20mg #34 to take 1 per day. She also had a urine drug screen which was positive for opiates, benzodiazepines and oxycodone. The sample was confirmed to be positive for benzodiazepines and oxycodone. The rescreening of the opiates was again

positive but not confirmed. The patient returned on 11/23/11 had a urine drug test was positive for opiates, benzodiazepines and oxycodone. Confirmation was performed on benzodiazepines and oxycodone which were both positive. A pill count was also performed on this visit. She returned on 12/14/11 complaining of a new shooting pain requested an increase in Percocet by one pill and other medications working ok. Dr. Wilson gave the following prescriptions: He increased the Percocet 10/325 to #120 4/day, oxycodone 15mg #120 4/day, soma 350mg #60 2/day, lyrica 100mg #90 3/day and Xanax 1mg #60 2/day. No other treatments or evaluations were requested. On the return visit of 1/12/12 no changes were made and the same prescriptions were issued. 2/9/12 she complained of poor sleep but medications were okay. She was given an increase in Percocet 10/325 #140 with directions of 1 every 6 hours, an increase in oxycodone 15mg #140 with directions of 1 every 6 hours, an increase in soma 350mg #70 with directions 1 every 12 hrs, Xanax 1mg #70 with directions every 12 hrs and Lyrica 100mg #105 one every 8 hours. It is unclear why the change in quantities except a notation was made on the follow up visit that the visit of 3/14/12 was 5 days late. On this visit the patient requested one more Xanax which was denied. Soma was to be decreased and then discontinued. The same prescriptions were issued except the soma was decreased to #30 and the quantities were the same as prescribed on 1/12/12. The follow up visit of 4/12/12 had the confirmation results from the previous visit that noted the patient to have valium or metabolite of valium in the urine which should have been positive for Xanax or its metabolites. Dr. Wilson made a note that the patient "may have been given the wrong med". The prescriptions issued were the same as previous except the oxycodone 15mg was decreased to #90. 5/10/11 the patient reported "unbearable pain the back" and "nerves shot". Notation was made by Dr. Wilson on a form titled, "Miscellaneous Patient Information" that the patient had 3 relatives dying of cancer and he refused an increase in Xanax but increased her oxycodone 15mg to #140 with the same directions of 1 every 6 hrs, Xanax 1mg was increased in quantity to #70 but the directions were the same, Percocet 10/325 was also increased to #140 with the same previous directions of 1 every 6 hrs and Lyrica was increased to #105 with the same previous directions.

DIAGNOSIS/TREATMENT- Below minimum standards for both.

The initial history and physical was complete and it was done by another physician. The diagnostic studies appeared to be valid and the diagnosis justified the use of treatment with opioid medications. MRI of the lumbar spine revealed a right L5-S1 hemiated disc with bilateral neural foraminal encroachment, a central disc herniation at L4-5 with bilateral neural foraminal encroachment and mild bulging of the L3-4 disc. An MRI of the cervical spine revealed a high grade stenosis at C5-6 with associated cord edema because of a large central and right sided C5-6 disc herniation with bilateral neural foraminal encroachment, bulging at C4-5 and a central disc protrusion at C3-4. A surgical consult was ordered on 7/13/11 but never followed up on. There was no indication in the record that Dr. Wilson reviewed the initial history and physical or the MRI studies; he never rendered a diagnosis or diagnoses that could be found in the documentation. There were never any physical examination notes by Dr. Wilson. There were no other treatments or referrals for

care or follow up on the one referral that was requested by the preceding physician. Utilization of urine drug testing was included however; there were concerns. The patient had upon several occasions not tested as she should have; missing the medication prescribed (oxycodone) and having medication not prescribed, (valium and possibly amphetamines and opiates); the consistently positive result of opiates when not expected was never tested by confirmation because the level was below the lab designated cutoff. There appeared to be a pill count x1; results were unclear. The documentation included urine drug screening regularly and monthly appointments. There were occasional tracking numbers indicating a KASPER had been obtained. These medications were increased without justification. Dr. Wilson indicated he was decreasing and he did eliminate the soma but other medications were increased. The opioid medications also appeared to be increased because the patient described personal stressors and anxiety. Opioids are not indicated for anxiety and stress.

RECORDS- Below minimum standards

There were neither records nor apparent attempts to obtain prior pain management records. The records were full of forms that had missing dates and incomplete identification. There were never any working diagnoses after Dr. Wilson began. Notes pertaining to office visits were confusing; visits had a "Follow up Triage" note prepared by the nurse often without any physician comment or note. Notes written by Dr. Wilson were sparse; they were almost nonexistent. As stated above there were no notes describing physical findings by Dr. Wilson. The controlled substance prescriptions were not written to standard; none had the patients address nor spelled out the numerical quantity, and dates frequently missed the year.

OVERALL OPINION- Below minimum standards and gross incompetence and gross ignorance

There was no documentation that Dr. Wilson examined this patient. He gave no explanation for the changes he made in her medications. He prescribed increases in opioid medications in response to complaints of increased anxiety; this was inappropriate. She was prescribed not only high dose opiate medication in its most abuseable form but in combination with benzodiazepines.

2. [REDACTED] Appeared to present for Initial evaluation on 1/27/2011. He complained of a work related injury that occurred in 1993 and 1996. His complaints were of upper back and shoulder pain, lower back pain that radiated down the left leg to the foot and some pain in the right leg to the back of the knee. He was seen at that time by Mary Beth Scott-Calor, DO. A physical examination was performed. It was noted that patient weighed 420 pounds. She diagnosed him with CRPS or CPS (complex pain complex regional pain syndrome or complex pain syndrome; it is unclear; CLBP (chronic low back pain), "left leg radicular pain" and what appeared to be sacroiliitis left greater than right. Her treatment plan was not entirely legible but indicated pt was to have Nucynta, tramadol and oxycodone 15mg. Copies of her prescriptions were not on the chart. Prior treatment included physical therapy and epidurals from 1997 thru 2000. The next office visit was on 3/31/11 and the physician was now Alex Argotte, MD. His treatment plan included referral for a MRI of the thoracic and lumbar spine and psychological evaluation and lab work. (A urine drug screen was sent to the confirmation lab which later returned positive for valium and soma; neither prescribed for the patient). He was given prescriptions for Ultram 50mg #120 4/day, Nucynta 100mg #150 5/day, lorazepam 1mg #90 3/day, Percocet 10/325 #120 4/day and Zoloft 100mg #30 1/day. The patient returned on 4/27/11 he complained of medications not lasting long enough and more anxiety. He reported a poor functional status. He completed a depression screening tool, lorazepam was discontinued, he was referred to an endocrinologist, orders were again written for MRI studies and a psychological evaluation. He appeared to have been questioned about the prior urine drug screen confirmation results which were not as expected and advised that he took his wife's valium and took soma that had been prescribed in years prior. Medications were the same except the lorazepam was discontinued. A urine drug screen was obtained and sent for confirmation which was again positive for soma. Visit of 5/24/11 the patient was instructed not to take medications not prescribed for him. Pt also requested to resume his lorazepam. He was given the following prescriptions; lorazepam 1mg #90 3/day was resumed and soma 350mg q12h pm #30, Nucynta 100mg was increased to #180 6/day and the Percocet and Zoloft remained the same and Ultram was increased to 8 /day. Visit of 6/20/11 patient reports medications are working. The next several visits were by Dr. Greenlaw and then Dr. Dehaven. Again diagnostic studies were ordered which also now included an MRI of the knee, referral to an internist and nutritionist and medications were adjusted. The patient complained about acetaminophen intake. Oxycodone 15mg #120 was added in place of Percocet, at the following visit this was increased to 30mg 9/19/11, Nucynta 100mg was decreased and then increased to #180 6/day, Ultram remained the same, lorazepam remained the same, Norflex 100mg #90 3/day was added for muscle spasms and Neurontin 800mg #90 3/day was added, the lorazepam was decreased to 1mg #30 1/day and all other medications remained the same. The patient's urine drug testing was again in June, July, and September positive for opiates but never confirmed.

10/20/11 Dr. Wilson sees the patient for the first time. He documents on a form called, "Miscellaneous Patient Information" that the patient has chronic pain and complains of pain in the low back, Ultram does not work well and Neurontin upsets his stomach and

patient is to see an endocrinologist. The triage nurse writes that patient has pain in his upper back and radiating into mostly the right side, meds working well and no other issues. Pt was given an order for an MRI of the cervical and thoracic spine. He is given prescriptions for Ativan 1mg #30 1/day, Nucynta 100mg #150 5/day, oxycodone 30mg #120 4/day, Ultram 100mg #120 4/day, and Zoloft 100mg #30 1 day. The Norflex and the Neurontin were discontinued. The patient missed his next appointment because his mother was in the hospital. However, there was a note dated 11/-/11 with partially completed answers from the patient regarding his pain etc. He was allowed to obtain a one week supply of his medications. 11/28/11 he returned for follow up. Patient requested an additional Ativan per day and assistance obtaining a motorized scooter. Triage note from the office staff describes patient having a new complaint stating the pt thought he had ruptured another disc, problems moving his back, stated he was taking soma prn. The following prescriptions were issued to the patient: oxycodone 30mg #124 directions 1 every 6 hours, Ultram 100mg #124 to take 1 every 6 hours, Nucynta 100mg #155 to take 1 every 4-6 hours, Ativan 1mg #31 to take 1 daily and Zoloft 100mg #31 to take on every day. 12/27/11 a note written on the "Miscellaneous Patient Information" form by someone other than Dr. Wilson writes the lab ok, patient requests increase in Ativan, Plan: double Ativan, write other meds same". This note did not have a signature or appear to be written by Dr. Wilson. The patient was issued the following prescriptions: Ativan 1mg #60 which was increased, doubled to 1 pill every 12 hrs, Nucynta 100mg #150 with directions for 1 every 5 hours, Ultram 100mg #120 1 every 6 hours, oxycodone 30mg #120 1 every 6 hours and Zoloft 100mg #30 to take daily. 1/24/12 no new complaints, no changes and the same prescriptions were issued. Dr. Wilson makes a note that the patient is satisfied and will continue the same meds. The same prescriptions were issued. 2/21/11 Dr. Wilson notes, "Pt satisfied with current regimen, plan: write same meds". Prescriptions were issued. 3/20/12 Dr. Wilson makes a note, "pt without complaints, plan: write same meds." The same prescriptions were issued. 4/17/12 Dr. Wilson requests MRI of "entire spine" and issues a written order for an MRI of the cervical and thoracic spine. The staff member notes on the triage note that the patient had been out of "oxy" since Sun, and pt suspected the pharmacy to have shorted him. It was also noted on the triage note that the patient had been "self medicating" and stated "Soma and klonidine was prev prescribed by this facility". Dr. Wilson wrote to continue the same medications but he added oxycodone 15mg #120 to take 1 every 6 hours and decreased the oxycodone 30mg to #60 with directions to take 1 every 12 hours and the remainders of the prescriptions issued were the same. 5/14/12 was the last documented visit in the chart. The triage note describes the patient to be "weaker". Dr. Wilson writes that the patient is satisfied with the current regimen and continues the same medications. Prescriptions issued were for increases in quantities of all: Zoloft 100mg #32, Ultram 100mg #128, Ativan 1mg #64, oxycodone 30mg #64, oxycodone 15mg #128 and Nucynta 100mg #160; there were no direction changes in any of the prescriptions issued.

DIAGNOSIS & TREATMENT- Below minimum standards for both.

The patient had findings on an MRI from 1997 and 1994 that clearly indicated degenerative disc disease of the lumbar spine with left paracentral disc hemiations at L5-S1 with displacement of the left S1 nerve root and a small annular tear and central disc bulging at L3-4 and L4-5. This pathology justified the use of some of the medications prescribed. There was never any documentation that Dr. Wilson examined the patient, he never rendered diagnoses that warranted the medications prescribed. While there were multiple orders for the patient to have updated MRI studies these were apparently never performed. Nor, was there any documentation of why the studies were not obtained. The only documentation about pain did not mention the neck; it is unclear why Dr. Wilson ordered an MRI study of the cervical spine. The choice to use two shorter acting, high risk opioids/ oxycodone was clearly inappropriate at the doses prescribed and in combination with Nucynta and Ultram. When Dr. Wilson increased doses albeit by small quantities there was no documentation as to why he was doing so. Increases in medications appeared to be in response to requests for additional Ativan. Dr. Wilson did increase the benzodiazepine; he doubled the quantity. He increased the quantity of Ativan and did not make any referral to psychiatry or psychological services. The patients' documented functional status never appeared to improve in spite of the multiple medications prescribed. The chart occasionally contained numbers that appeared to indicate tracking of a KASPER report but this was not consistent. The use of urine drug screening was noted to be marked "yes" in response to "Unanticipated urine screen". However, it is clear the urine drug screen was expected was at each visit. The patient also had several urine drug screens that included medications not prescribed and he acknowledged taking his spouses' medication. Dr. Wilson did not document any discussion regarding aberrant behaviors.

RECORDS – Below minimum standards.

The chart did contain a complete physical examination and history per Dr. Argotte. There were some prior records from the time the patient indicated he had been injured at work. There were records of a discogram and 2 prior MRI studies of the lumbar spine; dates 1998, 1997 and 1994 respectively. There was no documentation or indication that Dr. Wilson reviewed any of these records. The diagnosis of CRPS/CPS initially given to the patient was never validated or mentioned elsewhere in the chart. There was no documentation to indicate Dr. Wilson followed up on any of the prior studies or consultations ordered, including the one ordered by him. Frequently there were conflicting years on records, information written in pencil and lack of employee/physician signature. Prescriptions were not written to standard. There were never any addresses placed on the controlled substance prescriptions. The section in the chart that states "Progress Notes" does not correspond. Often what appeared to be a progress note was located in the "RX" section of the chart. There were several depression screens and tools to evaluate risk associated with the prescribing of opioid medications; these did not appear to be utilized by Dr. Wilson; the documentation indicated Dr. Argotte reviewed these.

OVERALL OPINION- Clearly below minimum standards.

Dr. Wilson never examined the patient, never documented or explained a change in medication related to the patient's condition. His decision to continue the combination of medications was clearly inappropriate. He was prescribing the maximum amounts of Tramadol to a patient also taking higher doses of an SSRI; Zoloft.

The patient was prescribed 4 controlled substances to treat his pain; 3 of which were scheduled II medications. Two of which were high dose in the most abusable form. Dr. Wilson also prescribed high dose benzodiazepine with the opioid/opiate medication which at the doses prescribed result in a dangerous and intoxicating mix. The selection of medications to treat the pain was inappropriate.

3. [REDACTED] Patient had an approximate 12 year history of chronic pain. She initially presented to Commonwealth Quality Healthcare (CQH) on 3/17/11. She was evaluated by A. Argotte, MD. She complained of "center" lumbar pain that was radiating to her anterior and lateral thigh; she stated the pain was constant and sharp. She complained of right hand numbness with activity. She had been to prior pain management physicians. She refused injections. Prior treatment consisted of opioid medications and other medications. She reported being unable to work. She would clean her home when pain levels allowed those activities. She was caring for her disabled husband who had also become a patient of CQH in 1/11. She had cervical, thoracic and lumbar MRI studies performed in 9/21/10 and 6/03/09. The cervical MRI was positive for congenital narrowing of the spinal canal because of short pedicles, multilevel disc bulging and a posterior disc herniation at C6-7 with cord compression. The thoracic MRI demonstrated multilevel disc bulging. The lumbar MRI demonstrated disc bulging from L3-4 through L5-S1 with facet hypertrophy and severe impingement upon the bilateral lateral recesses at L5-S1. She was diagnosed with muscle spasms, anxiety, chronic low back pain, depression and carpal tunnel syndrome. She was given a referral for physical therapy, an upper extremity nerve conduction study, and a psychological evaluation. She was to resume her present regimen of medications. She was given the following prescriptions: Diazepam 10mg #30 to take 1 every day, Nucynta 100mg #120 to take 1 every 6 hrs prn, Ultram 50mg #60 to take twice per day, Soma 350mg #60 to take every 12 hrs and Percocet 10/325mg #120 to take 1 every 6 hrs prn. The patient had follow up visits on 4/14/11, 5/10/11, 6/7/11 or 6/8/11, 7/6/11, 8/2/11, 8/28/11 or 8/29/11 and 9/29/11. These visits had conflicting dates recorded. They were conducted by Dr. Argotte, Dr. Greenlaw and Dr. Dehaven. There was a "Patient Pill Count Sheet" dated 4/23/11 with documentation that the patient was called in for a pill count but could not make it. Her medications prior to seeing Dr. Wilson were: Ativan 1mg #60, Nucynta 100mg #150, Soma 350mg #60, oxycodone 30mg #120, tramadol 100mg #180 and Paxil 25mg #30. On 11/3/11 Dr. Wilson saw the patient for the first time. He wrote on the "Miscellaneous Patient Information" form that "pt ok with present regimen and rewrite meds scripts same". An untitled check list type form had the date of 11/3/11 and yes/no responses to questions. The patient was given prescriptions with quantities that are confusing. Perhaps because the patients' next appointment was in more than 30 days she was given different quantities but this is not clear because there was no documentation to explain the decision. The following prescriptions were issued: Paxil 25mg #32 with directions 1 per day, Soma 350mg #64 with directions 1 every 12 hrs, oxycodone 30mg #128 to take 1 every 6 hrs, tramadol 100mg #180 to take 1 every 4 hrs, Nucynta 100mg #160 to take 1 every 4-6 hrs, and lorazepam 1mg #64 to take 1 every 12 hrs. The next appointment appears to be on 12/8/12. On this visit the chart contains two confusing prescriptions written by Dr. Wilson. One is for Nucynta with a notation that script needs to be written on a green one; another prescription for Nucynta is dated for 12/12/11 same quantity. A tramadol prescription was written but the date is 12/15/11 for 50mg #240. Dr. Wilson makes a note on the same miscellaneous form that Calloway lab test was within normal limits, the plan was to discontinue Soma, leave other meds the same and decrease oxycodone 30mg by 1 pill and increase oxycodone

15mg by 1 pill and the following month discontinue the oxycodone 15. A triage note for the same day appeared to be signed by [REDACTED]. The patient was given the following prescriptions: oxycodone 30mg #132 which was increased not decreased and directions were to take 1 every 6 hrs, lorazepam 1mg #66 which was increased with directions to take 1 pill every 12 hrs, the Nucynta 100mg #165 which was increased and no change in directions, tramadol which appeared to be phoned to the pharmacy and changed to 50mg #198 with directions to take 1 every 4 hrs and Paxil 25mg #33 which was an increase and no change in directions. (The Kasper report does not reflect these Rx as they are reflected by the copies in the chart). On 1/5/12 prescriptions were issued again for the patient but there is no note of any kind from Dr. Wilson. There is a triage note from an office person that was unremarkable. A urine drug screen was performed for that day opiates tested positive at more than 3000 but not confirmed. The prescriptions were given to the patient early by 2 days. Ultram 50mg #240 with directions 2 every 6 hours, Lorazepam 1mg #60 with directions 1 every 12 hrs, oxycodone 30mg #120 with directions 1 every 6hrs, Nucynta 100mg #150 with directions 1 every 5 hrs and Paxil 25mg #30 with 1 every day. 2/6/12 the patient returns and Dr. Wilson makes a note that the patient is satisfied with the current regimen and the plan is to write the same meds except decrease the oxycodone 30mg by 1. The patient was issued the following prescriptions: the oxycodone 30mg was decreased to #90, Ultram was changed to 100mg #120 to take 1 every 6 hrs, Lorazepam and Paxil remained the same. A prescription copy for oxycodone 10mg #90 with directions to take 1 pill every 8 hrs was in the chart for 2/16/12 but there is no note or documentation to explain its existence. 3/7/12 Dr. Wilson makes a notation that the patient is satisfied with her current regimen, requests 3 refills on her Paxil which he granted and he will continue to write same medications. The triage note from staff member Yavonda reports the patient to be complaining of low back, neck and sciatica pain and was having pain in her ovaries. The patient was given the same RX including another RX for the oxycodone 10mg #90. The lorazepam prescription had the date of 3/8/12 on it which was different from the other which had the 3/7/12 date. 4/2/12 The patient returned and was noted by Dr. Wilson to be satisfied with her current regimen and he was going to write for the same meds. The triage note documents that patient "may have took 1/2 Klonopin". The chart contains what appear to be copies of prescriptions issued on this visit but there is confusion. The chart does not appear to contain all copies of prescriptions issued. The KASPER lists Lorazepam #60 filled on 4/2, oxycodone 30mg #90 filled on 4/2/12 and Nucynta 100mg #150 filled on 4/2/12 and oxycodone 10mg #90 filled on 4/12/12. It is unclear what prescriptions the patient was issued in the office visit of 4/2/12. The last visit documented in the chart was on 4/30/12. Dr. Wilson notes the patient as doing well and to write the same meds. Prescriptions were issued for Lorazepam 1mg #56, oxycodone 10mg #84, oxycodone 30mg #84, Nucynta 100mg #140, Ultram 100mg #112 and Paxil 30mg #84.

DIAGNOSIS , TREATMENT & RECORDS-All three categories were below minimum standards.

The patient had a diagnosis of severe stenosis at multiple levels in her spine. The chart contained an adequate history and physical upon her initial treatment by Dr. Argotte. There was no documentation that Dr. Wilson ever examined the patient. He never attempted to clarify the possible diagnosis of carpal tunnel syndrome. There was no follow up on previously ordered studies and referrals. There were no other treatments for the patient except for medications. The attempts to monitor the patients' use of controlled substances were inadequate. Though urine drug screening was utilized at each visit the decision to cancel confirmation of presumed positive substances not prescribed was concerning. The patient admitted she was taking medications not prescribed for her but to her husband. Results of another screening indicated she had taken buprenorphine and hydrocodone; neither prescribed. The buprenorphine is found in a transdermal opioid medication called Butrans. Buprenorphine is also Suboxone. The confirmations initially requested for both of these substances were cancelled for reasons that were not clear. There was no documentation that the results were reviewed and considered by Dr. Wilson. There were other confirmations that were cancelled for reasons that are not clear. The prescribing mixture was inappropriate. Dr. Wilson exceeded the maximum recommended dose for the safe prescribing tramadol. This was particularly concerning because the patient was also prescribed SSRI medication which in combination with tramadol may cause seizures etc. The records never contained any working diagnoses. The chart had divided categories of records that were confusing and often had conflicting dates. The controlled substance prescriptions never were written to the appropriate and expected standard of also including the address of the patient. KASPER tracking numbers were at times on the triage record.

OVERALL OPINION- Below minimum standards and considered to be gross ignorance and gross incompetence.

There was never any documentation of a physical examination or diagnosis rendered by Dr. Wilson. He never followed up on any prior studies requested. He appeared to ignore obvious aberrant behaviors concerning high risk medications. He ignored repeated abnormal urine drug testing results. His prescribing of medications was grossly incompetent and without apparent concern for the safety of the patient. He prescribed multiple high risk medications with inappropriate doses and combinations.

4. [REDACTED] She appeared to have received care from Commonwealth Quality Health Care in 2010. (CQH) She was treated by numerous physicians at CQH. Physicians included Najam Azmat, MD; Mary Beth Scott-Calor, DO; Alex Argotte MD; R. Greenlaw, MD and H. Dehaven MD prior to Dr. Wilson. She presented with complaints of arm, elbow, low back and neck pain. She was involved in an accident at the age of 16 or 16 or 17 and fractured her left arm; the fracture required the placement of hardware. She was involved in motor vehicle accidents in 2001-2003 and in 2009. She began to have complaints of neck and back pain in addition to the arm pain. MRI studies taken in 2009 revealed the following: cervical spine study was normal except for straightening of the normal curve suggesting an underlying muscle spasm; thoracic spine was normal and the lumbar spine demonstrated a disc bulge at L5-S1. The patient also complained of significant anxiety and insomnia. She was diagnosed in 2010 with CPS/chronic pain syndrome, myofascial pain and "probably fibromyalgia" by the initial treating physician at CQH. (It is difficult to follow the flow of patient care due to the placement of records in the chart). There were episodes of aberrant behavior documented throughout the chart prior to Dr. Wilson's care. Examples include "borrowing" medications from friends, see note per Dr. Argotte on 3/10/11; purchasing medications "off the street", see note per illegible name written on "Miscellaneous Patient Information" sheet dated 12/14/10; note written "no pot" on 1/24/11 by what appears to be ? Dr? Some attempts at pill counts were not successful, see note written on 4/7/11 by Dr. Argotte. In addition, the patient had multiple red flags with urine drug screening. For example, the urine drug test performed on 9/30/11 did not pass validity testing and the sample contained opiates in addition to the oxycodone and benzodiazepine. The sample was not sent for confirmation of the hydrocodone (opiate). She was ordered to have a physical therapy psychiatric evaluation and other diagnostic studies but was unable to go because she reported financial limitations. On 9/30/11 she was given orders to have MRI studies of the cervical, thoracic and lumbar spine and a note indicated Percocet would be added until the results of the diagnostic studies were completed. 10/31/11 Dr. Wilson began care of the patient. There is a note under the "progress notes" tab of the chart that was not signed by anyone but lists a KASPER tracking number, vital signs and various questions. Under the "RX" tab of the chart is a note written on the same day which appears to be from Dr. Wilson and states, "pt satisfied with current med regimen, will script same meds and return in 1 month". The patient was given the following medications: oxycodone 15mg #90 to take 1 every 8 hrs, Percocet 10/650 #60 to take every 12 hrs and Xanax 2mg #60 to take 1 every 12 hrs. The urine drug screen on this date did not have benzodiazepines present as should be. 11/29/11 she returned for follow up and Dr. Wilson notes the abnormal lab, he also notes that the patient requests Fioricet for her headache because she took her mother's Fioricet and it "worked". He notes other medications are working well. He wrote he would continue all other medications. The following prescriptions were given: oxycodone 15mg #90, Percocet 10/650 #60, Xanax 1mg #30 and Fioricet #30 with directions to take 1 daily prn. The patient was called in for a pill count on 12/7/11 but stated she could come on the following Monday. She came for the pill count on 12/12/11 and it appeared to be okay. She was given an additional prescription for Xanax on that day because her prior

prescription was a partial prescription. The visit of 12/22/11 has a notation from Dr. Wilson, "Calloway 11/29 OK". She was given the same prescriptions as the 11/29/11 visit and in error was given an additional Xanax prescription. 1/19/12 patient returned for follow up. Dr. Wilson made a note that the patient goes by the name [REDACTED], she was satisfied with her current regimen and all medications were to be written the same. However, there was not a prescription noted for Floricet. The Xanax continued to be off the regular schedule as the patient picked up a prescription for Xanax on 12/27/11. 2/16/12 A triage note by the nurse/staff could not be found for this date. There was a note written by Dr. Wilson stating "no complaints, plan: write meds same". She was given the same prescriptions for oxycodone, Percocet and Xanax. A urine drug test on this date indicated there was no Xanax in the urine. 3/15/12 Dr. Wilson makes a note that patient was without complaints; benzodiazepines were negative and plan to write the same meds. She was issued the same prescriptions for oxycodone, Percocet and Xanax. 4/12/12 Dr. Wilson addressed the negative benzodiazepine result from the previous visit. He wrote a lengthy note as compared to prior notes and addressed in this note the patient's use of soft drinks and dental deterioration; he instructed her regarding proper dental hygiene. At this visit he writes his plan is to decrease the oxycodone by 1 pill and increase the Percocet by one and other medications to remain the same. He issued the prescriptions with changes as he described but did not explain why. Prescriptions issued were: Oxycodone 15mg #60 with directions 1 every 12 hrs, Percocet 10/650 #90 1 every 8 hrs and Xanax 1mg #60 every 12 hrs. 5/10/12 the patient's urine drug test was again negative for benzodiazepines. The follow up triage note from the nurse/staff indicates "pt was told no more bad labs 2 -bzo in final lab, -bzo today". Dr. Wilson makes a note, "pt w/o complaints, plan: write meds same". On this visit Dr. Wilson increased the patient's medications as follows and was given the following prescriptions: oxycodone 15mg #70 (with no change in directions) 1 every 12 hrs, Percocet 10/650 #105 (no change in directions) 1 every 8hrs and Xanax 1mg #70 (no change in directions) 1 every 12 hrs.

DIAGNOSIS & TREATMENT- Below minimum standard for both,

There never appeared to be a diagnosis given by Dr. Wilson. There was no documentation in the record that he ever examined the patient, reviewed prior studies or notes and followed up on prior diagnosis and plans. The diagnostic studies do not indicate the patient has a diagnosis that justified the use of the prescribed controlled substances for pain. She was treated with more than one high risk shorter acting opioid without the indications. The patient was given medications repeatedly while the record documented repeated aberrant behaviors. KASPER data reviewed indicates the patient was also given multiple early refills on her medications. Dr. Wilson never wrote any orders for consultations or referrals to diagnose pain complaints or treat her anxiety.

RECORDS - Below the minimum standard.

The organization of forms and documents in the chart was poor. The chart contains tab separators but the documents are placed throughout. An example of this is the placement of what appears to be a progress note and on a form titled, "Miscellaneous

Patient Information" in the RX tab and also appears at times in the "History and Physical" tab. There are numerous forms which do not contain any name, etc. There are notes written without any signature. As stated above there is no diagnosis by Dr. Wilson. The working diagnosis is never validated. None of the controlled substance prescriptions are written to standard; all without address, some without the year and none with the numerical quantity written out. There are tracking numbers periodically that indicate a KASPER report was obtained but rarely are the results of the report noted.

OVERALL OPINION- Clearly below the minimum standards. Grossly Ignorant and grossly incompetent.

Dr. Wilson continued to prescribe high risk medications without documentation that he examined the patient or rendered a diagnosis. He prescribed these medications to a patient that did not have the indications to use them and increased them frequently. Further, he ignored obvious behaviors that indicated the patient was either diverting the medication or developing an addiction to the medications. A review of the KASPER data indicated that the patient was given significant early refills from February thru May of 2012. While the record contains tracking numbers to indicate a KASPER report was obtained it is apparent by Dr. Wilson's actions indicate that he never considered this information while treating the patient or simply chose to ignore it. He counseled the patient about proper dental hygiene but did not address bad urine drug testing results. The decision making regarding not only the choice of medication but quantities is flawed. He departed from the minimum standards to such an extent that his care of the patient is concluded to be grossly ignorant and grossly incompetent.

5. [REDACTED] Patient appears to initially present to the facility in 2010. However, from review of the chart it is not conclusive as to when he actually presented. A consent form located in the "History and Physical" section does not have a date on it because white out has been used to cover up the date written on it. This form is some type of consent and contains a patient signature in several places; both dates on the form have been covered up with white out. He complained of chronic pain as a result of a motor vehicle accident in 2006. In that accident he sustained multiple fractures; right leg, left ankle (which required surgery) and left wrist. He also complained of lower back pain that was radiating down the leg. In the patient's self-reported questionnaire he reported that he had an arrest for a DUI in mid 2010. On another document it notes the patient to be on probation June/July 2012. The chart contains an MRI of the lumbar spine dated 5/16/2011 which was normal and a thoracic MRI dated 5/18/11 had mild disc space narrowing as a result of a disc bulge at T10-11. The patient was treated at CQM by N. Azmat, MD; M. Scott-Calar, DO; A. Argotte, MD; R. Greenlaw, MD; H. Dehaven, MD prior to Dr. Wilson. The records contained a history and physical examination per Dr. Argotte and a psychological evaluation as requested by Dr. Argotte. It was noted by prior physicians that the patient had experienced seizures. The outcome of the psychological evaluation was noted as "guarded" and it was suggested he be referred to a substance abuse professional for evaluation and referral to a neurologist evaluation for possible prior head injury. He was also given orders to have physical therapy. It was also during the care of Dr. Argotte that the patient was given the orders for MRI studies which were done and noted as above. There did not appear to be any follow up on the recommendations. The chart also contained numerous abnormal urine drug test results to include medications not prescribed, medications prescribed that were absent and detection of marijuana use. It appeared the patient was actually dismissed from the facility for noncompliance sometime in September 2011. At the time of dismissal he was being prescribed Neurontin, Xanax, Ultram and oxycodone. Dr. Wilson began to see the patient on 11/10/11. The patient was dismissed after his September visit and given two weeks of medications at the time of dismissal. When he returned he had clonazepam, opiates, oxycodone, Xanax and THC in the urine drug test. Dr. Wilson wrote a note on the "Miscellaneous Patient Information" form that the patient stated the Neurontin and Ultram do not help and the patient was complaining of breakthrough pain and insomnia. He instructed the patient to take 25mg Benadryl at bedtime, discontinue the Neurontin and Ultram, and add oxycodone 10mg for breakthrough pain. There was no discussion of the failed urine drug test, any apparent physical examination or documentation of prior consultation notes etc. There did not appear to be a KASPER report obtained at this visit. He was issued the following prescriptions: Xanax 1mg #68 with directions of 1 pill every 12 hrs, oxycodone 15mg #130 with NO directions and oxycodone 10mg #68 with directions for 1 pill every 12 hrs. 12/12/11 the patient returned for follow-up. The urine drug test at this visit for negative for benzodiazepines which were prescribed and okay for oxycodone. Dr. Wilson made a note on this visit that the prior urine test was positive for clonazepam; he would have the patient return in 15 days for a pill count and given same prescriptions except for Xanax enough for 15 days. He was issued prescriptions Xanax 1mg #30 to take 1 every 12

hrs, oxycodone 10mg #60 to take 1 every 12 hrs and oxycodone 15mg #120 to take 1 every 6 hours. Attempts to call the patient for a pill count on 12/19/11 and 12/20/11 were unsuccessful because they could not reach the patient. A pill count was performed on 1/3/12 and the quantities were not correct, the patient stated he thought he had misplaced some of the oxycodone. 1/10/12 the patient presented for follow up and the note from Dr. Wilson reports that patient is satisfied with the current regimen but complains of insomnia, the patient is requesting Xanax for sleep and Dr. Wilson wrote; "denied". The patient reported Ambien and Benadryl not working. Plan was to write for same medications and add Elavil 25mg for sleep. A urine drug test on this date was negative again for Xanax and positive for oxycodone and opiates. The opiates are never sent for confirmation. The patient was issued the following prescriptions: Elavil 25mg #30, oxycodone 10mg #60, Xanax 1mg #30 and oxycodone 15mg #120. A pill count is noted on 1/26/12 that the pharmacy employee "Tony" counted the patients medication at the pharmacy and it is as should be. 2/7/12 he returned for follow up and Dr. Wilson notes the patient to be satisfied with the current regimen and write same meds. The patient was issued the same prescriptions as the previous month. 3/7/12 The patient is issued the same prescriptions except the Xanax is now increased back to #60 with directions every 12 hrs. Dr. Wilson makes a note that the patients anxiety has increased and he will increase the Xanax by 1 and continue other medications the same. 4/4/12 the patient returned with complaints of poor sleep. Dr. Wilson makes a note that the patient reported to him the Elavil was "too weak for sleep", Dr. Wilson's plan was to change the oxycodone 10mg to Percocet 10/650 and decrease the oxycodone 15 by 1 pill and increase elavil to 75mg and continue other medications the same. The patient was issued the following prescriptions: Elavil 75mg #30, oxycodone 15mg #90 to take 1 every 8 hours, Percocet 10/650 #90 to take 1 every 8hrs and Xanax 1mg #60 to take 1 every 12hrs. The urine drug test on this day was positive for THC, Xanax, opiates and oxycodone. Opiates were not sent for confirmation. 5/7/12 note per Dr. Wilson states the patient was without complaints, patient wants to finish GED and join the military and then to college. Plan was to continue same medications. The patient was issued the same prescriptions but with a small increase all quantities with the same prior directions without explanation. Xanax 1mg #64, Elavil 75mg #32, Percocet 10/650 #96 and oxycodone 15mg #96. The urine drug test for this date was positive for THC and negative for benzodiazepines.

DIAGNOSIS, TREATMENT & RECORDS: All three areas are clearly below the minimum standards.

There is no documentation that Dr. Wilson ever examined the patient or rendered a diagnosis. The diagnostic studies do not justify the use of the medications prescribed. There did not appear to be any follow up on the prior orders for additional studies. The patient was evaluated by psychological services and the outcome of this evaluation indicated the patient needed to be evaluated by a substance abuse specialist. The record was clear that the patient had an arrest for a DUI and was on probation. There was never any documentation that Dr. Wilson considered this information in treating the

patient. There were no other therapies used to control his pain. The patient demonstrated multiple aberrant behaviors related to use of controlled substances. There were KASPER tracking numbers in the chart but the KASPER data did not appear to be considered. The patient was given multiple early refills and he actually was given Xanax #98 in 28 days according to KASPER data. The patient had quantities of medications that were inappropriate and not justified. The combination of high dose benzodiazepines with opioid medications was inappropriate. Continued use of benzodiazepines with the knowledge the patient failed to have this medication present in the urine is not acceptable. The records did contain multiple tracking numbers for KASPER data. All controlled substance prescriptions failed to be written to standard; omitting the patient's address and written numerical quantity, some did not have the year written and some lacked written directions.

OVERALL OPINION- Clearly below the minimum standards. The care of this patient was considered to be grossly incompetent, ignorant and negligent. Dr. Wilson prescribed multiple high risk opioid medications to a young patient that did not have the medical indications to be prescribed such medications. There is no explanation as to why this patient was allowed to return to the facility after he had been dismissed for aberrant behaviors. This patient was clearly demonstrating aberrant behaviors and should not have been prescribed controlled substances. This patient was most likely diverting the medications he was prescribed.

6. [REDACTED] The initial visit appears to be either September or November of 2010; the record is not clear. The patient reportedly was involved in a motor vehicle accident in 2003 and maybe in also 2007 (again the record is not clear) he continued to have pain in his lower back radiating to his leg and trouble sleeping. He also complained of neck pain radiating down both arms and his back. MRI and CT studies in the record are all essentially normal. These studies are from 6/17/2010 and 1/7/2008. There are of the lumbar and thoracic spine. The patient was treated by all the prior Commonwealth Quality Healthcare physicians and Dr. Wilson. His initial treatment included Soma, Valium and hydrocodone and these medications continued until the patient started seeing Dr. Wilson. There are no copies of prescriptions given to the patient included in the record before 9/20/11. The patient appears to have been dismissed from the facility in 4/18/12 for "bad labs/pill count". This patient's record is not in any order; it appears to have been removed from a ringed binder and placed in a yellow envelop after the patient was dismissed. 10/18/11 Dr. Wilson gave the patient the following prescriptions: Lorcet 10/650 #90 with directions to take 1 pill every 8 hrs, Soma 350mg #90 to take every 8 hrs, Valium 10mg #90 to take every 8 hrs and an order for the patient to have an MRI of the lumbar and thoracic spine because of pain with radiculopathy, possible compression with numbness and tingling. There was what appeared to be a triage note completed by "Sue" who describes left knee pain and pain in the lower back that was shooting up the spine and down the legs. He reported his meds were working but he still had pain. There is no note from Dr. Wilson or notations from him on the triage form. There was no diagnosis rendered. 11/16/11 The patient presented for follow up and the urine drug test was positive for oxycodone which was not prescribed. There are notes on the urine test form that have been covered up with white out and could not be read. The patient said he had taken his mother's Percocet. Dr. Wilson makes a note on the "Miscellaneous Patient Information" form that the patient was complaining of valium not helping and he was having breakthrough pain, his plan was to replace the valium with Xanax 1mg bid and replace the Lorcet with oxycodone 10mg 4 times per day and keep the Soma the same. He issued the following prescriptions: oxycodone 10mg #120 to take 1 pill every 6 hrs, Soma 350 #90 to take 1 every 8 hrs and Xanax 1mg #60 to take 1 every 12hrs. 12/14/11 The patient returns, reports a friend gave him an oxycodone 15mg and it worked better, ran out of medications and had to "borrow from friends and family" because his medications were stolen, "had entire safe stolen". He requested his oxycodone be raised to the 15mg. Dr. Wilson notes the patient's previous urine test results and that the patient took his mother's Percocet. He noted patient's complaint of the "oxy's barely" decrease pain; complaints of anxiety and plans to replace the oxycodone 10's with the 15 at #150, increase the Xanax by 1 per day and continue the soma. He issued the following prescriptions: oxycodone 15mg #150 to take 1 pill every 4-6 hrs, soma 350 #90 to take 1 every 8 hrs and Xanax 1mg #90 with directions to take 1 pill every 8 hrs. 1/12/12 he returned for follow up stating meds were working well per staff member "Follow up Triage" note per "Sue"; Dr. Wilson writes a note that the patient was complaining of breakthrough pain and anxiety and he planned to decrease soma by 1 pill, increase Xanax by 1 pill and add Percocet for breakthrough pain. He issued the following

prescriptions: Oxycodone 15mg #150 q5h, Percocet 10/650 #60 1 every 12 hrs, Soma 350mg #60 1 every 12 hrs and Xanax 1mg #120 to take 1 every 6 hrs. On 1/26/12 the pharmacy employee "Tony" called in a "pill count" which indicated all correct except he had 1 more Xanax than prescribed. 2/9/12 the patient presented and the follow up triage note by the nurse states "Pt says he will bring paperwork showing PI was dismissed". There is no documentation of explanation regarding this statement. It suggests the patient had been charged perhaps with a public intoxication offense. But it is unclear, not addressed or explained. Dr. Wilson does not mention this in his note. Dr. Wilson makes a note that states the patient is satisfied with the current regimen, and he plans to decrease the oxycodone by 1 and increase the Percocet by 1 and decrease the Soma by 1. He writes (lab e) but there is no explanation as to what he was stating. He also writes other meds same and "pt is maxed out". He issued the following prescriptions: oxycodone 15mg #120 1 every 6 hrs, Percocet 10/650 #90 1 every 8hrs, Soma 350mg #30 1 every day and Xanax 1mg #120 to take 1 every 6 hrs. 3/8/12 he returned and said his medications were helping as noted per the triage note from "Sue". Dr. Wilson makes a note that the patient was complaining of increased pain, he planned to add 1 Percocet, other meds same, he will let the patient continue Soma because he has been cut back from #120 pills. He gives the patient the following diagnoses: acrophobia, agoraphobia and claustrophobia. He issued the following prescriptions: oxycodone 15mg #120, Percocet 10/650 #120, Xanax 1mg #120 and Soma 350 #30. 4/4/12 the triage note states meds are helping, Dr. Wilson makes a note that the patient requested an increase in the oxycodone which was denied and all medications to stay the same. He issued the same prescriptions as the preceding month.

DIAGNOSIS, TREATMENT & RECORDS: All three are below the minimum standards.

There is no justifiable diagnosis in which to use scheduled 2 controlled substances. There is no history and physical in the record. There was no record of any follow up on diagnostic studies that were ordered. There were no other treatments or evaluations for this patient. There was no apparent follow up on the notation of public intoxication and illegal behavior related to controlled substances. The record included what appeared to be a printout from a local newspaper that listed the patient as being arrested for public intoxication with Dr. Wilson made the diagnoses of phobias as described above without any documentation as how he came to those conclusions. Treatment for the psychiatric diagnoses was not appropriate. Dr. Wilson prescribed high dose medications in its most abusable form to an individual that presented without the diagnoses to warrant such prescribing. Further, he continually increased the benzodiazepine, continued another sedating drug (soma) and in combination with high dose opioids. While there were frequent abnormal urine drug test results, the patient was continued on the same dangerous medications without justification. KASPER tracking numbers appeared consistently throughout the record but Dr. Wilson never made note of the information. The patient was given early refills on medications frequently; 2-4 days early. The patient demonstrated aberrant behaviors. The pill count phoned in from the pharmacy employee was highly suspect. It is also noted by this reviewer that the patient

Chester Dorion has the same pill count phoned in. The records were disorganized and incomplete. None of the controlled substances prescriptions had the patients address on them.

OVERALL OPINION – Clearly below minimum standards. Gross ignorance, negligence and incompetence.

Dr. Wilson prescribed high risk medications for many months on this patient while ignoring aberrant behaviors. He prescribed medications to this patient who did not have a diagnosis.

7. [REDACTED] This patient appeared to present on 7/28/11. He was dismissed in April 2012 for having cocaine in a urine drug test. (The records have been removed from a chart binder and placed into a yellow envelope. The contents are disorganized and it difficult to determine flow of care as the complete date is often not on the documents). He complained of lower back pain that radiated to his left leg. He reported to have had two prior back surgeries and the problem was precipitated by a motor vehicle accident in 2001. He also reported he had 2 prior knee surgeries. He had been a patient of another pain management center, "Care More" but stated he left because he was not happy with the physician. He reported the Percocet's and Lorcet were no longer helping him. Included in the record were several MRI reports. An MRI of the lumbar spine dated 12/9/2002 notes postoperative changes at L5-S1 consistent with a laminectomy on the left and fibrosis, disc degeneration and spondylosis at L4-5, minimal retrolisthesis of L5-S1; he reported some type of trauma in 7/11 and had MRI studies of the cervical spine dated 7/17/11 was normal, MRI of the thoracic spine dated 7/17/11 demonstrated a mild curvature of the upper spine but was otherwise normal; an MRI of the lumbar spine dated 7/17/11 demonstrated degenerative disc disease with acquired central canal and neural foraminal narrowing. Following a motor vehicle accident in 1/2012 he had an MRI of the lumbar spine dated 1/03/12 which demonstrated a minimal central disc bulge at L4-5, central and left paracentral disc bulge at L5-S1 on the left creating left neural foraminal stenosis and slightly displacing the S1 left nerve root sleeve and an MRI of the cervical spine on the same date (1/03/12) showed small diameter of the spinal canal probably due to congenitally short pedicles otherwise the study was normal. The patient had considered additional surgery and/or placement of a "nerve stimulator pump". The patient also reported he had a back brace. Prior to Dr. Wilson he was prescribed Neurontin for approximately 1 month, Xanax 1mg twice per day, oxycodone in various strengths including Percocet's and approximately one month of nortriptyline. 10/18/11 Dr. Wilson began seeing the patient. A note for the same date written on the "Miscellaneous Patient Information" form documents that patient not having any new complaints or injuries and his treatment plan will continue; the initials "Ya" appear on this note. Beneath that note Dr. Wilson wrote, Percocet 10/650 q8h #90, oxycodone 30mg q6h #120 and Xanax 1mg bid. He issued those prescriptions to the patient. 11/16/11 the patient returned for follow up and the follow up triage note reported the patient to have left knee pain, weather was intensifying his pain and a rock had fallen on him while working underground. He also complained of the Percocet's upsetting his stomach and not offering much relief. This note was not signed. Dr. Wilson makes a note that the patient complained of increased pain, Percocet's were upsetting his stomach, relief and he would replace the Percocet with oxy 15 and continue other medications the same. He issued the following prescriptions: oxycodone 15mg #93 with directions to take 1 pill every 8 hrs, oxycodone 30mg #124 to take 1 pill every 6 hrs and Xanax 1mg #62 to take 1 pill every 12 hrs. 12/15/11 The patient returned and complained of new pain in his neck and mid back as a result of a motor vehicle accident December 5th. The patient went to the ER for care following the accident. There is no signature or initials on the follow up triage note. Dr. Wilson makes a note on the "Miscellaneous Patient Information" form that the Calloway lab from 11/16/11 was okay;

a urine drug test was performed on this date and abnormal with amphetamines, THC and opiates in the screen in addition to the Xanax and oxycodone. The Xanax and oxycodone were expected to be in the urine. For unknown reasoning the amphetamines and opiates were not confirmed. There was no documentation by Dr. Wilson that he reviewed these results on the day the patient was present. The patient complained of more pain because he had been in a prior motor vehicle accident with the vehicle flipping over 3 times. Dr. Wilson planned to increase the oxy 15 by one and continue other meds the same, he made a note that the patient had "plateaued w/ox". He issued the following prescriptions: oxycodone 15mg #132 with directions to take 1 every 6hrs, oxycodone 30mg #132 to take 1 every 6 hrs and Xanax 1mg #66 to take 1 every 12 hrs. There appeared to be a pill count performed on 12/21/11 which for the most part was acceptable. 1/16/12 it appeared the patient was asked about the results from the previous month's urine drug test. The patient reported he had been a patient at a weight loss clinic for several months and received "Adlpex". He also reported he took Fioricet from his wife for a headache and had been around friends who were smoking THC. The follow up triage note states the patient understands he can be dismissed. This note is signed by L Kidd, RN. Dr. Wilson makes a note that the patient was satisfied with the current regimen and his plan was to continue the same meds. He issued the patient the following prescriptions: oxycodone 15mg #120, oxycodone 30mg #120 and Xanax 1mg #60. 2/13/12 the patient did not have any new complaints, the triage note circles yes to the question if the patient had visited another medical facility since the last visit and a notation is made, "neurologist-pt says he did not take anything". A urine drug test was again abnormal and contained THC. Dr. Wilson makes a note that the patient is satisfied with the current treatment regimen and he will decrease the oxycodone 30 by 1. He issued the following prescriptions: oxycodone 30mg #90, oxycodone 15mg #120 and Xanax 1mg #60. 3/12/12 The triage follow up notes patient to describe increased pain since the Dec motor vehicle accident, left knee and mid back pain. Dr. Wilson makes a note that the patient is without complaints and he plans to decrease the oxycodone 30mg by 1 and other medications to stay the same. He issues the following prescriptions: oxycodone 15mg #120, oxycodone 30mg #60 and Xanax 1mg #60. The urine drug test on this day was again abnormal; positive on screen for opiates and THC. 4/9/12 the patient returned and cocaine was in his urine. He was given a dismissal letter and prescriptions for 2 weeks of his medications. He was issued the following prescriptions: oxycodone 15mg #60, oxycodone 30mg #30 and Xanax 1mg #30. The patient dismissal letter included a note that if the final labs "come back - (negative) cocaine will call you and will be a pt again".

DIAGNOSIS & TREATMENT -Below the minimum standards for both.

The patient appeared to have proper diagnostic studies for his back complaints. It would appear the patient had a lumbar spine condition that did cause pain. There was discrepancy in the diagnostic studies; one diagnostic study did not indicate the prior back surgery and one did. If the patient had back surgery he would have been very young and this age would be approximately 15-17 years old. There were also no records from the prior pain management care. There were no physical examination

notes to indicate the patient had lumbar scarring. The patient never appeared to have any diagnostic studies of his left knee indicating the cause of his pain complaints. There never appeared to be any physical examination of the patient by anyone. There no notes to indicate that Dr. Wilson ever examined the patient or rendered a diagnosis other than for pain and anxiety. The patient was treated with 2 short acting opioid medications with multiple doses in combination with high dose benzodiazepines. There were no other adjunctive therapies utilized or referrals. If the patient had anxiety problems that required benzodiazepines he should have been referred to a psychiatrist for evaluation of this problem and proper treatment. The patient was ultimately dismissed when he used cocaine. However, he was treated for approximately 8 months by Dr. Wilson while he obviously ignored the indicators of aberrant behavior.

RECORDS – Below the minimum standards.

There was no history and physical, follow up evaluations lack appropriate content, the controlled substance prescriptions were never written to standard. The records contain multiple urine drug testing results but appeared to be ignored. The record contained triage follow up notes that did not correlate to notations made by Dr. Wilson. The triage notes often did not have any signatures. The records contained multiple tracking numbers for the KASPER data but this too appeared to be ignored. In review of KASPER data for this patient, he was given multiple early refills of controlled substances without explanation.

OVERALL OPINION – below the minimum standards and gross ignorance, negligence and incompetence.

Dr. Wilson demonstrated incompetence and lack of knowledge in treating pain and prescribing medications to treat pain. He failed to adequately prevent probable fraud and abuse of high risk controlled substances. Dr. Wilson failed to practice the most fundamental and basic component of medicine; conducting a physical examination and formulating a diagnosis. There was no indication that he did either one.

8. [REDACTED] 12/22/11 the patient initiated care with Commonwealth Quality Health Care/Dr. Wilson. He had been under the care of another pain specialist/Kentucky Pain Physicians in Pikeville, Kentucky; Robert Windsor, MD. He reported leaving that facility because "the medication wasn't helping and the Dr. wouldn't listen." He said he had back pain for approximately 3 years. He reported that he had used a heating pad and a back brace. He also reported that he was disabled due to "bad" nerves. He stated he was previously under the care of a psychiatrist for depression and anxiety. Dr. Wilson makes a note on the "Miscellaneous Patient Information" form that the patient presented to be "evaluated with complaint of chronic pain lower back". The plan was "ox 10's #120, Klonopin 1mg #60. The patient reported he was on hydrocodone 7.5, clonazepam 1mg and tizanidine 4mg. A urine drug test was performed on this initial visit and abnormal for multiple benzodiazepines, oxycodone and opiates. Records were obtained from the prior pain management physician and these included office visit notes and diagnostic studies. An MRI of the lumbar spine was essentially normal except for mild disc bulging at L4-5 and L5-S1. A nerve conduction and EMG study was performed on 8/9/11 and the result was normal. Dr. Wilson issued the patient the following prescriptions: oxycodone 10mg #120 to take 1 every 6 hrs and Klonopin 1mg #60 to take 1 pill every 12 hrs. 1/23/12 the patient returned for follow up and stated he was involved in a motor vehicle accident on January 3rd. He reported was seen in the ER and said everything was fine but he was having increased pain. This information is written on the "Miscellaneous Patient Information" form by L. Kidd, RN. The follow up triage note for the same day also completed by Kidd, RN notes the patient reporting the Klonopin is not strong enough, there were no new complaints, he may have taken a Xanax at his uncle's funeral. Dr. Wilson makes a note that the patient is complaining that the oxy's are too weak, Klonopin does not work and plans to replace the oxy 10's with 15's and replace the Klonopin with Xanax. He issues the following prescriptions: oxycodone 15mg #120 to take 1 every 6hrs and Xanax 1mg #60 to take 1 every 12 hrs. The urine drug test on this date is positive for barbiturates, no benzodiazepines, opiates and oxycodone; the confirmation testing was negative for benzos and oxycodone but is not conclusive. 2/20/12 the follow up triage note reports pts meds are working good, he reported he was seen in the ER for a cold. Dr. Wilson writes the patient is without complaints and to write the same meds. The urine drug test on this date was positive for multiple benzodiazepines, opiates and oxycodone. The patient was issued the same prescriptions as the preceding month. 3/19/12 the follow up triage note says the pain had increased in his lower back and he was asking for break thru pain medication, he was warned about previous lab results, the note was signed by L. Kidd, RN. The urine drug test was negative for benzodiazepines. Dr. Wilson makes a note that the patient was asking for breakthrough, "benz labs are a concern. Plan to increase oxy 15 by 1 and other meds same, trend labs closely". Dr. Wilson continued the Xanax 1mg #60 to take every 12 hrs and was given an increase in his oxycodone 15mg to every 5 hr #150. 4/16/12 he returned for follow up and did not have any new complaints was warned about inconsistent labs and asked for an increase in Xanax due to difficulty sleeping and "stays aggravated". This note again per L. Kidd, RN. A urine drug test for this date was again negative for Xanax, tramadol, opiates and

oxycodone. There was no documentation or notes from Dr. Wilson but he issued the following prescriptions: Xanax 1mg #60, oxycodone 15mg #120 and Percocet 10/650 #60. Percocet was added to the mixture on this visit with no explanation. 5/14/12 the patient was dismissed from the facility and given 15 day prescriptions. There is no note or documentation from Dr. Wilson. He issued the following prescriptions: Xanax 1mg #30, oxycodone 15mg #60 and Percocet 10/650 #60.

There were 3 attempts at pill counts; 2 the patient was unable to either be reached or he could not come in and one pill count appeared to be okay basically ok.

DIAGNOSIS & TREATMENT- Below minimum standards for both.

This patient did not have a diagnosis that warranted the use of the opioid medications prescribed. Dr. Wilson never obtained a history and physical. There was no documentation that he examined this patient. Dr. Wilson frequently increased the medications without any written explanation for his actions.

RECORDS- (The record contains a document that the Kirk Law Firm is representing the patient for an injury claim from the motor vehicle accident of 1/3/2012 and related release of information forms). There was no physical examination. There were no follow up notes.

OVERALL OPINION- Below minimum standards. Gross negligence, ignorance and incompetent.

Dr. Wilson prescribed high risk opioid medications to a patient without a diagnosis and with indication that the medication would most probably be diverted.

9. [REDACTED] Initially presented on 3/28/11 with complaints of pain that began after multiple car accidents at the age of 18; approximately 2005. She was treated at a prior pain management clinic and was under the care of "Dr. Albert" who prescribed Soma, Xanax, Percocet, Lorcet and stomach medications. She complained of upper back and neck pain shooting down her spine into her lower back and making her right leg numb. She indicated she was presenting for pain medications and informed that prior treatment included physical therapy and the use of a heating pad. MRI studies were in the chart and on 6/24/2010 the cervical spine results indicated mild disc bulging from C4-5 thru C7-T1 with congenital narrowing of the spinal canal due to short pedicles and a muscle spasm at the time of the study; lumbar and thoracic study on the same date demonstrated multilevel disc bulging with a right paracentral posterior disc herniation an associated radial tear at T11-12, there was also bilateral facet hypertrophy at the L5-S1 level with moderate impingement upon the bilateral lateral recesses. A. Argotte, MD did the initial evaluation which included a physical examination and history. He referred the patient to a spine surgeon, physical therapy, orders for lab work and a psychological evaluation. He issued the following prescriptions: Percocet 7.5/500mg #60 with directions to take 1 q12hr prn, Soma 350mg #30 to take q24hrs prn, Lorcet #120 to take 1 every 6hrs prn and Xanax 1mg #30 to take 1 every 24hrs prn. The patient was unable to keep her follow up appointment because of family surgery. She returned on 5/18/11 she had the requested lab work performed. Her urine drug screen was questionable. She reported her medications were working well. It was not explained why the patients medications lasted beyond 30 days. She reported symptoms of depression and stated she was in the process of going through a divorce. The psychiatric/psychological evaluation was scheduled. The patient was issued prescriptions for soma #30, Lorcet #120, Paxil 10mg #30, ibuprofen 600mg #90, Neurontin 100mg #60, Percocet 7.5/500 #60 and Xanax 1mg #30. 6/15/11 Pt reported the medications were helping. She thought Paxil was causing itching. She was issued the following prescriptions: Soma #30, Paxil was increased to 20mg #30, Neurontin was changed to 200mg bid #60, Lorcet #120 and ibuprofen 600mg #90. He made note that he eliminated the Xanax because it was not in the urine. Percocet also appeared to be eliminated. 7/7/11 the facility doctor was now Dr. Greenlaw who issues the following prescriptions: Neurontin 300mg #60, ibuprofen 600mg #90, Soma 350 #30, Lorcet #60, Percocet 7.5/500 #90 and Xanax .5mg #30. Paxil and ibuprofen were not longer prescribed for the patient. She reported on this visit she had to double up on her Lorcet because she was not prescribed the Percocet on the prior visit. Visits from 8/4/11 thru 9/28/11 were conducted by Dr. Dehaven. The patient reported overall her medications were working. The September urine drug screen was not as it should have been. Prior to her first visit with Dr. Wilson she had increases in Xanax, Percocet and Neurontin. 10/26/11 Dr. Wilson begins to see the patient. The triage note per "Yavonda" notes patients medications are working. Dr. Wilson writes a note that "pt Calloway shows essentially no narcs in system other meds ok" and plan is to order 15 days of narc and have pill count. The lab results are not as Dr. Wilson thought. Oxycodone and Xanax were in the urine. He issues the following prescriptions: Xanax 1mg #60, Neurontin 300mg #90, Percocet 10/650 #45 and Lorcet 10/650 #30. A pill count attempt on

11/4/11 could not be done because the patient could not be reached. On 11/9/11 the patient was issued 15 days of the Lorcet and Percocet. It is not clear if she had the pill count or not. 11/23/11 she returned and reported her meds were working good per follow up triage note; this note is not signed by any staff member nor Dr. Wilson. Dr. Willson makes a note that "Calloway okay", the patient requested one more "perc" and he planned to replace the Percocet with oxy 10's #120 and other meds to remain the same. He issued the following prescriptions: oxycodone 10mg #130 with directions to take 1 every 6 hrs, Xanax 1mg #68 with directions to take 1 every 12hrs, Lorcet 10/650 #68 to take 1 every 12hrs and Neurontin 300mg #102 to take every 8 hrs. There appeared to be a pill count request that was unsuccessful on 12/23/11 because the patient could not be contacted. 12/27/11 the patient returned stating her meds were helping but the oxycodone made her feel funny. The triage note was not signed. Dr. Wilson makes a note stating the oxy made patient feel dizzy, she was taking them on an empty stomach he instructed her to take them with meals and otherwise she is satisfied with her regimen and he planned to continue the same medications. He issued prescriptions for the same medications except he changed the quantity to 30 day supply. 1/24/12 she reported she was not sleeping well, the oxycodone made her feel dizzy and high and had new right leg numbness. She also reported she didn't need as many Neurontin. This triage note is signed by L. Kidd, RN. Dr. Wilson writes a note that the oxycodone doesn't work as well as the Percocet, he plans to replace the oxycodone with Percocet and increase the Lorcet by 1 pill and continue all other meds. He issued the following prescriptions: Percocet 10/650 #90, Lorcet 10/325 #90, Xanax 1mg #60 and Neurontin 300mg. 2/21/12 there were no new complaints noted on the follow up triage note, the entire physical assessment note including a nursing diagnosis with suggestion to send the patient for a psych evaluation, was completed by L. Kidd, RN. Dr. Wilson makes a note that the patient was without complaints and plan is to write the same meds. He issues the same prescriptions as per previous month. 3/20/12 follow up triage note reports no new complaints but states "Norco" gives her a headache and she had sleep deprivation. Pt also reported on this visit that she had a visit with another provider for a breast exam. Dr. Wilson makes a note that the patient is without complaints and he plans to write the same medications. He issues the same medications as the preceding month. 4/17/12 triage note indicates the patient is having right arm and right leg numbness and is being evaluated for masses in her breast and stomach, this form is completed by Butcher, (SMA). Dr. Wilson makes a note that the patient is without complaints, a left breast mass and right lower quadrant mass requiring surgery for diagnosis, plan is to write for same meds and a general surgery referral. He issues the same prescriptions as the preceding month. 5/14/12 the triage note indicates the meds are helping, the report on her breast and stomach are "good". Dr. Wilson notes the patient is without complaints and plans to write for the same meds. He issues the same prescriptions but increases the quantities on all slightly without any explanation.

DIAGNOSIS- &TREATMENT- Below minimum standards

This patient had a diagnosis that did warrant the use of opioids to treat pain. However, there did not appear to be any physical examination by Dr. Wilson. There was an adequate history and physical examination on the chart as obtained by Dr. Argotte. There was no documentation to suggest that Dr. Wilson reviewed the prior diagnostic studies. Dr. Wilson never rendered a diagnosis. The patient had various complaints as noted on the follow up triage note by staff members; but Dr. Wilson's notes often were contradictory; "no complaints" etc. There were no other treatments utilized. The previously requested studies and evaluations were never followed up on. There were regular urine drug tests and tracking numbers to indicate KASPER data was obtained. The controlled substance prescriptions were consistently written without the patients address. There was no indication for the prescribing of Xanax. The notes by Dr. Wilson do not reflect the data written in the triage notes.

RECORDS - Borderline

OVERALL OPINION - Below minimum standards.

The prescribing was inappropriate; the physician demonstrated gross ignorance and gross negligence.

10. [REDACTED] Initial visit to the Commonwealth Quality Health Care was on 7/13/11. She complained of pain in her feet, lower back, legs and knees. She reported to have been in a 4-wheeler accident and this caused pain. She also reported after giving birth to twins she had more pain. She had been to a pain management physician and reported the medications he gave her worked but he retired. She also reported that use of a heating pad helped and putting a board under her mattress helped. She reported her last pain medications to be in 2/11. The urine drug test on the initial visit was negative for any medications but positive for THC. It was noted that a test for the integrity of the urine sample was out of range. An MRI study of the lumbar spine from 10/5/2010 was on the chart and results were normal. She reported that she had been taking Lorcet 10/650 #120, Percocet 10/650 #30, Soma 350 #60, Xanax 2mg #30 and Fioricet #30. Dr. Greenlaw was physician in the facility at that time and issued the following prescriptions: Xanax 1mg #60 with directions to take 1 pill every 12 hrs, Baclofen 20mg #90 1 every 8hrs, Lorcet 7.5/500 #120 1 every 6hrs and Fioricet #30 1 every 24 hrs prn. She returned on 8/10/11 and reported her medications were working but asked to have the Lorcet 10 and said the Baclofen made her sick; "soured stomach". There was no signature of the person who actually wrote this note but H. Dehaven did sign at the bottom and date it 8/10/11. There appears to be an additional note intended for 8/10/11 but it has the date 8/11/11 on this note but is also signed by H. Dehaven and dated 8/10/11. The urine drug test was again positive for THC. Dr. Dehaven now appeared to be the practicing physician and issued the following prescriptions: Xanax 1mg #60, Lorcet 10/325 #120 and Fioricet #30. 9/9/11 the patient is complaining of pain in both feet and Dr. Dehaven plans to refer her to a podiatrist. The urine drug test is again positive for THC. There is an additional note for this same day under the "RX" tab of the chart and states the patient requested to have Lorcet 10/650 instead of 10/325. The same prescriptions were issued but the Lorcet was changed to 10/650 #120. 10/10/11 Dr. Wilson begins care of the patient. The triage note states the patient was having tingling in her neck and sharp pain in her left and right shoulder, left and right shooting, sharp leg pain and left knee pain and sharp back pain. Meds were working. The urine drug test was positive for THC now x4. Someone wrote of note on the "Miscellaneous Patient Information" form that appeared to be the handwriting of "Yavonda" but it was signed by Dr. Wilson. This note reports the patient to have toothaches from exposed nerve endings, increase pain symptoms at times and having muscle spasms. The patient asked for Soma. She was issued the same prescriptions as the preceding month except the Lorcet was changed back to 10/325mg. There was no documentation of examination or other diagnostic studies. 11/7/11 repeat urine drug testing indicated THC was in the urine now for the 5th time in a row. The patient reported meds were helping but sometimes she needed an extra Xanax. Dr. Wilson makes a note that the patient reports her pain to return early after each dose and other meds were okay. His plan is to increase the Lorcet back to the 10/650 and continue other meds the same. He issued the following prescriptions: Xanax 1mg #64 to take 1 pill every 12hrs, Lorcet 10/650 #160 to take 1 every 4-6 hrs and Fioricet #32 to take 1 daily. 12/7/11 the urine drug test for this visit was again positive for THC-6th time; the specimen did not pass integrity testing by having the oxidant screen out of range. The patient reported her meds were

working well but on some days she may have some extra pain. Dr. Wilson writes a note that the patient was complaining of breakthrough pain and he planned to add oxycodone 10 #60 and continue all other medications. She was issued the following prescriptions: Xanax 1mg #60, Fioricet #30, Lorcet 10/650 now #150 and oxycodone 10mg #60 to take 1 every 12 hrs. 1/5/12 follow up triage note reports pain has gotten better with meds and the oxycodone 10 "really worked". Dr. Wilson makes a note that the patient is satisfied with current regimen and plans to write the same meds. He issued the same prescriptions as the preceding month. 2/2/12 the triage note indicates the meds are working and patient is having left knee pain. Dr. Wilson notes the patient is requesting an increase in the oxy quantity or strength and he writes denied, otherwise no complaints. He informs the patient the Lorcet will be "leveled off" at #90 and plans to decrease this by 1 pill and continue all other medications. He issues the same prescriptions except the Lorcet 10/650 is #120 now. 3/1 or 3/2/12 one note lists follow up as 3/2. The urine drug test on this date is now negative for THC but fails the integrity test. She reports her medications to be working. There is no note from Dr. Wilson on this date and he issues the same prescriptions as the preceding month. She returns on 3/29/12 the triage note indicates meds are working well, Dr. Wilson makes a note that she is without complaints, and his plan is to decrease her Lorcet by 1 pill and increase her oxycodone by 1 pill and leave the other medications the same. A urine drug test on this date is again positive for THC. He issues the prescriptions as planned. 4/26/12 the patients' urine drug test is conflicting, she denies use of THC, she states her medications are working, Dr. Wilson makes a note that the patient is requesting an increase in Xanax which he plans to deny and otherwise patient is satisfied with her medications; he issues all medications the same as the previous month. 5/23/12 documentation on the triage follow up note per staff Beltcher notes the patient reports her pain has increased because of gardening, her urine drug test was positive for THC, she reports occasional smoking of THC to help with pain and she was counseled regarding possible dismissal for THC use. The note from Dr. Wilson notes the patients request for increase in pain medications because of gardening; he plans to increase the oxycodone 10mg to 15mg and leave other medications the same. He increases all medications and issues the following prescriptions: oxycodone 15mg #105 with directions to take 1 every 8 hrs, Lorcet 10/650 #140 to take 1 every 6 hrs, Fioricet #35 to take 1 daily, and Xanax 1mg #70 to take 1 pill every 12 hrs.

DIAGNOSIS, TREATMENT & RECORD- Below the minimum standards for all three. There was no diagnosis established that indicated the patient should be treated with high risk opioid medications. There was no documentation that Dr. Wilson ever examined the patient. There was no follow up for further investigation of her pain complaints. There was no working diagnosis. The repeated aberrant behaviors regarding illegal drug use and repeated questionable adulterated urine test results were ignored. The patient was continued on high risk medications.

OVERALL OPINION – Below minimum standards.

The care provided by Dr. Wilson indicated not only gross ignorance but also negligence and incompetence. This patient should not have been prescribed this combination of medications. This patient did not have any pathology that warranted opioid medications. There was no history and physical examination.

11. [REDACTED] (This patient was also an employee of Commonwealth Quality Medical Care). It appeared the patient presented in March 2011. The initial consents and forms have conflicting dates; some data filled out in pencil and some with signatures in pencil. Dr. Argotte initially evaluated the patient on 3/10/11. She complained of chronic right hip pain as a result of a 2004 stress fracture while in military service. She also reported being in multiple motor vehicle accidents in 2003, 2004 and 2005. She denied any hospital care following the motor vehicle accidents. She described ongoing and chronic pain in her lower back and right hip. She also reported a history of a tibia and foot fracture that occurred in approximately 2004. She complained of headaches. She reported she had spinal steroid injections in 2006/2007 and physical therapy in 2007. She also reported begin treated in 2010 for anxiety and depression. MRI studies of the lumbar spine dated 9/13/08 note the patient to have L5-S1 disc desiccation with an annular tear and a small left paracentral disc protrusion. Cervical x-rays dated 10/09/08 are normal. An MRI/MRA of the brain was normal on 5/15/2008. X-rays of the pelvis were normal except for the presence of surgical clips in the left pelvis. X-rays of the SI joints were normal on 10/0/08. Bone density study of the left hip and lumbar spine on 8/25/08 was normal. (Prior records from 12/9/08 describe concerns regarding the patient's use of large amount of controlled substances while in the military, screening questionnaires at that time were suggestive of substance abuse but not diagnostic, and presentation on physical exam at that time suggested opioid withdrawal. The conclusion of the physician who provided pain management at that time, at another facility, stated, "All of this information together suggests some degree of substance abuse or concerns thereof"). Dr. Argotte diagnosed the patient with lumbar disc bulging and requested a new MRI. He resumed prescribing of medications and gave orders for MRI studies, physical therapy evaluation, psychiatric evaluation and lab work. He issued prescriptions for Percocet 10/325 #120, Lorcet 10/325 #30, Ambien 10mg #30 and Xanax 1mg #60. The prescriptions written by Dr. Argotte from March 2011 until June of 2011 were concerning. There were prescriptions without the name of the patient but signed in the chart from Dr. Argotte. From March until June, the patient requested more medications, denied use of cocaine, failed a urine drug test once by not having Percocet in the urine when prescribed and failed another urine drug test for not having Xanax present in the urine when it was prescribed, used more Xanax than prescribed and did not have any of the testing or referrals done as ordered. In July, August and September of 2011 Dr. Greenlaw and then Dr. Dehaven saw the patient. There are concerning prescription copies that appear without a name but signed by the physician. The patient was now receiving Tylox, Oxycodone 15mg, Klonopin 1mg and Ambien 10mg. In September she failed another urine drug test by having medication not prescribed for her in the urine; hydrocodone and the Klonopin was not in the urine but prescribed. On this same visit she requested additional doses of medication for anxiety. 10/10/11 Dr. Wilson issued prescriptions for the patient for the first time. There was no note from Dr. Wilson. A note written on the "Miscellaneous Patient Information" form for that date appears to be written by a staff member. Dr. Wilson issued the following prescriptions to the patient: Tylox 5mg #120, Oxycodone 15mg #120, Ambien 10mg #30 and Klonopin .5mg to take 1/2 tab #15. 10/31/11 the patient returned and a note written by Dr. Wilson

reported her to be complaining of a sore throat, she was satisfied with her current med regimen; he would write for a Z-pack and continue other meds. The urine drug test was negative for the prescribed Klonopin. He issued oxycodone 15mg #120, Tylox 5/500 #120, Ambien 10mg #30 and Klonopin 1mg #60. He issued these prescriptions within 21 days from the previous prescriptions without explanation. 11/28/11 The patient presented for follow up; Dr. Wilson made a note that the patient was satisfied with her current regimen and continue to write for the same medications: 12/12/11 The patient presented again early for an appointment but at this appointment stated on 11/30/11 her medications were stolen. A statement written by the patient on the form titled, "Miscellaneous Patient Information" and dated 12/12 stated she had arrived home from work on 11/30/11 and was met by social services and the police. She was told they received a complaint that she was selling her pain medications. They requested to see her medications and she learned at that time that all of her oxycodone 15mg was gone (filled #120 on 11/28/11) and #68 of her Tylox was remaining from the #120 she filled on 11/28/11. She wrote that this appeared to be an "obvious set up" from the neighbors who were in a property dispute with her. She also reported that she went to the hospital the next day and took a drug test to prove she had been taking her medications. Dr. Wilson's plan was to have a pill count and issued prescriptions for the same medications. There was no documentation that the patient went for the urine drug test as she claimed. 1/3/12 At this follow up visit Dr. Wilson notes the patient to be complaining of increased pain due to cold weather and he plans to increase her oxycodone 15mg by one. He issued the prescriptions for: Oxycodone 15mg #150, Tylox #120, Klonopin 1mg #60 and Ambien 10mg #30. The next two follow up visits appear to have the dates altered. There are prescriptions written for 2/20/12 but a 2 is written over a 1. These prescriptions appear to be written on 1/26/12 but were clearly altered to be 2/20/12. The record contains a note written by Dr. Wilson on 2/20/12 that states the patient was satisfied with her current regimen and he issued the same prescriptions. These are the prescriptions that have the 2 written over the 1 on the date. There is an unsigned "Follow up Triage" note that indicates the current medical regimen will continue. There is a prescription issued by Dr. Wilson for blood pressure medication with what appears to be written 1/20/12 or 1/26/12; this date has been altered and there are no notes corresponding to either date. There is no documentation for a March visit but there are prescription copies in the record for 3/8/12. The 8 on the prescriptions appears to have been written over the top of another number. The prescriptions were: Lisinopril 5mg # 30, oxycodone 15mg #150, Ambien 10mg #30 and Percocet 10/325 #120. 4/5/12 Dr. Wilson makes a note that the patient is without complaint and he will decrease the oxycodone by one. The prescriptions were issued for Ambien 10mg #30, Klonopin 1mg #60, Oxycodone 15mg #120 and Percocet 10/325 #120. 5/15/12 a follow up triage form is used but not signed by anyone; this form indicates the current medical regimen will continue. There is a note by Dr. Wilson that reports the patient was without complaint and he will write for the same medications. He issued the same prescriptions as the preceding month.

DIAGNOSIS-Below minimum standards.

The patient did have a diagnosis that may cause pain but did not warrant the medications prescribed. Dr. Wilson never appeared to render a diagnosis. There was no use of the acceptable methods of establishing a patient diagnosis such as a physical examination, use of additional laboratory and radiographic studies. Dr. Wilson never requested any other testing or studies. Incidentally, Dr. Wilson also prescribed blood pressure medications to this patient without the proper standards being taken.

TREATMENT- Below minimum standards.

The patient had records that described prior concerns about the patient displaying substance abuse behaviors; there was no documentation that these records were reviewed by Dr. Wilson. It never appeared that Dr. Wilson examined the patient. There was no follow up on referrals or diagnostic studies requested by other physicians at the same facility prior to Dr. Wilson's arrival. The patient continued to be prescribed high risk medications regardless of her urine drug test results. The use of controlled substances did not appear to be monitored. There was no KASPER data, no follow up on abnormal urine drug screens. There was no explanation for the increase in medications from Tylox 5mg to Percocet 10/325. There were no other therapies used to treat this patient.

RECORDS- Below minimum standards.

The chart contained numerous forms that were filled out in pencil, forms had conflicting date/years on them, the controlled substance prescriptions were not written to standard and many did not have the name of the patient written on the prescription itself. None of the controlled substance prescriptions had the address of the patient written on the prescription. There were prescriptions that were signed but the left blank. There are prescriptions that appear to have the dates altered. There is no mention of KASPER data being obtained except when under the care of Dr. Argotte.

OVERALL OPINION- Below minimum standards. Grossly incompetent, grossly ignorant and grossly incomp.

Did Dr. Wilson sign prescriptions in advance? The prescriptions written in January and February appeared to be in his handwriting but they were obviously altered. Did the patient who was also an employee alter the existing record? The KASPER data obtained for the dates of the patient prescriptions with Dr. Wilson for the consultant to review clearly indicate conflicting prescriptions when compared to the chart. Had a KASPER report been obtained and reviewed by Dr. Wilson he could have stopped the behavior. It appears he did not monitor the patient in any way regarding these high risk medications. The one time he planned for a pill count it never was mentioned thereafter. Another concern is that he prescribed controlled substance to his fellow employee. Prescribing to an employee or fellow employee constitutes unethical behavior. Dr. Wilson prescribed high risk medications that most probably were being diverted and he was completely negligent in taking the proper precautions to prevent such behaviors. In summary, this patient was prescribed medications that were excessive and Dr. Wilson's behavior was unethical and grossly negligent.

KASPER data for this patient does not correspond to the prescription copies that were in the record. Prescriptions were filled on 10/10/11, 10/31/11, 11/02/11, 11/22/11, 11/28/11, 12/12/11, 1/3/12, 1/26/12, 2/20/12, 3/12/12, 4/13/12. This patient was using 3 different pharmacies and her husband was also a patient of Dr. Wilson's receiving similar medications.

12 [REDACTED] (Husband of employee [REDACTED]) Presented to facility 4/20/11 referred by his spouse who was an employee and a patient of the facility. He complained of lower back pain that originated after a motor vehicle accident in either 2003 or 2004. He provided an MRI report from Florida dated 2/12/09 which reported bulging of the annulus fibrosus at L4-5 and L5-S1 and partial dehydration of the L4-5 disc. He reported having physical therapy in 2004 which did not help. He did not have any other therapies or consultations.

Pt acknowledged he "borrowed" his mother's Percocet. His pharmacy printout indicated he had been prescribed hydrocodone and filled this on 3/29/11. His initial urine drug test was confirmed positive for morphine sulfate, hydrocodone and oxycodone/oxymorphone. Dr. Argotte prescribed Lorcet 10/650 #120 and ibuprofen 800 mg #90. He was also given orders to be evaluated by physical therapy and psychiatry. He presents again on 5/1/11 and reports the Lorcet is not helping but he did not want more pain medication but needed something for sleep, he was unemployed but was able to cut grass and performs weight lifting exercises. An MRI of the spine was ordered on this visit. He was issued Ambien 10mg #30, Lorcet 10mg #135 which was 11 days from the last RX, and ibuprofen. The chart follow up notes are confusing as to dates. There is a Calloway lab record with the date of a urine specimen collected on 5/11/11; there is no other record found in the chart that the patient was seen on that date. The next visit of 6/1/11 noted pt did not have the MRI studies done as ordered, the Lorcet was decreased to #120 and other medications continued. 7/20/11 is the next visit, he complained the pain was not controlled by the medication and he requests breakthrough medications and something to treat his anxiety. Dr. Greenlaw is now taking care of him and again MRI studies are ordered, he is issued Ultram 50mg #120, Lorcet 1/65 #120 and ibuprofen. On 8/17/11 he is now seen by Dr. Dehaven and the patient reports meds are not working at all. He is issued Percocet 7.5.325 #60, oxycodone 15mg #60, Percocet 10/325 #120 and Ambien 10mg #30. There is no note from the physician. The same prescriptions were issued for 9/26/11 by Dr. Dehaven. 10/24/11 Dr. Wilson sees the patient for the first time. A note made by a staff member indicates meds are working great for the patient but he has had "several spells with groin and side pain...treated by urologist previously, no conclusive findings". Dr. Wilson makes a note that the patient requests the Percocet be discontinued because of expense and is asking for an increase in the oxy 15 to #155. Dr. Wilson writes his plan is to discontinue the Percocet and increase the oxycodone 15 to #155, continue Ambien he makes a note that the patient requests weaning off opioids after? (Cannot read the word). Dr. Wilson did not do as he planned; he issued the following prescriptions for the patient: Percocet 10/325 #120, oxycodone 15mg #60 and Ambien 10mg #30. He also wrote an order for the patient to have an MRI without contrast of the c-spine. A urine drug test was performed on this visit and was noted to be positive for hydrocodone and oxycodone. A note on the lab form stated patient took hydrocodone from an old script. There are no visit notes for 11/14/11 however a urine drug test was positive for alcohol in addition to opiates and oxycodone. 12/5/11 he returned and Dr. Wilson makes a note that the patient was satisfied with the current regimen and plans to continue same. On this visit he is issued the following prescriptions: oxycodone 15mg #150 and Ambien 10mg #30. There is no discussion

of the changes made. 1/16/12 Dr. Wilson makes a note that the patient is satisfied with his current regimen, had a head and chest cold and pt requested an antibiotic. He wrote that he would continue the same meds and give a Z-pack. The prescriptions issued were not the same as the previous month and he was issued the following prescriptions: Percocet 10/325 #60, oxycodone 15mg #150, Ambien 10mg #30 and a Z-pack. 2/13/12 Dr. Wilson makes a note that the patients was without complaints and continue same meds. A note written by a staff member on a form titled, "Follow-Up Triage" notes the patient went to the urologist who prescribed him Opana but the notation stated the patient did not fill the Opana. Dr. Wilson issued the same prescriptions as the preceding month. 3/26/12 Dr. Wilson makes a note that the patient was without complaints and write for the same meds. However, he issued the same medications but increased the Percocet 10/325 to #90, oxycodone 15mg remained #150 and the Ambien was #30. There was no explanation for the change. 5/21/12 is the last record for the patient. A follow up triage note is not completed and not signed. Dr. Wilson makes a note that the patient is satisfied with the current regimen and continue same meds. Again, he issues the prescription of Percocet with an increase now to #120 and the oxycodone 15mg remains #120.

DIAGNOSIS & TREATMENT- Both are below minimum standards.

Dr. Wilson never renders a diagnosis. The diagnosis indicated by the MRI study from 2009 does not justify the medications prescribed for this patient. The MRI findings are essentially normal and do not suggest severe, chronic back pain. There is no indication that Dr. Wilson ever examined the patient; no initial or follow up examinations. When he makes a note that the patient would like to wean off opioids he does not demonstrate any action toward that goal. In fact, he increases the high risk opioid medication for the patient. There was never any follow up on the abnormal urine drug tests, requests for imaging studies or other referrals. There were no other treatments or adjuncts used. There were no precautions regarding the use of the high risk medications prescribed. There were no KASPER reports noted. The visit history was not clear. It appeared the patient presented for an appointment and failed a urine drug test but there was no documentation or follow up for these results.

RECORDS- Below minimum standards.

Many of the forms were not signed by the patient or a staff member. Many of the forms had conflicting dates. The controlled substance prescriptions were not written to standard. There was no working diagnosis. The follow up notes were inadequate. The only examination was the history and physical performed by Dr. Argotte.

OVERALL OPINION- Below minimum standards. Gross ignorance, negligence and incompetence.

Dr. Wilson prescribed excessive amounts and high risk medications to a patient without a diagnosis that justified the use of these medications. He continued to prescribe to this patient who demonstrated aberrant behaviors. He ignored the patients request to stop opioid medications. He did not appear to have any plan other than to continue the same

medications yet he increased them repeatedly. There was no monitoring of this patient and his controlled substance prescriptions. A KASPER report may have alerted Dr. Wilson to possible prescription fraud.

KASPER data does not match the prescription history in the chart. There are copies of prescriptions in the chart for 10/24/11, 12/5/11, 1/16/12, 2/13/12, 3/5/12 and 5/21/12. The KASPER data indicates that prescriptions were also filled for 11/14/11, 12/27/11, 3/5/12 and 4/16/12 in addition but there are no records in the patients' chart that correspond to these prescriptions.

(The patients spouse, an employee and patient of the facility, also had suspicious prescriptions in her chart as well as concerning KASPER data.)

13. [REDACTED] This patient was treated at Commonwealth Quality Healthcare by 4 physicians prior to Dr. Wilson. There was no history and physical under the designated "History /Physical" tab in the chart. The section of the chart labeled, "Progress Notes" appears to contain the only history and physical examination of the patient and this was conducted by Dr. Argotte on 3/7/11. The patient had a long history of chronic pain with initial traumatic injuries as a child; shoulder and clavicle fractures. IN 1991 he sustained injuries to his lower back and neck. He reported that he had right carpal tunnel disorder but refused surgery. Additionally he complained of severe bilateral knee pain and was going to have a total knee replacement. He reportedly had prior arthroscopic knee surgeries. He had psychiatric issues of anxiety and depression and had previously been under a psychiatrist care in 2010. Diagnostic studies included in the chart included: Whole body bone scan of 10/15/09 which was positive for prior rib fractures, and knee disease; MRI of the lumbar spine 2/1/2010 positive for mild to moderate L4-5 spinal stenosis as a result of disc bulging, osteophytes and congenitally short pedicles and bulging of the disc at L5-S1; MRI of the cervical spine on 2/1/2010 C5-6 and C6-7 disc bulging with bilateral and neural foraminal encroachment and hypertrophic facet joint change; radiographs of the knees 6/9/11 demonstrated moderately advanced degenerative disease of the right knee and mild on the left; MRI of the right knee demonstrated a bone contusion of the medial tibial plateau and an incomplete tear of the anterior cruciate ligament; the left knee had moderate degenerative changes and an MRI of the left ankle on 12/01/2010 demonstrated severe degenerative changes. His plan of care at that time included continuation of current medications which were oxycodone 30mg bid and oxycodone 15mg bid for breakthrough pain, soma 350 for muscle spasms, elavil 10mg at bedtime, referral to physical therapy and attempts to obtain prior psychiatric records. The patient had a urine drug test on this visit and was positive for marijuana and he indicated he would stop. He was diagnosed with chronic low back pain with spinal stenosis, cervical disc bulging with foraminal stenosis and facet hypertrophy and severe osteoarthritis of the knees needing a right total knee replacement. Dr. Argotte planned to wean the patient off oxycodone and change to Percocet, add an arthritis medication and address depression and anxiety. The patient had Valium in the urine at the June visit which was not prescribed. At the July, August and September visits his care was provided by Dr. Greenlaw and Dr. Dehaven. His medications now included Celexa 20mg, Xanax 1mg #90, Ultram # 90, Neurontin 800mg #90, Norflex 100mg #30 and oxycodone 30mg #120. 10/10/11 Dr. Wilson initiates care of the patient. A note written on the "Miscellaneous Patient Information" sheet by a staff member lists the medications he is taking and that he will have a total knee replacement. He is issued the same prescriptions of celexa 20mg, oxycodone 30mg #120, Xanax 1mg #90, Neurontin 800mg #90, Norflex 100mg #30, and Ultram 50mg #90. 11/7/11 Pt returned for follow up, Dr. Wilson makes a note that the patient was scheduled for knee replacement surgery in 8 days and he would increase pain medications by increasing the oxycodone 30mg to #150 and adding oxycodone 15mg #60. He gave the patient the increased medications as planned and continued all other medications. 12/5/11 he returned for follow up after having his knee surgery. The patient was having increased pain. Dr. Wilson issued all the same medications as the

previous visit except he increased the oxycodone 15 mg to #90. 1/3/12 the patient was issued the same prescriptions as the preceding month but the oxycodone 15mg was reduced to #60. There was no note or documentation that correlates to this date. 2/9/12 There are prescriptions issued to the patient for this date of oxycodone 15mg #30, Ultram 50mg #45, oxycodone 30mg #75, Neurontin 800mg #45, xanax 1mg #45 and celexa 20mg #15. 2/28/12 Dr. Wilson makes a note that the patient was doing well and he would decrease the oxycodone 30mg by one and increase the oxycodone by one and continue all other medications. 3/27/12 Dr. Wilson makes a note that the patient was doing well, warned about bad lab results and issued all medications the same except for a decrease in Xanax by 1 pill. While he makes a note of the changes planned, he did not decrease the Xanax and the oxycodone 15mg and oxycodone 30mg were issued with quantity of #90 and #120. 4/23/12 The patient returned for follow up and a note written by "Whitney" on the "Miscellaneous Patient Information" sheet states the patient would need to find another clinic because he could not function on the amount of medication he was getting. He could not handle the decrease in oxycodone. The note further states, "Pt will not ever be taken back as a patient due to his constant drug seeking behavior". At the bottom of this same paper it appears Dr. Wilson made a note, "oxy 30/60, 15/120, will be no more than this". However, the patient was issued prescriptions that do not correspond to his plan. He was issued the following prescriptions: oxycodone 15mg #90, oxycodone 30mg #120, Xanax 1mg #90, celexa 20mg #30, Ultram 50g #90, Neurontin 800mg #90 and Norflex 100mg #30. 5/21/12 a follow up triage note states the patient was adjusting to his medications. Dr. Wilson makes a note that the patient is complaining of persistent pain and he will decrease the oxy 30 by 1 and make other adjustments next month by decreasing the oxycodone 30 mg and increasing the oxycodone 15mg. The patient was issued the following prescriptions: oxycodone 30mg #90, oxycodone 15mg #90, celexa 20mg #32, Neurontin 800mg #90, Xanax 1mg #90, Norflex 100mg #32 and Ultram 50mg #90.

DIAGNOSIS- Within minimum standards.

This patient had a diagnosis that justified the use of controlled substances to treat his pain. There were never any documentations that Dr. Wilson examined the patient or rendered a diagnosis.

TREATMENT- Within minimum standards.

The patient had regular follow up visits to evaluate his need for controlled substances. He had urine drug testing. There were KASPER tracking numbers occasionally noted in the chart. Combining Xanax with the opioids in the doses prescribed was concerning.

RECORDS- Below minimum standards.

There is one physical examination in the record. There was no documentation that Dr. Wilson ever examined the patient. The follow up notes were not acceptable. The controlled substance prescriptions were not written to standard. There were no records of the hospitalization describing the total knee replacement; no physical therapy notes.

OVERALL OPINION-Below minimum standards.

The combination of high dose opioid medication with large quantities of benzodiazepines is dangerous; Dr. Wilson prescribes this combination as though there are no consequences. There were no other treatment options offered for this patient. There were no referrals to psychiatry or other specialists. The fact that no documentation was found to show that Dr. Wilson examined the patient is concerning.

14. [REDACTED] (Former owner of Commonwealth Quality Healthcare). Pt complained of chronic pain that began after having a motor cycle accident in 2002 and ATV accident in 2004. The chart lists several dates for these accidents and it is unclear when they actually occurred. She reported that she sustained a pelvic and clavicle fracture. She complained of chronic lower back, neck pain and headaches. The only physical examination documented in the chart is per Dr. Argotte on 3/1/11. diagnostic studies on the chart included an MRI of the lumbar spine dated 8/19/2011 from Missouri which was positive for a posterior broad based disc bulge and a left paracentral protrusion causing stenosis at L4-5 and facet hypertrophy at L5-S1; an MRI of the cervical spine dated 8/3/2009 positive for foraminal narrowing at C3-4 and C4-5. (This patient had radiograph reports from Tampa Florida, Missouri and Kentucky in her chart). She reported she was taking oxycodone 15mg #120, soma 350mg qd prn, Xanax 1 mg, valium 5mg qd and Fioricet. She denied having physical therapy. Dr. Argotte wrote orders for her to be evaluated by psychiatry for anxiety, depression and chronic pain and physical therapy for muscle strengthening and increasing range of motion. He issued the following prescriptions: oxycodone 15mg #120, Xanax 1mg #30, Imitrex and flonase. Over the next several months Dr. Argotte attempted adjunctive therapies such as ibuprofen and continued the same medications. There were no patient visits for the next several months because the patient had taken a job in Oklahoma. 11/10/11 Dr. Wilson issued prescriptions for the patient. A note written for this date states there are no copies of these prescriptions in the chart because they accidentally got shredded. The prescriptions were written for the patient because she was in Oklahoma working. 11/22/11 Dr. Wilson made a note in the chart that the patient complained of chronic pelvic pain due to a 4-wheeler accident, continue oxycodone 15mg #120. A notation on the same form states patient is out of town working and she stopped by to get script, will not fill until due. He issued the following prescriptions to the patient: oxycodone 15mg #120 and Xanax 1mg #15. There is a follow up triage note that is confusing with date 12/08/11 stating no side effects from medications, continue same plan and no changes; this note is signed by Andrea Kennedy. There are no prescriptions with the 12/9/11 date on them. 12/14/11 Dr. Wilson issues prescriptions for oxycodone 15mg #120 and Xanax 1mg #30. It appears the patient was not seen but had prescriptions sent by mail. 1/12/12 note written on the "Miscellaneous Patient Information" form states, [REDACTED] is still in Oka working! Meds working well! There is no signature on this form and does not appear to be in Dr. Wilson's handwriting. 2/8/12 Prescriptions were issued for oxycodone 15mg #120 and Xanax 1mg #30. It does not appear that the patient was seen by Dr. Wilson on this day. 3/5/12 Dr. Wilson makes a note that the patient is satisfied with her current regimen and the plan is to continue the same medications. He issues the same prescriptions as the preceding month. 4/5/12 Dr. Wilson writes the same note as the preceding month that the patient was satisfied with her regimen; he would continue the same prescriptions and issues the same prescriptions. However, on 4/5/12 the patient was not seen and there were notes initialed by "JC", that the "patient could not get a flight but will be here in the morning". So it appears the patient was not seen on 4/5/12 by Dr. Wilson but he wrote a note indicating he had seen her as noted above. 5/3/12 Dr. Wilson makes a note, "pt without

complaints, continue same meds". However, he issued both prescriptions with increased quantities and no explanation. Prescriptions were for oxycodone 15mg #140 and Xanax 1mg #35.

DIAGNOSIS – Below minimum standards.

There appeared to be justification for controlled substances per the imaging studies. However, there were no physical examination notes per Dr. Wilson, no additional testing obtained.

TREATMENT- Below minimum standards.

There were no other treatment options or modalities for this patient. There was no follow up on the referrals to psychiatry or physical therapy. There were indications that the patient was continued on high risk medication without being evaluated. There was no explanation for the increase in the benzodiazepine. This patient was not being monitored for her controlled substance use. She was not evaluated regularly.

RECORDS- Below minimum standards.

There were no physical examination notes or adequate progress notes by Dr. Wilson. The record appears to indicate he wrote notes when the patient was not present. A KASPER report appeared to have been requested twice. The controlled substance prescriptions were not written to the required standard.

OVERALL OPINION- Below minimum standards. Gross negligence.

It is grossly negligent to prescribe controlled substances for a patient that you have not met or examined. The combination of high dose opioid and benzodiazepine is unsafe.

15. [REDACTED] (This patient is an employee of Commonwealth Quality Healthcare). She complained of chronic lower back pain that radiated down her legs for approximately 2 yrs. The pain began after caring for her husband by lifting etc. She had prior treatment by Dr. Azmat and Mary Beth Calor, DO. Dr. Calor also treated the patient's hypertension and thyroid disorder. There were few records in the chart and of the records they are in a disheveled fashion with many pages being blank. A copy of an MRI of the lumbar spine report appears in the record dated 10/27/2008. It is positive for a mild posterior disk bulge at L3-4, probable L3-4 radial tear, bilateral facet hypertrophy and right neural foraminal stenosis, a midline disk herniation at L4-5 with bilateral facet hypertrophy and moderate to severe impingement upon the right lateral recess and mild disk bulging at L5-S1. The only documented physical examination was per Dr. Argotte on 4/6/11. On 4/4/11 the chart contains a document that appears to be completed by the patient. This form is one that is utilized by the medical provider to ascertain information about the pain complaint along with vital signs. Dr. Argotte ordered the patient to have MRI studies of her cervical, thoracic and lumbar spine, physical therapy evaluation for muscle strengthening and improve range of motion; and a psychiatric evaluation for anxiety, depression and chronic pain. He issued prescriptions for Percocet 10/650 #120, Neurontin 200mg #60 and ibuprofen 800mg #90. A urine drug test performed on 4/6/11 was negative for any substances. A notation dated 6/6/11 per Dr. Argotte states he will no longer see the patient for pain management. There is no explanation. A urine drug test dated 6/27/11 is noted in the record and positive only for hydrocodone; at this time the patient was being treated with Percocet. 11/23/11 Dr. Wilson makes his first note on the patient. This note appears to be with some corrections or white out marks, it is unclear what happened to the note. In his note he writes the patient complains of neck and lower back pain, the present MRI's were verified but were greater than 5 years old and his plan was to get new MRI studies of the spine. He also writes that his plan will be for Tylox 5/500 bid, Percocet 10/325 qid and ox 10 one daily. The date on this note appears to be altered. The KASPER data obtained by the consultant indicates for this date the patient filled oxycodone 5/500#60, phentermine 37.5mg #60, and Endocet 10/325 #150. The chart contains copies of prescriptions that do not match the notation date. Also included in the chart are copies of prescriptions dated 10/18/11 for Percocet 10/325 #150, Adipex 37.4mg #60, Neurontin 100mg #120 and Norvasc 10mg #30. There was one prescription copy dated 11/18/11 for Tylox 5/500 #60 and has #3 of 4 at the top; the other copies are not found in the record. There were no other prescription copies for this date. The next note appears to be written on 12/23/11 but this date also looks to be altered somewhat. Dr. Wilson notes something about Calloway lab, it is unclear whether the lab was okay or not, the patient was requesting Percocet in place of Lorcet and his plan was to add Percocet 10/325 #120. (He had not prescribed Lorcet for the patient according to the chart). A follow up triage note dated 12/22/11 is in the chart but does not have the patient's name or any other signature. There are no copies of prescriptions for either of these dates in the chart. 1/11/12 again there is a follow up triage note that does not have the patient's name or other signatures; it appears in the same handwriting and appears to be the patient's handwriting. Dr. Wilson has a note for this date but this date too has been

altered by writing over it. He writes the patient is satisfied with her current regimen. The remainder of his note is not legible. It appeared to state something about a weight loss drug and he planned to write for the same medications. There are no copies of prescriptions in the chart from this date. On 2/9/12 a follow up triage form is in the chart but does not have any name or identification. There are no notes from Dr. Wilson.

DIAGNOSIS- Below minimum standards.

MRI studies indicate the patient had a condition which could cause pain. However, Dr. Wilson never rendered a diagnosis. There was no documentation that he ever examined the patient. There did not appear to be any attempt to obtain previously ordered MRI studies.

TREATMENT- Below minimum standards.

The use of multiple controlled substances to treat this patient's pain was inappropriate. There was no follow up on previously ordered diagnostic studies by other physicians nor Dr. Wilson. There was only one KASPER data notation. The urine drug testing was not as it should have been and these results were never addressed. There were no other treatments or therapies ordered. A treatment plan was not followed.

RECORDS- Below minimum standards.

There were no physical examinations, no working diagnoses. The notes were grossly inadequate. The chart contained forms/documents that were either blank, not marked appropriately with identifiers or not signed by anyone. It was obvious often the patient who was also an employee filled out some of her follow up forms. There were obvious discrepancies in dates on both follow up forms and prescriptions. It appeared Dr. Wilson tried to make his notes match his prescribing upon 2 occasions after the fact.

OVERALL OPINION- Below minimum standards. Grossly negligent.

It is unethical to prescribe controlled substances for an employee/fellow employee. The treatment was inappropriate. There was no examination or medical diagnosis rendered.

16. [REDACTED] This patient had lower back and left lower extremity pain that began approximately 17yrs prior, following a crushing injury by a heavy piece of equipment called a dozer. He also complained of pain in his neck and shoulders for approximately 10yrs following a motor vehicle accident. He had been to a physician for pain management but that physician was "shut down" according to the patient. He presented to Commonwealth Quality Healthcare in 3/11. The mainstay of his pain management treatment had been with hydrocodone, soma, Xanax and tramadol. Dr. Argotte initially evaluated the patient conducting a history and physical and found him to be reliable. He discontinued the soma; continued Xanax at 1mg every 12 hrs as needed, increased his tramadol and resumed hydrocodone, (Lorcet 10/650 #120). He ordered physical therapy, a left shoulder x-ray, MRI of the cervical and lumbar spine and psychological evaluation. He was also to return to his internist/family physician for blood pressure and diabetes management. An existing MRI report of the lumbar spine was obtained dated 9/12/05 and results indicated severe L4-5 facet degenerative disease causing bilateral foraminal narrowing and an anterolisthesis of L4 on L5 and a large left L5-S1 paracentral disc extrusion affecting the left S1 nerve root with degenerative disc disease also at that level. An MRI of the left lower extremity for the same date indicated degenerative changes involving the third and fourth MTP joints consistent with osteochondrosis. He returned the following month doing well with medications; Dr. Argotte began Elavil 25mg at bedtime and Neurontin 600mg every 24hrs and continued the other medications for pain. It was also noted on this visit Dr. Argotte prescribed blood pressure medications. The patient went for the psychological evaluation on 4/26/11 and the resulting report sent to Dr. Argotte concluded the patient was determined not to pose any risk to self or others, was currently doing okay managing pain and stress and the patient was not interested in receiving any services at that time. The patient also went for the physical therapy evaluation on 3/30/11 and a treatment plan was developed to improve range of motion and reduce pain. The patient had the MRI of the lumbar spine performed on 8/30/11 and was noted for moderate degenerative disc disease, neural foraminal narrowing, grade 1 spondylolisthesis at L4-5 and a large left and central disc herniation at L5-S1. Dr. Greenlaw began care of the patient in July 2011, medications continued except he added oxycodone 15mg instead of the Lorcet. Neurontin had been discontinued because it gave him a rash but was prescribed again at a lower dose. 10/26/11 Dr. Wilson begins care of the patient. He made the following notes; patient was having breakthrough pain and tramadol wasn't helping, Calloway lab was ok, Kasper was ok, increase the oxy to 30mg tid and tramadol tid. He issued the following prescriptions to the patient: Ultram 50mg #90, oxycodone 30mg #90 (the patient had been on oxycodone 15mg #100 the previous month from the previous physician), Xanax 1mg #60 and Elavil 25mg #30. 11/23/11 note per Dr. Wilson states the patient was satisfied with his current regimen and his plan was to continue the same medications. He issued the same prescriptions as the preceding month. There was a form that indicated attempts were made to phone the patient for a pill count but the phone was never answered. 12/22/11 Dr. Wilson makes a note that the patient was satisfied with the current regimen, plan was to continue same medications and Calloway "Ok'd by nurses". He issued the same prescriptions as the preceding month. 1/19/12

Follow up triage note by staff describes patient to be doing well on meds but needs new sleeping med. Urine drug testing demonstrated high levels of opiates but was never sent for confirmation after the patient was no longer being prescribed hydrocodone. Dr. Wilson makes a note that the patient was satisfied with his current regimen but Elavil was not helping with sleep and he would replace Elavil with Ambien. He was issued the same prescriptions except no Elavil which was replaced by the Ambien as planned; 10mg #30. 2/16/12 the follow up triage note reported the patient to be complaining of more shoulder pain in the previous weeks; a form titled, "FOLLOW-UP PATIENT" was completed by Kidd, RN. This appeared to be a physical examination form. Dr. Wilson makes a note that the patient was without complaints, he planned to decrease the oxy 30 and add oxy 15, the remainder of his note is not clear as to the meaning, "Plan: Leave last 30". He issued the following prescriptions to the patient: oxycodone 15mg #30, oxycodone 30mg #60, Ultram 50mg #90, Xanax 1mg #60 and Ambien 10mg #30. 3/15/12 patient returned for follow up and was reporting numbness in his right arm, Dr. Wilson makes a note that the patient was warned about a pill count, that he was complaining of shooting pain and tingling, plan was to continue the oxy 30 and increase the oxy 15 and add Neurontin 600mg #60 and continue all other medications. He issued the following prescriptions: oxycodone 15mg #90, oxycodone 30mg #30, Neurontin 600mg #60, tramadol 50mg #90, Xanax 1mg #60 and Ambien 10mg #30. 4/12/12 the patient returned and reported doing well. Dr. Wilson makes a note the patient was without complaints, plan was to replace the oxy 30 with Percocet 10 #90, continue all other medications and the following month to discontinue the tramadol. He issued the following prescriptions: oxycodone 15mg #90, Percocet 10/650 #90, tramadol 50mg #90, Xanax 1mg #60, Ambien 10mg #30 and Neurontin 600mg #60. 5/10/12 The follow up triage note per staff reports that patient without any new complains, Dr. Wilson makes a note that the patient was without complaints and plans to write the same medications. However, he issued prescriptions without the changes he planned from the previous month and with no change in directions but also increased the quantities of each. He issued the following prescriptions to the patient: oxycodone 15mg #105, Percocet 10/650 #105, tramadol 50mg #105, Xanax 1mg #70, Ambien 10mg #35 and Neurontin 600mg #70.

DIAGNOSIS- Below minimum.

There was no documentation that Dr. Wilson examined the patient as a means to make an evaluation and render a diagnosis. The patient clearly had lumbar pathology that could result in the pain he described. There was never any diagnosis of his shoulder and neck pain. There was never any diagnosis rendered regarding his left foot pain and study results. Dr. Wilson never documented a diagnosis of any kind.

TREATMENT- Below minimum.

The use of controlled substances as part of this patients overall treatment plan was appropriate. It is also concerning that the patient had a previous problem tolerating Neurontin at low doses yet it was prescribed again at a higher dose. Neurontin was

prescribing again in response to the patients shoulder complaints. When the patient complained of shoulder pain, numbness and tingling there did not appear to be any physical examination by Dr. Wilson. Dr. Argotte originally ordered a shoulder x-ray and a cervical MRI; there was neither documentation of follow up on those previously ordered studies or documentation of ordering any studies to evaluate the patients' complaints. The patient was evaluated by physical therapy when he saw Dr. Argotte. There were never any additional records or discussions regarding physical therapy following that initial evaluation. There were no other adjunctive therapies suggested such as interventional injections therapies. There were no other referrals made such as to the orthopedist or spine specialist. The only other prior adjunct used for the patient per documentation was a back brace. The patient did have urine drug testing and occasional KASPER data notations. When the patient had high levels of opiates in his urine drug screening it was never sent for confirmation.

RECORDS-Below minimum.

The records contained acceptable urine drug testing documentation. The controlled substance prescriptions were not written to standard. The record contained 2 radiograph reports on another patient. There were no physical examinations by Dr. Wilson documented. There was no working diagnosis. Most of the consents have the appropriate date and signing.

OVERALL OPINION- Below minimum standards. Gross ignorance and incompetence.

Dr. Wilson never examined the patient. Appropriate testing was not obtained. Dr. Wilson demonstrates a general "disconnect" in medical decision making. He planned to decrease medication and eliminate some medication but he did the opposite; he increased and added medications. The record indicates Dr. Wilson does not appear to use rational medical decision making based upon knowledge and understanding of how to utilize these medications.

17. [REDACTED] Initial visit appears to be on 8/2/11. The patient reported he had pain in his lower back as the result of two motor vehicle accidents. He complained of constant pain that radiated down both legs. By his report this was his first visit to a pain treatment facility. He denied medications but did report he took pills from his wife and the staff notes reads, "both were white". He reported that he was disabled and unemployed and could not read or write. There was no physician history and physical; the physician providing care at this time was Dr. Dehaven. A copy of an MRI of the thoracic spine dated 9/30/2009 was in the chart. The results indicated degenerative changes in the thoracic spine with mild bilateral recess narrowing at T11-12 and minimal levoscoliosis of approximately 6 degrees. The patient was given a diagnosis (in what appears to be the handwriting of employee Yavonda Lazar) of "deg changes T spine, scoliosis at mid Thoracic Area '09". The patient was issued the following prescriptions: Vallum 5mg #30, Lorcet 10/650 #90 and Neurontin 400mg #90. The patient returned on 8/30/11. There is a note written by "Ya" on the "Miscellaneous Patient Information" form that states the patient was "informed he will be on strict probation. States he can't read or write and his wife filled out his paperwork and he wasn't clear on rules, promises he will follow the rules and comply". He further reported "got meds mixed up on accident" with his wife's meds. This note is signed by Dr. Dehaven. The record contained a urine drug test result which was positive for oxycodone; but this test result belonged to his father, [REDACTED] date of birth [REDACTED]. He was issued prescriptions for Vallum 5mg #30, Hydrocodone 10/325 #90 and Neurontin 400mg #90. He returned on 9/28/11 and a note written on the "Miscellaneous Patient Information" form was in the handwriting of employee Yavonda Lazar, states patient had been under more stress and was taking an extra pain pill at night, Lorcet 10/650 was issued and increased to #120, the vallum and Neurontin remained the same. A urine drug test for this date had Klonopin present per confirmation but this was not prescribed. The chart contains a note that the urine test results were ok. 10/27/11 Dr. Wilson initiates care, makes a note that the patient requests increase in Vallum, pain levels ok and he will write prescriptions. There is also a triage note written by employees for the same date. A urine drug test on this date was noted not to pass one component of the validity screen; result of out of range. Dr. Wilson issued the following prescriptions and each had an increase in quantity with no change in directions: Lorcet 10/650 #128, Vallum 5mg #64, and Neurontin 400mg #96. 11/28/11 The patient returned for follow up said medications were working; Dr. Wilson makes a note that the patient was satisfied with the current regimen and he planned to write the same medication. A urine drug screen for this date was positive for oxymorphone verified per confirmation which indicated either use of oxycodone that had completely metabolized to oxymorphone or oxymorphone use. He issued the following prescriptions and again with quantities that were not explained: Lorcet 10/650 #124, Vallum 5mg #62 and Neurontin 400mg #93. In mid November, a pill count had been attempted but was unsuccessful due to inability to contact the patient. 12/27/11 A urine drug test again resulted positive for oxymorphone. A follow up triage note by Kidd, RN reports patient as not having any idea why his test was positive for "oxy". Dr. Wilson makes a note that the Calloway lab was positive for oxymorphone, the patient was satisfied with his current regimen and he planned a pill count in 15 days for the Lorcet and other meds the same. He issued the same prescriptions as the previous month except the quantity of the Lorcet was

not #60. There was documentation in the chart for a pill count performed on 1/9/12 which appeared to be okay and on this date he was issued another prescription for #60 Lorcet. 1/23/12 He returned and stated his wife was prescribed oxycodone and she may have gotten it mixed up with his valium. Dr. Wilson makes a note that the patient was warned about "ox" in lab; patient was satisfied with current regimen and continues same meds. He issued the following prescriptions: Lorcet 10/650 #120, Valium 5mg #60 and Neurontin. 400mg #90. 2/20/12 The patient was without complaint and the same medications were issued. 3/19/12 he returned for follow up and was complaining of more pain at when lying down at night, Dr. Wilson makes a note that the patient requested one more Lorcet, he would increase the Lorcet and continue other meds the same. He issued the same prescriptions with the exception of Lorcet 10/650 which now he increased the quantity to #150. 4/17/12 the patient reported his pain had decreased Dr. Wilson makes a note that patient was without complaints and write for same meds. The same prescriptions were issued. 5/14/12 the triage follow up note states the patient was asking for an increase in Vallum for sleep at night. Dr. Wilson makes a note that the patient was complaining of Insomnia, otherwise without complaints and plan is to write the meds the same. However, he issued all prescriptions with increases and adds a sleeping pill: Lorcet 10/650 #160, Vallum 5mg #64, Ambien 10mg #32 and Neurontin 400mg #96.

DIAGNOSIS- Below minimum standard.

This patient did not have a diagnosis that warranted the pain medication prescribed. Dr. Wilson never rendered a diagnosis. There was no apparent physical examination from Dr. Wilson or anyone. There were no additional tests obtained in which to make a diagnosis.

TREATMENT- Below minimum standard.

This patient was treated with excessive amounts of acetaminophen in combination with his opiate medication. The amount of amount medication prescribed was excessive and not indicated. When he complained of any symptom he generally had all medications increased. When he complained of sleeping difficulty he was given not only a sleeping pill in addition to the benzodiazepine he was taking but increases in the benzodiazepine, opiate and Neurontin. There were no documented attempts to use adjunctive therapies or make any referrals. There were no psychological or psychiatric referrals. There were multiple problems with urine drug studies. Utilization of urine drug testing was problematic.

RECORDS- Below minimum standard.

There was NO history and physical. The follow up notes by the physician were inadequate. The chart contained lab results that belonged to his father. The controlled substance prescriptions were never written to the expected standard. There were frequent notations that KASPER data had been obtained. Urine drug testing was performed albeit with difficulty in utilizing the results. A pill count was performed.

OVERALL OPINION- Below minimum standard. Grossly negligent, incompetent and ignorant.

Dr. Wilson did not appear to assess the patient. He noted what the patient was requesting, i.e., another pain pill, and complied regardless of the risk or indication. The addition of multiple benzodiazepines in addition to the high dose opiate was very concerning.

18. [REDACTED] The initial visit appears to be 6/8/11 and was conducted by Dr. Argotte. The patient had chronic pain for many years with the onset beginning in 1991 with a reaching type of injury. He complained of pain in his neck radiating to his left shoulder, lower back pain radiating to both legs and muscle spasms. He reported being under the care of a Dr. Karel for pain management for approximately 7 years until "Health Dept closed him". Dr. Karel referred him to Southern Ohio Pain Management, he obtained care there for approximately 3 months and then that facility was closed down. The Southern Ohio Pain Management facility reopened but the patient reportedly became frustrated with continued appointment changes so he presented to Commonwealth Quality Healthcare for treatment. He reported prior treatment with epidural injections, physical therapy, and medications. His recent history was positive for peptic ulcer disease with recent stomach bleeding stomach. His history was positive for alcoholism; he obtained rehabilitation treatment and was sober at least for 20 years. He also reported prior problems with depression requiring treatment twice. He also reported being discharged from military duty for being unfit medically; the chart contained copies of these records. At the time of his evaluation with Dr. Argotte, his driver's license was suspended due to not having insurance. Physical examination was positive for abnormalities including muscle weakness in his right lower extremity. Diagnostic studies were ordered; physical therapy and psychological evaluations were ordered. Prior imaging studies were obtained dating from 1995 until 2008/9. The updated studies performed on 6/29/11 indicated the patient had lumbar degenerative disc disease with a posterior annular tear and a right paracentral disc herniation contacting the right S1 nerve root at L5-S1, thoracic facet hypertrophy at T8-11 with small central disc protrusions at T8-9 and T9-10, and cervical spondylosis, advanced at C4-5 and 5-6, with cord compression at C5-6 and stenosis. Dr. Argotte issued the following prescriptions: Percocet 10/325 #150, Ambien 10mg #30, Wellbutrin 75mg #60, Norflex 100mg #30 and Neurontin 100mg #60. When the patient returned for follow up, Dr. Argotte was no longer practicing at the facility. Reassessment forms for this follow up date of 7/7/11 were for the most part not completed. The office visit forms/notes were confusing for the next several months and it is not clear who actually made the treatment plans. The prescriptions were per Dr. Greenlaw and Dr. Dehaven. The 7/7/11 prescriptions were for oxycodone 15mg #120, Norflex 100mg #30, Neurontin 400mg #90 and a referral to an orthopedic surgeon was also written on the same date. Prescriptions the following month were for Percocet 10/650 #60, oxycodone 30mg #120, Xanax 2mg #60 and Neurontin 400mg #90. In September the same prescriptions were issued but now included Soma 350mg #30 and Nexium 40mg #30. In September the patient was called for a pill count and he stated he was in Ohio and would be in as soon as possible. Another phone note for September documents the patient phoning to report he went to the ER for unbearable pain. The 9/29/11 prescriptions were for all the previous medications except the Soma 350 was increased to #60 and the Percocet 10/650 was increased to #90. 10/26/11 Dr. Wilson begins to see the patient and makes a note that the Calloway lab was ok and he writes the letters MRI E; it is unclear but appears to be referring to the MRI reports; he notes the patient was without complaints but writes he will increase the Nexium by 5. The directions were to take 1 Nexium 40mg every 18 hrs. The triage follow up also notes the patient to being doing well and without complaints. Dr. Wilson issues the same prescriptions as the

preceding physician but increases the quantity of the Nexium to #45. 11/23/11 he returns for follow up, the follow up triage note indicates the patient is doing well, the right knee gives out and the patient thinks he may need to change the Percocet to oxy 10 or 15mg if possible. Dr. Wilson makes a note that the patient was satisfied with the current regimen, he planned to decrease the ox 30's to #90, replace the Percocet with ox 10's, add nortriptyline and continue other medications. He issued the following prescriptions: oxycodone 10mg #90, oxycodone 30mg #90, soma 350mg #60, Xanax 1mg #120, Nexium 40mg #45 and nortriptyline 25mg #90. There is documentation that a pill count was requested on 12/1/11; the patient was left a message to call back. On 12/19/11 the patient presented for a pill count; he was short several days of oxycodone 30mg and oxycodone 10mg. 12/22/11 he presented requesting medications to be adjusted and complained of his left knee giving out. Dr. Wilson makes notes that the Calloway lab was ok, the nortriptyline was no help, muscle spasms were diminishing, the ox's were weak and his plan was to discontinue the soma and nortriptyline and replace the oxycodone 10 with oxycodone 15mg and leave other meds the same. He also makes a note that the patient is "maxed on ox's". He issues the following prescriptions: oxycodone 15mg #90, oxycodone 30mg #90, Xanax 1mg #60 and Nexium 40mg #45. 1/23/12 he returns and describes increasing pain and increasing marital stress and divorce; Dr. Wilson makes notes that the patient requested more Xanax and he would grant this and requested more oxycodone 15mg but would deny this; he would leave other medications the same except also decrease the Nexium to #30. He issued the following prescriptions: oxycodone 15mg #90, Xanax 1mg #90, oxycodone 30mg #90 and Nexium 40mg #30. 2/20/12 he reports having increased pain because of decreased medications, Dr. Wilson notes the patient is satisfied with his current regimen, complains of an upper respiratory infection and requests a Z-pack, plan is to decrease the oxy 30 by 1 and increase the oxy 15 by 1 and add a Z-pack. The following prescriptions were issued: oxycodone 15mg #120, oxycodone 30mg #609, Xanax 1mg #90, Nexium 40mg #30 and a Z-pack. 3/19/12 Dr. Wilson makes notes the complained of being dizzy, cold and clammy and bad nausea approximately 2-3 weeks prior to the appointment and writes, "suggestive of MI patient. Pt also complains of ED". Plan was to advise the patient to be "evaluated for probable MI and plateau meds". Dr. Wilson issued the same prescriptions as the preceding month. The urine drug test for this date was positive for morphine. This was addressed on the follow up visit when the patient was questioned and reported taking one of his father's meds by "accident", he said he would bring proof that his father took that medication. On the follow up visit of 4/16/12 Dr. Wilson notes the patient took his father's morphine by mistake and writes, "I give second chances". His plan was to replace the oxy 30 with Percocet 10/650 #120 and leave the other medications the same. He issued the prescriptions as follows: oxycodone 15mg #120, Percocet 10/650 #120, Xanax 1mg #90 and Nexium 40mg #30. The urine test on this day was positive for amphetamines; per confirmation it appeared to be adderall. There was a note on the front of the chart that stated "+methamphetamine", "no Calloway goes to Sue for dismissal".

DIAGNOSIS- Minimum standards.

There was a complete history and physical per Dr. Argotte and more than adequate diagnostic studies that justified the use of controlled substances. Again, concerning is the lack of documentation that Dr. Wilson examined or diagnosed the patient. He never gave any diagnoses.

TREATMENT- Below minimum standards.

The patient was never examined by Dr. Wilson. When the patient repeatedly complained about his knees Dr. Wilson never examined him. The record was clear that this patient was at higher risk for the use of controlled substances given his history of alcoholism and depression. This patient may have been most suited for long acting opioid medications; not multiple short acting medications. Further, the patient described being treated by what most probably was a pill mill in Ohio and when called for a pill count he was unable to come for the pill count because he was in Ohio. Records should have been obtained or at minimum a phone inquiry to learn if the patient was continuing to obtain pain medication from Ohio. The patient repeatedly complained of psychosocial stressors and was given increased doses of Xanax. He was never referred for supportive services such as a psychologist or psychiatrist after Dr. Argotte left. The previously requested referrals were never followed up on.

RECORDS- Within minimum.

There was an appropriate history and physical examination performed by Dr. Argotte. There were diagnostic studies and multiple urine drug tests. Frequently there were tracking numbers for KASPER data. There were regular visits. Physician examinations were nonexistent after Dr. Argotte left. None of the controlled substance prescriptions were written to the required standard.

OVERALL OPINION- Below minimum standards. Gross ignorance, neglect and incompetence.

It is completely unacceptable to never examine the patient. The obvious indicators that the patient may have been treated prior at a pill mill was ignored. Dr. Wilson demonstrated a persistent "disconnect" in prescribing for this patient, his notes often did not correlate to the patient complaints. When the patient complained of persistent knee pain, there was no examination, no attempt to diagnose the problem.

19. [REDACTED] Presented to the facility on 7/27/11. He had been in a motor vehicle accident on 7/6/11. He was extradited from the vehicle initially evaluated at one hospital and transferred to another hospital. After 2 days he was discharged home with the diagnosis of a C2 avulsion fracture and a C5 fracture. The chart contains records from the hospital admission and included radiographs. The CT of the head and neck demonstrated scalp lacerations and an avulsion fracture of the C2 vertebral body and nondisplaced fractures of the left C5 pedicle and lamina with extension into the left C5 inferior articular facet and subluxation of the left C5-6 facet joint. An MRI of the cervical spine on 7/7/11 showed a C5-6 posterior central disc protrusion with annular tear and mild narrowing of the canal. Thoracic and lumbar studies were normal as were radiographs of the extremities. He complained of neck, arm lower back and leg pain. He was taking hydrocodone for pain. Documentation was on the chart that the patient was prescribed hydrocodone 5/500 #40 for 7 days, when he was discharged from the hospital and a second prescription for hydrocodone 7.5/500 #40 on 7/18/11. A urine drug test on this date was positive for hydrocodone. Dr. Dehaven was the physician at the facility, made of notation of the fracture, advised the patient to wear his cervical collar at all times, no driving in any car and follow up with surgical services. There is no physical examination except as noted by staff member, "Ya". "Ya" also completed the physicians' diagnosis and orders sections which Dr. Dehaven signed. The patient was issued the following prescriptions: oxycodone 15mg #120, tramadol 50mg #90, valium 10mg #30 and baclofen 20mg #90. On the next visit, employee "Ya" again wrote what appeared to be a physician note that Dr. Dehaven signed and noted the patient was to be referred for a neurosurgical consult, he had numbness and pain in his neck, shoulders. The same prescriptions were issued but the oxycodone 15mg was increased to #150 and the Ultram was increased to #120. The oxycodone was not in the urine drug test for this date as it should have been. The next visit of 9/20/11 the patient had THC in his urine test and there was no oxycodone in his system; he was given a warning. Baclofen was discontinued and Neurontin was added, the oxycodone, Ultram and vallum remained the same. There was notation that the patient had a follow appointment with another physician and a new MRI was possibly going to be done. 10/18/11 Dr. Wilson begins care of the patient. Notes were made by "Ya" on the "Miscellaneous Patient Information" form that were confusing; the Ultram did not help, Dr. Wilson signed his last name by this statement, Percocet would be added and vallum would be increased. There is no explanation for the decision to use Valium. The note also states, "Pt strongly urged to consult with surgeon". There were no physical examination notes. Dr. Wilson issues the following prescriptions: oxycodone 15mg #150, Percocet 10/650 #60, Vallum 10mg #60 and Neurontin 300mg #90. The urine drug test for this date was positive again for THC, absence of the vallum and ultram was present. 11/15/11 Dr. Wilson makes a note that the patient was complaining of breakthrough pain and he would replace the oxy 15 with 30's, replace the valium with Klonopin, leave the Percocet the same and adjust the Neurontin. He issued the following prescriptions: oxycodone 30mg #90, Percocet 10/650 #60, Klonopin 1mg #30 and Neurontin 600mg #90. The urine drug test on this day was confirmed positive for Valium and Klonopin yet it had not been prescribed yet to the patient. 12/15/11 The patient complained of not

sleeping and spasms but the meds were helping. Dr. Wilson makes a note that Calloway lab ok for 11/15, the patient was complaining of shooting left neck pain and insomnia; plan was to increase the Neurontin and Klonopin and leave other medications the same. He issued the following prescriptions all with increases: oxycodone 30mg #99, Percocet 10/650 #66, Klonopin 1mg #66 and Neurontin 900mg #99. 1/16/12 Patient now complained of headaches and ear numbness and running out of Klonopin. Dr. Wilson makes notes that the patient was warned noncompliance could lead to dismissal and planned to write the same meds. He issued the following prescriptions: oxycodone 30mg #90, Percocet 10/650 #60, Klonopin 1mg #60 and Neurontin 800mg #90. 2/13/12 the patient was satisfied with his current regimen and he plans to adjust Klonopin, oxycodone and Percocet. He issued the following prescriptions to the patient: oxycodone 30mg #60, Percocet 10/650 #90, Klonopin 1mg #30 and Neurontin 800mg #90. 3/12/12 the patient had THC in his urine drug test, stated medications were helping. Dr. Wilson makes a note that the patient was complaining of increased pain and he planned to increase the Percocet, convert the oxy 30 to 15mg and decrease the Klonopin. He issued the following prescriptions: oxycodone 15mg #120, Percocet 10/650 #120, Klonopin .5mg #30 and Neurontin 800mg #90. 4/9/12 There is no note or documentation from Dr. Wilson but there is a dismissal letter for "bad labs". Dr. Wilson issued the following prescriptions: oxycodone 15mg #60, Percocet 10/650 #60, Klonopin .5mg #15 and Neurontin 800mg #45.

DIAGNOSIS- Below minimum standards.

This patient clearly had a diagnosis that justified the use of controlled substance to treat pain. However, his pain was from an acute injury and was anticipated to improve. There was no physical examination by anyone in the record except for the physician at the hospital who treated the patient for his initial injuries.

TREATMENT- Below minimum standards.

The rapid transition from a mild dose of a scheduled 3 narcotic to the use of more than one high dose, scheduled 2 narcotics was inappropriate. Dr. Wilson continued the same prescribing without any documented examination or attempt to obtain consultation or repeat imaging studies. The patient was treated with inappropriate doses of medications. He was given early refills and quantities that did not make sense.

RECORDS- Below minimum standards.

There was no initial history and physical documentation by the physicians at, Commonwealth Quality HealthCare. There were no follow up examination records. Follow up notes were inadequate. The controlled substance prescriptions were never written to the required standard. Urine drug testing was done and there were tracking numbers indicating KASPER data had been obtained.

OVERALL OPINION- Below minimum standards. Grossly negligent, incompetent and ignorant.

There was no documentation that Dr. Wilson ever examined this patient. He did nothing to evaluate the patient's need for continued controlled substances. The hospital discharge physicians determined the patient to need a very low dose of hydrocodone for a short period of time. Dr. Wilson escalated this patient's use of controlled substances; he took the patient from a total of 20mg of hydrocodone to 110 mg of oxycodone without any justification; without any documentation of why the patient was not improving as expected.

20. [REDACTED] He initially presented on 8/22/11 complaining of chronic neck and lower back pain that began in 2008. He reported getting hurt when working in the coal mines and also having 2 motor vehicle accidents. He reported prior treatment by a pain management facility. He listed his medications to be oxycodone 15 #120, Vicodin, Xanax #30 and Lyrica; but he reported the vicodin and Lyrica did not help with his pain. Prior treatment for pain listed per the patient included physical therapy, steroid shots in his neck and back and the use of a neck brace. Diagnostic studies in the record included an MRI report of the cervical spine dated 11/27/2008. This report noted a right deep cervical lymph node at the level of carotid bifurcation, moderate degenerative changes and a C6-7 disc herniation with moderate central canal and moderate bilateral foraminal narrowing; and MRI of the lumbar spine dated 9/19/2009 was noted for L4-5 bilateral neural foraminal narrowing due to significant facet hypertrophy and a synovial cyst; other levels had mild bulging. A staff member makes notations on a triage form and this is signed by Dr. Dehaven. There is no history and physical in the chart. There is no documentation that Dr. Dehaven examined this patient. The patient reported poor sleep, sharp pain when turning his head, constant lower back pain with radiating right leg pain. There were no copies of prescriptions noted from Dr. Dehaven. There is a patient phone in note from the patient for 9/1/11; the patient called to report he could not take the Neurontin. 10/18/11 Dr. Wilson begins care of the patient. The triage note per "Sue" notes the patient to be complaining of neck, upper back to low back, numbness in right hand and arm and bilateral leg pain, meds not helping much. A note was written on the "Miscellaneous Patient Information" form by staff member "Ya" that says that patient could not take nortriptyline because it made him feel drunk and disoriented, that he was prescribed oxycodone for break thru pain and Xanax for anxiety. Dr. Wilson signed this note. He issued the patient the following prescriptions: Xanax 1mg #64, Ambien CR 10mg #32, oxycodone 30mg #90, and oxycodone 15mg #64. 11/17/11 the patient the Ambien was not helping, Dr. Wilson makes a note that the patient is satisfied with his current regimen; write same scripts except no Ambien. He issued the following prescriptions: Xanax 1mg #68, oxycodone 15mg #68 and oxycodone 30mg #102. 12/19/11 the patient reported medications were working well, Dr. Wilson notes the lab was okay, the patient was satisfied with the current regimen, complained of bronchitis for 4 days, continued same medications and gave a prescription for a Zpack. He issued the same prescriptions as the preceding month of Xanax 1mg #60, oxycodone 15mg #60 and oxycodone 30mg #90. 1/17/12 follow up triage note reports the patient doing well, Dr. Wilson makes a note that the patient is satisfied with the current regimen, continue same meds and "follow ox labs". The same prescriptions as the preceding month were issued to the patient. 1/31/12 the patient had a pill count and had extra medication for each by 3-5 pills. 2/14/12 the patient reported medications were working well but he was having headaches and took a Fioricet he had. The urine drug test was positive for barbiturates. Dr. Wilson notes the patient to be without complaints and he plans to decrease the oxycodone 30mg by 1 and increase the oxycodone 15mg by 1. He issued the same prescriptions as the preceding month with changes. 3/14/12 follow up triage note states the patient did not have any new complaints but was having increased pain due to decreased medications. Dr. Wilson writes a note that the patient complained of

persistent pain and anxiety and he would increase the Xanax and adjust the other medications. He issued the following prescriptions: Xanax 1mg #90, oxycodone 30mg #30 and oxycodone 15mg #120. 4/17/12 no new complaints, medication was not as effective because of the reduction, the urine drug test was negative for benzodiazepine, the patient had an appointment for 4/13/12 but had to reschedule to this date, Dr. Wilson makes a note that the patient was without complaints and he was going to replace the oxy 30 with Lorcet. He issued the following prescriptions to the patient: Xanax 1mg #90, oxycodone 15mg #120 and Lorcet 10/650 #90. 5/14/12 follow up triage note indicates the patient has increased pain with the changes in medications, Lorcet was not helping at all, Dr. Wilson makes a note that Lorcet was no help and the Percocet help very little, he will replace the Lorcet with oxy 10 and decrease the Xanax by 1. He issued the following prescriptions: Xanax 1mg #64, oxycodone 30mg #32 and oxycodone 15mg #128.

DIAGNOSIS - Below minimum standards.

The cervical and lumbar pathology indicated on the MRI report from 2009 could cause pain and the use of controlled substances could be justified. Both studies had pathology that indicated further investigation but this was never addressed. There was no physical examination in the record from anyone. A diagnosis was never rendered.

TREATMENT - Below minimum standards.

There were no adjunctive therapies of any kind for this patient. The patient reported he had prior physical therapy and steroid injections, but records were never obtained from the previously treating facility/provider.

RECORDS - Below minimum standards.

There was no history and physical in the record. None of the controlled substance prescriptions were written to the expected standard. There were tracking numbers indicating KASPER data had been obtained. Urine drug testing results were in the chart.

OVERALL OPINION - Below minimum standards. Gross ignorance, incompetence and neglect.

Dr. Wilson prescribed high risk medications to a patient that a history and physical was never obtained by him or anyone else. His prescribing routine is questionable; using multiple high risk opioids in combination with benzodiazepines is concerning. There was no apparent attempt to evaluate the patient with additional studies or refer. He did not practice medicine in taking care of this patient.

21. [REDACTED] She presented as a new patient to Dr. Wilson, 2/28/12. She reported she had been treated for 3 years by another pain management facility but it was now too far for her to drive to because she had moved. She reported the onset of her pain to begin after several car wrecks and a fall at a store. She complained of neck pain that caused migraine headaches, lower back pain and right knee pain. She reported prior treatment included hydrocodone, Percocet and oxycodone, Lidoderm patches and physical therapies. She also reported that she had been in a suboxone treatment program 12/6/11. An MRI of the cervical spine dated 10/6/09 noted mild disc bulging at C5-6, C6-7 and T1-2 with mild right foraminal stenosis at C6-7; an MRI of the sacrum dated 10/6/09 was normal; MRI of the right knee on 7/7/09 was normal and an MRI of the lumbar spine dated 7/7/09 was normal. The patient completed new patient questionnaires, a "detailed pain assessment and physical assessment" form was completed by Kidd, RN The nurse gave a nursing diagnosis of, "chronic pain (lb) r/t destruction of nerve tissue" There was no history, no physical examination or diagnosis rendered by Dr. Wilson. He made a note, "New pt with justified pathology, triage note and form reviewed, pt interviewed and examined. There was no documentation of his physical examination or description by Dr Wilson of the abnormal pathology or a diagnosis. He wrote his plan was to prescribe medications and he issued the following prescriptions to the patient: Percocet 10/650 #120, oxycodone 10mg #60, Xanax mg #90, Neurontin 100mg #30 and Imitrex 100mg #30. 3/27/12 the patient returned for follow up complaining of burning leg and foot pain. She was also complaining of knee pain. A urine drug test was positive for medication not prescribed but she reported having remaining hydrocodone was a prior prescription. Dr. Wilson makes a note that the patient complained her analgesics were too weak, requests stronger Neurontin; he planned to decrease the Percocet and replace the oxy 10 with 15mg and increase the Neurontin. He issued the following prescriptions: Percocet 10/650 #90, oxycodone 15mg #90, Xanax 1mg #90, Neurontin 300mg #60 and Imitrex 100mg #30. 4/24/12 Triage note indicates migraines were worsening, she was noted to have had Valium in the previous urine drug test and would be see her primary care doctor for elevated blood pressure, Dr. Wilson makes notes that Imitrex and Fioricet are not help with headaches he plans to replace Imitrex with stadol decrease the oxy 15 and increase the Percocet. He issued the following prescriptions: Percocet 10/325 #120, oxycodone 15mg #60, Xanax 1mg #90, Butorphanol nasal spray #1 bottle and Neurontin 300mg #60. 5/21/12 patient reports migraines are improving but she is not sleeping well, the urine drug test from 4/24/12 was negative for benzodiazepines and oxycodone but positive for hydrocodone, Dr. Wilson makes notes that the patient was without complaints and he plans to write for the same medications. He issued the following prescriptions to the patient: Percocet 10/325 #128, oxycodone 15mg #64, Xanax 1mg #92, Butorphanol nasal spray #1 bottle and Neurontin 300mg #64.

DIAGNOSIS- Below minimum standards.

The only diagnosis rendered for this patient was an inappropriate nursing diagnosis. While Dr. Wilson did note he reviewed the triage sheet and examined the patient there was no documentation of a history and physical examination by him. The diagnostic

studies were for the most part normal and did not justify the use of high dose controlled substances.

TREATMENT- Below minimum standards.

This patient had been in a prior pain management program for treatment. There were no records of prior treatment. The patient also reported recent treatment in a Suboxone treatment program. The use of the controlled substances to treat her pain complaints was not justified. There were no referrals to diagnostic testing ordered to further evaluate her pain complaints. Prior studies were essentially normal. The patient also had repeated urine drug test problems.

RECORDS- Below minimum standards.

The lack of physician history, physical and diagnoses was unacceptable. The controlled substance prescriptions were not written to the expected standard. Tracking numbers were documented that indicated KASPER data was obtained. Follow up physician notes were inadequate.

OVERALL OPINION- Below minimum standards. Grossly negligent, ignorant and incompetent.

Dr. Wilson failed to obtain a diagnosis or diagnoses that justified the use of the controlled substances. He not only prescribed, inappropriately, high dose, high risk opioid medications but added benzodiazepines. Further, he added Stadol which is an opioid agonist/antagonist. The prescribing of Stadol in combination with the opioids is dangerous and can precipitate opioid withdrawal. He ignored the patients' prior history of drug dependency. He treated this patient while ignoring the obvious indicators she was most probably diverting her medications.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1440

FILED OF RECORD
OCT 22 2012

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY ROLAND B. WILSON, M.D., LICENSE NO. 23084,
2460 DERBY DRIVE, SHELBYVILLE, INDIANA 46176-9241

K.B.M.L.

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, considered this matter at its October 18, 2012, meeting. At that meeting, Inquiry Panel A considered a memorandum by Doug Wilson, Medical Investigator, dated September 27, 2012; an investigative report from Stephen C. Johnson, Office of the Inspector General, Drug Enforcement, dated April 25, 2012; typed correspondence from Jannie Castle, Owner of Commonwealth Quality Healthcare, undated; e-mail correspondence from Andrea Kennedy, Commonwealth Quality Healthcare, dated June 5, 2012; typed correspondence from the licensee, Roland B. Wilson, Jr., M.D., dated May 31, June 5 and September 23, 2012; a September 4, 2012, Board consultant report; typed correspondence from Michael Radar, Calloway Laboratories, dated September 21, 2012; typed correspondence from Wesley Combs, Commonwealth Quality Healthcare, undated; typed correspondence from Jannie Castle, Owner of Commonwealth Quality Healthcare, dated September 21, 2012; typed correspondence from Andrea Kennedy, Commonwealth Quality Healthcare, (with attachments), undated; handwritten correspondence from Otis Cooley, Jr., undated; handwritten correspondence from Larry Hall, dated September 23, 2012; handwritten correspondence from (first name illegible) Spears, dated September 18, 2012; handwritten correspondence from Michelle McCoy, undated; handwritten

correspondence from Jess Fletcher, undated; and typed correspondence from the Board Consultant, dated October 16, 2012. The licensee was present at the Panel's October 18 meeting and was heard by the Panel before the Panel chose to take action in this matter.

Having considered all of this information and being sufficiently advised, Inquiry Panel A 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 it, Inquiry Panel A concludes there is probable cause to make the following Findings of Fact, which support its Emergency Order of Suspension:

1. At all relevant times, Roland B. Wilson, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is anesthesiology.
3. At all relevant times, the licensee practiced at Commonwealth Quality Healthcare, LLC.
4. On or about April 25, 2012, Stephen C. Johnson, Pharmacist Consultant, Office of Inspector General, Drug Enforcement and Professional Practices Branch of the Cabinet for Health and Family Services ("Drug Enforcement"), reviewed and analyzed the licensee's KASPER records (for the period October 1, 2011 through April 19, 2012) and noted several concerns, including:
 - Possible prescribing to employees;
 - Prescribing of same or similar controlled substances to persons with similar last names;
 - Use of addictive drug combinations;
 - Polypharmacy;
 - Concerns about the ages of some patients; and

- Atypical distances traveled

Mr. Johnson identified twenty-one (21) of the licensee's patients with prescribing patterns reflective of these concerns and recommended further investigation by the Board.

5. During the course of the investigation, the Board obtained medical records for a number of employees and/or employee family members of Commonwealth Quality Healthcare, LLC. When the Board's investigator first questioned the licensee about prescribing to these persons, the licensee stated that this was improper and he did not do that. However, when confronted with patient charts, he acknowledged that he had prescribed for one employee and could not recall whether he prescribed for another.
6. A Board Consultant reviewed twenty-one (21) of the licensee's patient charts and found that the licensee failed to conform to or departed from acceptable and prevailing medical practices and that he engaged in a pattern of acts which demonstrated gross incompetence, gross ignorance and gross negligence. The Board Consultant stated

Dr. Wilson chose to practice in a facility that mirrored a "pill mill."...

The organization of the charts was difficult at best. The charts were separated by tabs but the documentation in the tabs often did not correspond to what was contained in the tabbed section. All patient charts had some type of consents for treatment albeit many were not signed appropriately; some charts lack any signature from staff or the patient. Many of these consents had the wrong year on them. There were several records that had data covered up by using "white out" liquid erasure... Some of the charts had forms completed in pencil. Often there was illegible writing by Dr. Wilson.

... Some charts had tracking numbers to indicate KASPER data had been obtained but this was very inconsistent. For most of the charts the KASPER data was not acknowledged. I found more often than not, patients were given numerous early refills on their prescriptions for both

benzodiazepines and opioid medications. There was no explanation of documentation for the early refills.

All of the patient charts contained reports from Calloway Lab indicating regular urine drug testing was performed at each patient visit. However, the utilization of this information was questionable. Frequently, the results were ignored. There were many occurrences of abnormal results that should have been clarified by additional testing and this was not done. ... There were several incidents where the facility cancelled the confirmation of a urine drug test. ... Frequently amphetamine positive results were not clarified. There were many occasions in which a urine sample did not pass integrity testing. Again, this was not addressed. Nearly 100% of the twenty one charts reviewed had failed urine drug testing results and many failed urine drug testing numerous times.

...

... There were several patients that were given multiple controlled substance prescriptions repeatedly without being seen. None of the prescriptions written for controlled substances by Dr. Wilson were written to standard. ... There were some prescriptions with the dates that had obviously been altered.

It was apparent to me that Dr. Wilson demonstrated a lack of knowledge and a level of competence that would be expected of a physician practicing pain management. He acknowledged that as an anesthesiologist of twenty-eight years, he "was not familiar" with oral pain medications. Further, he never practiced as a physician providing medical management. He demonstrated a lack of ability repeatedly in prescribing as noted by the combinations of medications and the dosing of medications. While I was concerned about his general lack of knowledge, I was disturbed by his obvious neglect to the basic fundamentals of the practice of medicine and the resulting lack of appropriate and prudent medical care. ... A nursing examination cannot be substituted for the examination by the physician. A nursing diagnosis is not a medical diagnosis. A medical diagnosis is rendered after an examination by the physician. There was no initial examination or focused physical examination results documented by Dr. Wilson. None of the 21 charts contained documentation that a history and physical examination was performed by Dr. Wilson. None of the charts had documentation that he examined the patients at follow up visits regardless of their complaints. There were some charts that did not have a history of physical examination from anyone.

Dr. Wilson did nothing to establish a diagnosis or formulate a working diagnosis. Not only were his follow up evaluations lacking in any documentation of an examination but in general the follow up patient visit notes were incomplete and inconsistent. The notes were often two

or three lines and most commonly stated the "patient satisfied with the current regiment" and "without complaints." These notes were frequently the opposite of the information the patient gave to the triage nurse/staff member. There were frequent examples of the patient complaining of new symptoms or changes in symptoms. ... Again, Dr. Wilson never documented that he physically examined the area(s) of concern. He never addressed the problem except to increase either the opioid medication or the benzodiazepine. ...

Dr. Wilson not only neglected to formulate a diagnosis, he never followed up on any diagnostic testing previously ordered by the other physicians prior to his employment with the facility. Rarely did he order a diagnostic study and then he did, he never followed up on the status of the study. It was frequently unclear whether the patient actually went for the ordered study or not.

Dr. Wilson prescribed benzodiazepines regularly to his patients regardless of age and obvious risk factors associated with the use of these medications. He frequently prescribed benzodiazepines in response to a patient's complaint of increased pain. He would increase the benzodiazepine when the patient asked for additional pain medications. There were frequent occasions that a patient did not have the prescribed benzodiazepine in their urine. This did not influence his prescribing of the medication. He not only continued the prescribing of these medications but increased the dose/frequency repeatedly. ...

...

It is my opinion that Dr. Wilson did not practice medicine that was consistent with the acceptable standards and prevailing medical practice. ...in addition, he committed a pattern of acts that I determined to be grossly negligent, grossly ignorant and grossly incompetent.

...

In summary, the pattern of acts includes:

1. Prescribing high risk medication to patients without examining the patient or determining a diagnosis.
2. Prescribing opioid medications to patients without indications for their use.
3. Prescribing benzodiazepines for patients without a diagnosis that warranted the use of these medications.
4. Prescribing benzodiazepines in combination with opioid medications without any concern for the risk associated with this combination; as though there were no consequences when combining these medications.
5. Prescribing controlled substances for patients with multiple incidents of aberrant behaviors.

6. Increasing the quantities and doses of opioids and benzodiazepines in response to the patient asking for increases rather than upon investigation of the problem.
7. Repeatedly prescribing benzodiazepines and increasing the doses in response to complaints of increased pain.
8. Never referring the patient for other therapies such as a psychiatrist, interventional pain specialist, physical therapy or surgeon. ...
9. Prescribing combinations and doses of medications that exceeded recommended doses and cautions. ...
10. Prescribing medications that may cause deleterious side effects from their use. ...
11. Continued to prescribe to patients within increasing doses while noting his intentions to decrease medications.
12. Continued prescribing of high risk opioid medications and benzodiazepines without explaining any of the aberrant behaviors to include failed urine drug testing, early refills, incidents with medications, etc. Rarely a mention was made regarding the aberrant behavior but the explanation was inadequate.

(The consultant's report, including summary reviews of each individual chart, is attached hereto and incorporated herewith in its entirety.)

7. The Board Consultant also found that "Dr. Wilson's practice of pain management constitutes a danger to the health, welfare and safety of the citizens of the Commonwealth of Kentucky. He prescribed with a level of flagrant neglect and without any obvious concern for the ramifications of his actions."
8. The Panel has reviewed the investigation and finds that the licensee's failure to comply with acceptable and prevailing medical practices in the manner detailed above demonstrates that the licensee has not exhibited the ability to practice medicine safely.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel A 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 medical 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) the physician has violated the terms of an order placing him on probation; or b) a physician's practice constitutes a danger to the health, welfare and safety of his 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)(a), (3) and (4).
4. The Panel concludes there is probable cause to believe this physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
5. The Board may draw logical and reasonable inferences about a physician's practice by considering certain facts about a physician's practice. If there is proof that a physician has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the physician 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 physician's practice presents representative proof of the nature of that physician's practice in general.

Accordingly, probable cause to believe that the physician has committed certain violations in the recent past presents probable cause to believe that the physician will commit similar violations in the near future, during the course of the physician's medical practice.

6. The United States Supreme Court has ruled that it is not a 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, 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 his right to a prompt post-deprivation hearing under this statute.

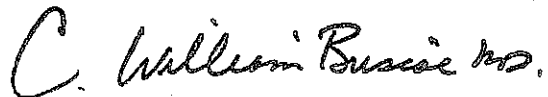
EMERGENCY ORDER OF SUSPENSION

Based upon the foregoing Findings of Fact and Conclusions of Law, Inquiry Panel A hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by Roland B. Wilson, M.D., is SUSPENDED and Dr. Wilson is prohibited from performing any act which constitutes the "practice of medicine," 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.

Inquiry Panel A further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee.

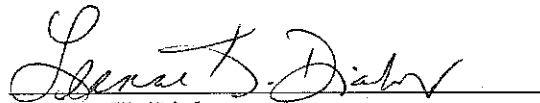
SO ORDERED this 22nd day of October, 2012.



C. WILLIAM BRISCOE, M.D.
CHAIRMAN, INQUIRY PANEL A

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 a copy was mailed via certified mail return-receipt requested to the licensee, Roland B. Wilson, M.D., 2460 Derby Drive, Shelbyville, Indiana 46176 and at 387 Edgewood Drive, Prestonsburg, Kentucky 41653 on this 22nd day of October, 2012.



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

Pain Management Consultants, LLC

1169 Eastern Parkway, Suite 2211 Louisville, KY 40217
Phone (502) 635-2775 Fax (502) 371-0475

Jeffrey W. Berg, M.D.
Carole A. Buskirk, ARNP

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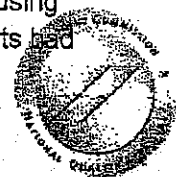
Expert Review of Roland B. Wilson, MD
Summary of Findings/Narrative Report
Consultant: Jeffrey W. Berg, MD

I have reviewed 21 patient charts of Dr. Wilson, KASPER data from January 1, 2011 thru May 1, 2012; the investigative report prepared by Doug Wilson dated 6/11/12; and the written responses by Janie Castle, Andrea Kennedy and Dr. Wilson. I also reviewed the policies and procedures for Commonwealth Quality Health Care. I understand my review is of Dr. Wilson but it is important to evaluate the facility in which he elected to practice medicine. I will occasionally make reference to a specific chart or charts to further explain and describe a particular concerning practice. However, the referenced chart is not intended to be the only example of a particular practice habit or behavior by Dr. Wilson.

I am going to begin my review with general observations and opinions of the facility, including the operating policies and procedures. The facility was problematic in regard to new patient procedures, use of MRI reports, urine drug testing and record keeping.

Dr. Wilson chose to practice in a facility that mirrored the practices of a "pill mill". To become a patient at Commonwealth Quality Healthcare, a referral from another medical provider was not required. A prospective patient had to present with a six month pharmacy printout, a copy of an MRI report, a valid Kentucky identification card or drivers license, a social security card and cash payment for an initial visit and a urine drug test. The prospective patient was questioned if they had taken suboxone, methadone, methamphetamine, fentanyl or cocaine. If these drugs were found in the patients' urine they would not be a patient. The facility indicated they would validate the MRI report brought in by the patient and obtain one from the treating facility. If this procedure was followed a patient chart should contain two MRI reports; none of the charts contained two. The policy and procedure indicated the physician would review all KASPER reports and all data obtained on the patient and then he would determine if a patient was "worthy" of treatment at the facility.

The organization of the charts was difficult at best. The charts were separated by tabs but the documentation in the tabs often did not correspond to what was contained in the tabbed section. All patient charts had some type of consents for treatment albeit many were not signed appropriately; some charts lack any signature from staff or the patient. Many of these consents had the wrong year on them. There were several records that had data covered up by using "white out" liquid erasure; an example of this is in chart summary #5. Some of the charts had forms completed in pencil. Often there was illegible writing by Dr. Wilson.



accredited by the
Joint Commission

Some charts had tracking numbers to indicate KASPER data had been obtained but his was very inconsistent. For most of the charts the KASPER data was not acknowledged. I found more often than not, patients were given numerous early refills on their prescriptions for both benzodiazepines and opioid medications. There was no explanation or documentation for the early refills.

All of the patient charts contained reports from Calloway Lab indicating regular urine drug testing was performed at each patient visit. However, the utilization of this information was questionable. Frequently, the results were ignored. There were many occurrences of abnormal results that should have been clarified by additional testing and this was not done. One chart included test results that belonged to another patient; the patient was told of these results which were abnormal for his particular treatment plan. (See chart summary #17). There were several incidents where the facility cancelled the confirmation of a urine drug test. An example of this was when the patient tested positive for buprenorphine (suboxone), the confirmation was cancelled and there was no discussion of these results (See chart summary #3). The high levels of opiates were never confirmed. Frequently, amphetamine positive results were not clarified. There were many occasions in which a urine sample did not pass integrity testing. Again, this was not addressed. Nearly 100% of the twenty one charts reviewed had failed urine drug testing results and many failed urine drug testing numerous times.

There were occasional attempts at pill counts. Of the few successful pill counts it was difficult to determine the outcome. Several charts noted the pill count was not as it should be. Many attempts at pill counts were unsuccessful as might be expected. Two charts contained pill counts that were accepted by Dr. Wilson to be okay but these were questionable. These charts had documentation of a phoned in pill count from an individual named "Tony" who was employed at the local pharmacy. "Tony" reported by phone that the patient had the correct number of pain pill remaining from their prescription. This is not an acceptable practice. Particularly concerning is the lack of the full name and title of the individual calling to report the pill count (See chart summary #5 and #6 for detail).

Most patients had regular, monthly office visits. There were several patients that were given multiple controlled substance prescriptions repeatedly without being seen. None of the prescriptions written for controlled substances by Dr. Wilson were written to standard. None of his prescriptions contained the patients address. Some of the prescriptions lacked the numerical quantity written out and some lacked dates. There were some prescriptions with the dates that had obviously been altered.

It was apparent to me that Dr. Wilson demonstrated a lack of knowledge and a level of competence that would be expected of a physician practicing pain management. He acknowledged that as an anesthesiologist of twenty eight years, he "was not familiar" with oral pain medications. Further, he never practiced as a physician providing medical management. He demonstrated his lack of ability repeatedly in prescribing as noted by the combinations of medications and the dosing of medications. While I was concerned about his general lack of knowledge, I was disturbed by his obvious neglect to the basic fundamentals of the practice of

medicine and resulting lack of appropriate and prudent medical care. Fundamental to the practice of medicine, the physician not only obtains verbal information from the patient to explore the chief complaint and history of present illness but performs an examination of the patient. Dr. Wilson informed the investigator that he examined his patients. It was specifically reported to the investigator that "all new patients are required to have a physical examination". There were physical examinations by L. Kidd, RN as documented on a new patient form that also resulted in a nursing diagnosis. (See chart summary #9 and #21). A nursing examination cannot be substituted for the examination by the physician. A nursing diagnosis is not a medical diagnosis. A medical diagnosis is rendered after evaluation by the physician. There was no initial examination or focused physical examination results documented by Dr. Wilson. None of the 21 charts contained documentation that a history and physical examination was performed by Dr. Wilson. None of the charts had documentation that he examined the patients at follow up visits regardless of their complaints. There were some charts that did not have a history or physical examination from anyone.

Dr. Wilson did nothing to establish a diagnosis or formulate a working diagnosis. Not only were his follow up evaluations lacking in any documentation of an examination but in general the follow up patient visit notes were incomplete and inconsistent. The notes often were two or three lines and most commonly stated the "patient satisfied with the current regimen" and "without complaints". These notes were frequently the opposite of the information the patient gave to the triage nurse/staff member. There were frequent examples of the patient complaining of new symptoms or changes in symptoms. For example, some of these symptoms included neck pain which was new, radicular pain which was new and new complaints of joint pain i.e., knee pain. Again, Dr. Wilson never documented that he physically examined the area(s) of concern. He never addressed the problem except to increase either the opioid medication or the benzodiazepine. A particularly concerning example is chart summary #19. This young man had an acute injury but was expected to recover. He continued with severe pain and he requested opioid medications. Dr. Wilson did nothing to investigate the cause of the continued pain. He rapidly transitioned this patient from a mild analgesic to more than three high dose opioid and benzodiazepine medications without justification or any investigation of the problem.

Dr. Wilson not only neglected to formulate a diagnosis, he never followed up on any diagnostic testing previously ordered by the other physicians prior to his employment with the facility. Rarely did he order a diagnostic study and when he did, he never followed up on the status of the study. It was frequently unclear whether the patient actually went for the ordered study or not.

Dr. Wilson prescribed benzodiazepines regularly to his patients regardless of age and obvious risk factors associated with the use of these medications. He frequently prescribed benzodiazepines in response to a patient's complaint of increased pain. He would increase the benzodiazepine when the patient asked for additional pain medications. There were frequent occasions that a patient did not have the prescribed benzodiazepine in their urine. This did not influence his prescribing of the medication. He not only continued the prescribing of these

medications but increased the dose/frequency repeatedly. In one particular patient he diagnosed the patient with multiple psychiatric disorders; acrophobia, agoraphobia and claustrophobia etc. There was no documentation as to how he made these diagnoses. He never referred the patient to a psychiatrist or psychologist despite multiple patient complaints and behaviors of anxiety and depression. He prescribed multiple sedating and high risk medications. (See chart summary #6). This patient also presented with multiple aberrant behaviors.

An example of Dr. Wilson's medical care is noted in chart summary #5. This 21 year old male patient did not have a diagnosis that warranted the prescribing of high dose opioid medications. His diagnostic studies were essentially normal. He did have some type of leg and ankle surgery in the past following a motor vehicle accident. This patient was sent for psychological evaluations per Dr. Argotte and these evaluations suggested he should be referred to a substance abuse professional. His medical history was also positive for seizures. He was prescribed high dose opioid medications in combination with benzodiazepines without justification for their use and in spite of multiple failed urine drug screens and aberrant behaviors. This patient's urine drug testing was repeatedly negative for benzodiazepines. Another example of this type of medical care by Dr. Wilson is in chart summary #6. There were times Dr. Wilson issued controlled substance prescriptions without any documentation that the patient had been seen. (See chart summary #8).

It is my opinion that Dr. Wilson did not practice medicine that was consistent with the acceptable standards and prevailing medical practice. His general prescribing of medications which includes both controlled and noncontrolled medications appeared to be disconnected. In addition, he committed a pattern of acts that I determined to be grossly negligent, grossly ignorant and grossly incompetent.

Dr. Wilson also violated ethical principles established by the American Medical Association's Code of Medical Ethics and the KRS Medical Practice Act by prescribing controlled substances to at least two of his fellow employees; Lavonda Lazar and Andrea Kennedy.

In summary, the pattern of acts includes:

1. Prescribing high risk medications to patients without examining the patient or determining a diagnosis.
2. Prescribing opioid medications to patients without indications for their use.
3. Prescribing benzodiazepines for patients without a diagnosis that warranted the use of these medications.
4. Prescribing benzodiazepines in combination with opioid medications without any concern for the risk associated with this combination; as though there were no consequences when combining these medications.
5. Prescribing controlled substances for patients with multiple incidents of aberrant behaviors.

6. Increasing the quantities and doses of opioids and benzodiazepines in response to the patient asking for increases rather than upon investigation of the problem.
7. Repeatedly prescribing benzodiazepines and increasing the doses in response to complaints of increased pain.
8. Never referring the patient for other therapies such as a psychiatrist, interventional pain specialist, physical therapy or surgeon. Dr. Wilson reported to the investigator that he referred to others when indicated. Review of the charts did not reveal this. In fact he neglected to refer.
9. Prescribing combinations and doses of medications that exceeded recommended doses and cautions. For example, high doses of acetaminophen and tramadol. High doses of tramadol; more than 400mg per day in combination with other SSRI/SNRI medications without any apparent concern for the risk of serotonin syndrome and seizure. He prescribed in this manner to a patient with a documented history of seizures.
10. Prescribing medications that may cause deleterious side effects from their use. An example includes prescribing Stadol to a patient on high dose opioid medications. The use of this medication could precipitate opioid withdrawal.
11. Continued to prescribe to patients with increasing doses while noting his intentions to decrease medications.
12. Continued prescribing of high risk opioid medications and benzodiazepines without explaining any of the aberrant behaviors to include failed urine drug testing, early refills, incidents with medications etc. Rarely a mention was made regarding the aberrant behavior but the explanation was inadequate.

Dr. Wilson's practice of pain management constitutes a danger to the health, welfare and safety of the citizens of the Commonwealth of Kentucky. He prescribed with a level of flagrant neglect and without any obvious concern for the ramifications of his actions.

Submitted: _____

Jeffrey W. Berg, MD

CHART REVIEWS

RE: Roland B. Wilson, MD

1. [REDACTED] Dr. Argotte initially evaluated this patient on 4/13/11. She reported a 20 year history of chronic pain in the back, neck and most joints; anxiety and depression. She reported that she had been under the care of a pain specialist prior but left because she did not like the doctor. She reportedly had physical therapy and injections but did not benefit from these therapies. She also reported a prior evaluation from a neurosurgeon. She was diagnosed with uncontrolled pain as a result of cervical, thoracic and lumbar pain, arthritis, anxiety and fibromyalgia. Dr. Argotte reviewed radiology studies from 3/2009 and indicated the following results; cervical degenerative disc disease with disc bulging and herniation, facet arthropathy and spinal stenosis; lumbar degenerative disc disease with herniation, facet hypertrophy and stenosis. She was prescribed an opioid analgesic for pain- Percocet 10/650 4/day; a muscle relaxer-baclofen 10mg 3/day; an AED-lyrica 75mg 3/d; an NSAID-diclofenac 50mg daily and an antidepressant-Paxil 10mg daily. The lyrica and Paxil were increased at the next visits. The last visit with Dr. Argotte appeared to be 6/9/11. The patient returned on 7/13/11 and saw Dr. Greenlaw who was now the physician for the facility. He referred the patient for a surgical consult and prescribed the following medications: Ultram 50mg 3/day, oxycodone 15mg 4/day, Xanax 1mg 2/day, diclofenac 100mg per day, lyrica 100mg 3/d, baclofen 20mg 3/day and celexa 20mg per day. This appeared to be the only visit with Dr. Greenlaw and on 8/10/11 the patient returned for follow up and was seen by Dr. Dehaven. She reported to him that she needed stronger pain medications. She was prescribed Xanax 1mg 2/d, Lorcet 10/325 2/day, oxycodone 15mg 4/day, lyrica 100mg 3/day, baclofen 20mg 3/day and celexa 20mg daily. She returned on 9/8/11 and all medications remained the same except baclofen was discontinued and soma 350mg 3/d was prescribed; Lorcet was discontinued and Percocet 10/325 3/day was initiated. Dr. Wilson began treating the patient on 10/12/11. The patient reported pain but stated meds were helping. A urine drug test was performed and negative for benzodiazepines and oxycodone but positive for amphetamine and opiates. The specimen was sent for confirmation of oxycodone which was negative. She was given the same medication prescriptions as per the previous visit prescribed by Dr. Dehaven. 11/9/11 she returned and reported she was out of soma and the other medications were not working for her. The confirmation report for the urine test of 10/12/11 was negative for oxycodone. The specimen was screened again by the confirmation lab and resulted positive for benzodiazepines and opiates but not confirmed. The level of amphetamine was not conclusive. A notation was made on the follow up triage form, "med may need to be reevaluated". She was given the following prescriptions: Percocet 10/325 #45 to take 1 every 8 hrs, oxycodone 15mg #60 to take 1 every 6 hrs, lyrica #102 to take 1 every 8 hrs, Xanax 1mg #30 to take 1 twice per day, soma 350mg #102 to take 1 every 8 hrs and celexa 20mg #34 to take 1 per day. She also had a urine drug screen which was positive for opiates, benzodiazepines and oxycodone. The sample was confirmed to be positive for benzodiazepines and oxycodone. The rescreening of the opiates was again

positive but not confirmed. The patient returned on 11/23/11 had a urine drug test was positive for opiates, benzodiazepines and oxycodone. Confirmation was performed on benzodiazepines and oxycodone which were both positive. A pill count was also performed on this visit. She returned on 12/14/11 complaining of a new shooting pain requested an increase in Percocet by one pill and other medications working ok. Dr. Wilson gave the following prescriptions: He increased the Percocet 10/325 to #120 4/day, oxycodone 15mg #120 4/day, soma 350mg #60 2/day, lyrica 100mg #90 3/day and Xanax 1mg #60 2/day. No other treatments or evaluations were requested. On the return visit of 1/12/12 no changes were made and the same prescriptions were issued. 2/9/12 she complained of poor sleep but medications were okay. She was given an increase in Percocet 10/325 #140 with directions of 1 every 6 hours, an increase in oxycodone 15mg #140 with directions of 1 every 6 hours, an increase in soma 350mg #70 with directions 1 every 12 hrs, Xanax 1mg #70 with directions every 12 hrs and Lyrica 100mg #105 one every 8 hours. It is unclear why the change in quantities except a notation was made on the follow up visit that the visit of 3/14/12 was 5 days late. On this visit the patient requested one more Xanax which was denied. Soma was to be decreased and then discontinued. The same prescriptions were issued except the soma was decreased to #30 and the quantities were the same as prescribed on 1/12/12. The follow up visit of 4/12/12 had the confirmation results from the previous visit that noted the patient to have valium or metabolite of valium in the urine which should have been positive for Xanax or its metabolites. Dr. Wilson made a note that the patient "may have been given the wrong med". The prescriptions issued were the same as previous except the oxycodone 15mg was decreased to #90. 5/10/11 the patient reported "unbearable pain the back" and "nerves shot". Notation was made by Dr. Wilson on a form titled, "Miscellaneous Patient Information" that the patient had 3 relatives dying of cancer and he refused an increase in Xanax but increased her oxycodone 15mg to #140 with the same directions of 1 every 6 hrs, Xanax 1mg was increased in quantity to #70 but the directions were the same, Percocet 10/325 was also increased to #140 with the same previous directions of 1 every 6 hrs and Lyrica was increased to #105 with the same previous directions.

DIAGNOSIS/TREATMENT- Below minimum standards for both.

The initial history and physical was complete and it was done by another physician. The diagnostic studies appeared to be valid and the diagnosis justified the use of treatment with opioid medications. MRI of the lumbar spine revealed a right L5-S1 herniated disc with bilateral neural foraminal encroachment, a central disc herniation at L4-5 with bilateral neural foraminal encroachment and mild bulging of the L3-4 disc. An MRI of the cervical spine revealed a high grade stenosis at C5-6 with associated cord edema because of a large central and right sided C5-6 disc herniation with bilateral neural foraminal encroachment, bulging at C4-5 and a central disc protrusion at C3-4. A surgical consult was ordered on 7/13/11 but never followed up on. There was no indication in the record that Dr. Wilson reviewed the initial history and physical or the MRI studies; he never rendered a diagnosis or diagnoses that could be found in the documentation. There were never any physical examination notes by Dr. Wilson. There were no other treatments or referrals for

care or follow up on the one referral that was requested by the preceding physician. Utilization of urine drug testing was included however; there were concerns. The patient had upon several occasions not tested as she should have; missing the medication prescribed (oxycodone) and having medication not prescribed, (valium and possibly amphetamines and opiates); the consistently positive result of opiates when not expected was never tested by confirmation because the level was below the lab designated cutoff. There appeared to be a pill count x1; results were unclear. The documentation included urine drug screening regularly and monthly appointments. There were occasional tracking numbers indicating a KASPER had been obtained. These medications were increased without justification. Dr. Wilson indicated he was decreasing and he did eliminate the soma but other medications were increased. The opioid medications also appeared to be increased because the patient described personal stressors and anxiety. Opioids are not indicated for anxiety and stress.

RECORDS- Below minimum standards

There were neither records nor apparent attempts to obtain prior pain management records. The records were full of forms that had missing dates and incomplete identification. There were never any working diagnoses after Dr. Wilson began. Notes pertaining to office visits were confusing; visits had a "Follow up Triage" note prepared by the nurse often without any physician comment or note. Notes written by Dr. Wilson were sparse; they were almost nonexistent. As stated above there were no notes describing physical findings by Dr. Wilson. The controlled substance prescriptions were not written to standard; none had the patients address nor spelled out the numerical quantity, and dates frequently missed the year.

OVERALL OPINION- Below minimum standards and gross incompetence and gross ignorance

There was no documentation that Dr. Wilson examined this patient. He gave no explanation for the changes he made in her medications. He prescribed increases in opioid medications in response to complaints of increased anxiety; this was inappropriate. She was prescribed not only high dose opiate medication in its most abuseable form but in combination with benzodiazepines.

2. [REDACTED] Appeared to present for initial evaluation on 1/27/2011. He complained of a work related injury that occurred in 1993 and 1996. His complaints were of upper back and shoulder pain, lower back pain that radiated down the left leg to the foot and some pain in the right leg to the back of the knee. He was seen at that time by Mary Beth Scott-Calor, DO. A physical examination was performed. It was noted that patient weighed 420 pounds. She diagnosed him with CRPS or CPS (complex pain complex regional pain syndrome or complex pain syndrome; it is unclear; CLBP (chronic low back pain), "left leg radicular pain" and what appeared to be sacroiliitis left greater than right. Her treatment plan was not entirely legible but indicated pt was to have Nucynta, tramadol and oxycodone 15mg. Copies of her prescriptions were not on the chart. Prior treatment included physical therapy and epidurals from 1997 thru 2000. The next office visit was on 3/31/11 and the physician was now Alex Argotte, MD. His treatment plan included referral for a MRI of the thoracic and lumbar spine and psychological evaluation and lab work. (A urine drug screen was sent to the confirmation lab which later returned positive for valium and soma; neither prescribed for the patient). He was given prescriptions for Ultram 50mg #120 4/day, Nucynta 100mg #150 5/day, lorazepam 1mg #90 3/day, Percocet 10/325 #120 4/day and Zolof 100mg #30 1/day. The patient returned on 4/27/11 he complained of medications not lasting long enough and more anxiety. He reported a poor functional status. He completed a depression screening tool, lorazepam was discontinued, he was referred to an endocrinologist, orders were again written for MRI studies and a psychological evaluation. He appeared to have been questioned about the prior urine drug screen confirmation results which were not as expected and advised that he took his wife's valium and took soma that had been prescribed in years prior. Medications were the same except the lorazepam was discontinued. A urine drug screen was obtained and sent for confirmation which was again positive for soma. Visit of 5/24/11 the patient was instructed not to take medications not prescribed for him. Pt also requested to resume his lorazepam. He was given the following prescriptions; lorazepam 1mg #90 3/day was resumed and soma 350mg q12h prn #30, Nucynta 100mg was increased to #180 6/day and the Percocet and Zolof remained the same and Ultram was increased to 8 /day. Visit of 6/20/11 patient reports medications are working. The next several visits were by Dr. Greenlaw and then Dr. Dehaven. Again diagnostic studies were ordered which also now included an MRI of the knee, referral to an internist and nutritionist and medications were adjusted. The patient complained about acetaminophen intake. Oxycodone 15mg #120 was added in place of Percocet, at the following visit this was increased to 30mg 9/19/11, Nucynta 100mg was decreased and then increased to #180 6/day, Ultram remained the same, lorazepam remained the same, Norflex 100mg #90 3/day was added for muscle spasms and Neurontin 800mg #90 3/day was added, the lorazepam was decreased to 1mg #30 1/day and all other medications remained the same. The patients urine drug testing was again in June, July, and September positive for opiates but never confirmed.

10/20/11 Dr. Wilson sees the patient for the first time. He documents on a form called, "Miscellaneous Patient Information" that the patient has chronic pain and complains of pain in the low back, Ultram does not work well and Neurontin upsets his stomach and

patient is to see an endocrinologist. The triage nurse writes that patient has pain in his upper back and radiating into mostly the right side, meds working well and no other issues. Pt was given an order for an MRI of the cervical and thoracic spine. He is given prescriptions for Ativan 1mg #30 1/day, Nucynta 100mg #150 5/day, oxycodone 30mg #120 4/day, Ultram 100mg #120 4/day, and Zoloft 100mg #30 1 day. The Norflex and the Neurontin were discontinued. The patient missed his next appointment because his mother was in the hospital. However, there was a note dated 11/-/11 with partially completed answers from the patient regarding his pain etc. He was allowed to obtain a one week supply of his medications. 11/28/11 he returned for follow up. Patient requested an additional Ativan per day and assistance obtaining a motorized scooter. Triage note from the office staff describes patient having a new complaint stating the pt thought he had ruptured another disc, problems moving his back, stated he was taking soma prn. The following prescriptions were issued to the patient: oxycodone 30mg #124 directions 1 every 6 hours, Ultram 100mg #124 to take 1 every 6 hours, Nucynta 100mg #155 to take 1 every 4-6 hours, Ativan 1mg #31 to take 1 daily and Zoloft 100mg #31 to take on every day. 12/27/11 a note written on the "Miscellaneous Patient Information" form by someone other than Dr. Wilson writes the lab ok, patient requests increase in Ativan, Plan: double Ativan, write other meds same". This note did not have a signature or appear to be written by Dr. Wilson. The patient was issued the following prescriptions: Ativan 1mg #60 which was increased, doubled to 1 pill every 12 hrs, Nucynta 100mg #150 with directions for 1 every 5 hours, Ultram 100mg #120 1 every 6 hours, oxycodone 30mg #120 1 every 6 hours and Zoloft 100mg #30 to take daily. 1/24/12 no new complaints, no changes and the same prescriptions were issued. Dr. Wilson makes a note that the patient is satisfied and will continue the same meds. The same prescriptions were issued. 2/21/11 Dr. Wilson notes, "Pt satisfied with current regimen, plan: write same meds". Prescriptions were issued. 3/20/12 Dr. Wilson makes a note, "pt without complaints, plan: write same meds." The same prescriptions were issued. 4/17/12 Dr. Wilson requests MRI of "entire spine" and issues a written order for an MRI of the cervical and thoracic spine. The staff member notes on the triage note that the patient had been out of "oxy" since Sun, and pt suspected the pharmacy to have shorted him. It was also noted on the triage note that the patient had been "self medicating" and stated "Soma and klonidine was prev prescribed by this facility". Dr. Wilson wrote to continue the same medications but he added oxycodone 15mg #120 to take 1 every 6 hours and decreased the oxycodone 30mg to #60 with directions to take 1 every 12 hours and the remainders of the prescriptions issued were the same. 5/14/12 was the last documented visit in the chart. The triage note describes the patient to be "weaker". Dr. Wilson writes that the patient is satisfied with the current regimen and continues the same medications. Prescriptions issued were for increases in quantities of all: Zoloft 100mg #32, Ultram 100mg #128, Ativan 1mg #64, oxycodone 30mg #64, oxycodone 15mg #128 and Nucynta 100mg #160; there were no direction changes in any of the prescriptions issued.

DIAGNOSIS & TREATMENT- Below minimum standards for both.

The patient had findings on an MRI from 1997 and 1994 that clearly indicated degenerative disc disease of the lumbar spine with left paracentral disc herniations at L5-S1 with displacement of the left S1 nerve root and a small annular tear and central disc bulging at L3-4 and L4-5. This pathology justified the use of some of the medications prescribed. There was never any documentation that Dr. Wilson examined the patient, he never rendered diagnoses that warranted the medications prescribed. While there were multiple orders for the patient to have updated MRI studies these were apparently never performed. Nor, was there any documentation of why the studies were not obtained. The only documentation about pain did not mention the neck; it is unclear why Dr. Wilson ordered an MRI study of the cervical spine. The choice to use two shorter acting, high risk opioids/ oxycodone was clearly inappropriate at the doses prescribed and in combination with Nucynta and Ultram. When Dr. Wilson increased doses albeit by small quantities there was no documentation as to why he was doing so. Increases in medications appeared to be in response to requests for additional Ativan. Dr. Wilson did increase the benzodiazepine; he doubled the quantity. He increased the quantity of Ativan and did not make any referral to psychiatry or psychological services. The patients' documented functional status never appeared to improve in spite of the multiple medications prescribed. The chart occasionally contained numbers that appeared to indicate tracking of a KASPER report but this was not consistent. The use of urine drug screening was noted to be marked "yes" in response to "Unanticipated urine screen". However, it is clear the urine drug screen was expected was at each visit. The patient also had several urine drug screens that included medications not prescribed and he acknowledged taking his spouses' medication. Dr. Wilson did not document any discussion regarding aberrant behaviors.

RECORDS - Below minimum standards.

The chart did contain a complete physical examination and history per Dr. Argotte. There were some prior records from the time the patient indicated he had been injured at work. There were records of a discogram and 2 prior MRI studies of the lumbar spine; dates 1998, 1997 and 1994 respectively. There was no documentation or indication that Dr. Wilson reviewed any of these records. The diagnosis of CRPS/CPS initially given to the patient was never validated or mentioned elsewhere in the chart. There was no documentation to indicate Dr. Wilson followed up on any of the prior studies or consultations ordered, including the one ordered by him. Frequently there were conflicting years on records, information written in pencil and lack of employee/physician signature. Prescriptions were not written to standard. There were never any addresses placed on the controlled substance prescriptions. The section in the chart that states "Progress Notes" does not correspond. Often what appeared to be a progress note was located in the "RX" section of the chart. There were several depression screens and tools to evaluate risk associated with the prescribing of opioid medications; these did not appear to be utilized by Dr. Wilson; the documentation indicated Dr. Argotte reviewed these.

OVERALL OPINION- Clearly below minimum standards.

Dr. Wilson never examined the patient, never documented or explained a change in medication related to the patient's condition. His decision to continue the combination of medications was clearly inappropriate. He was prescribing the maximum amounts of Tramadol to a patient also taking higher doses of an SSRI; Zoloft.

The patient was prescribed 4 controlled substances to treat his pain; 3 of which were scheduled II medications. Two of which were high dose in the most abusable form. Dr. Wilson also prescribed high dose benzodiazepine with the opioid/opiate medication which at the doses prescribed result in a dangerous and intoxicating mix. The selection of medications to treat the pain was inappropriate.

3. [REDACTED] Patient had an approximate 12 year history of chronic pain. She initially presented to Commonwealth Quality Healthcare (CQH) on 3/17/11. She was evaluated by A. Argotte, MD. She complained of "center" lumbar pain that was radiating to her anterior and lateral thigh; she stated the pain was constant and sharp. She complained of right hand numbness with activity. She had been to prior pain management physicians. She refused injections. Prior treatment consisted of opioid medications and other medications. She reported being unable to work. She would clean her home when pain levels allowed those activities. She was caring for her disabled husband who had also become a patient of CQH in 1/11. She had cervical, thoracic and lumbar MRI studies performed in 9/21/10 and 6/03/09. The cervical MRI was positive for congenital narrowing of the spinal canal because of short pedicles, multilevel disc bulging and a posterior disc herniation at C6-7 with cord compression. The thoracic MRI demonstrated multilevel disc bulging. The lumbar MRI demonstrated disc bulging from L3-4 through L5-S1 with facet hypertrophy and severe impingement upon the bilateral lateral recesses at L5-S1. She was diagnosed with muscle spasms, anxiety, chronic low back pain, depression and carpal tunnel syndrome. She was given a referral for physical therapy, an upper extremity nerve conduction study, and a psychological evaluation. She was to resume her present regimen of medications. She was given the following prescriptions: Diazepam 10mg #30 to take 1 every day, Nucynta 100mg #120 to take 1 every 6 hrs prn, Ultram 50mg #60 to take twice per day, Soma 350mg #60 to take every 12 hrs and Percocet 10/325mg #120 to take 1 every 6 hrs prn. The patient had follow up visits on 4/14/11, 5/10/11, 6/7/11 or 6/8/11, 7/6/11, 8/2/11, 8/28/11 or 8/29/11 and 9/29/11. These visits had conflicting dates recorded. They were conducted by Dr. Argotte, Dr. Greenlaw and Dr. Dehaven. There was a "Patient Pill Count Sheet" dated 4/23/11 with documentation that the patient was called in for a pill count but could not make it. Her medications prior to seeing Dr. Wilson were: Ativan 1mg #60, Nucynta 100mg #150, Soma 350mg #60 oxycodone 30mg #120, tramadol 100mg #180 and Paxil 25mg #30. On 11/3/11 Dr. Wilson saw the patient for the first time. He wrote on the "Miscellaneous Patient Information" form that "pt ok with present regimen and rewrite meds scripts same". An untitled check list type form had the date of 11/3/11 and yes/no responses to questions. The patient was given prescriptions with quantities that are confusing. Perhaps because the patients' next appointment was in more than 30 days she was given different quantities but this is not clear because there was no documentation to explain the decision. The following prescriptions were issued; Paxil 25mg #32 with directions 1 per day, Soma 350mg #64 with directions 1 every 12 hrs, oxycodone 30mg #128 to take 1 every 6 hrs, tramadol 100mg #180 to take 1 every 4 hrs, Nucynta 100mg #160 to take 1 every 4-6 hrs, and lorazepam 1mg #64 to take 1 every 12 hrs. The next appointment appears to be on 12/8/12. On this visit the chart contains two confusing prescriptions written by Dr. Wilson. One is for Nucynta with a notation that script needs to be written on a green one; another prescription for Nucynta is dated for 12/12/11 same quantity. A tramadol prescription was written but the date is 12/15/11 for 50mg #240. Dr. Wilson makes a note on the same miscellaneous form that Calloway lab test was within normal limits, the plan was to discontinue Soma, leave other meds the same and decrease oxycodone 30mg by 1 pill and increase oxycodone

15mg by 1 pill and the following month discontinue the oxycodone 15. A triage note for the same day appeared to be signed by [REDACTED]. The patient was given the following prescriptions: oxycodone 30mg #132 which was increased not decreased and directions were to take 1 every 6 hrs, lorazepam 1mg #66 which was increased with directions to take 1 pill every 12 hrs, the Nucynta 100mg #165 which was increased and no change in directions, tramadol which appeared to be phoned to the pharmacy and changed to 50mg #198 with directions to take 1 every 4 hrs and Paxil 25mg #33 which was an increase and no change in directions. **(The Kasper report does not reflect these Rx as they are reflected by the copies in the chart).** On 1/5/12 prescriptions were issued again for the patient but there is no note of any kind from Dr. Wilson. There is a triage note from an office person that was unremarkable. A urine drug screen was performed for that day opiates tested positive at more than 3000 but not confirmed. The prescriptions were given to the patient early by 2 days. Ultram 50mg #240 with directions 2 every 6 hours, Lorazepam 1mg #60 with directions 1 every 12 hrs, oxycodone 30mg #120 with directions 1 every 6hrs, Nucynta 100mg #150 with directions 1 every 5 hrs and Paxil 25mg #30 with 1 every day. 2/6/12 the patient returns and Dr. Wilson makes a note that the patient is satisfied with the current regimen and the plan is to write the same meds except decrease the oxycodone 30mg by 1. The patient was issued the following prescriptions: the oxycodone 30mg was decreased to #90, Ultram was changed to 100mg #120 to take 1 every 6 hrs, Lorazepam and Paxil remained the same. A prescription copy for oxycodone 10mg #90 with directions to take 1 pill every 8 hrs was in the chart for 2/16/12 but there is no note or documentation to explain its existence. 3/7/12 Dr. Wilson makes a notation that the patient is satisfied with her current regimen, requests 3 refills on her Paxil which he granted and he will continue to write same medications. The triage note from staff member Yavonda reports the patient to be complaining of low back, neck and sciatica pain and was having pain in her ovaries. The patient was given the same RX including another RX for the oxycodone 10mg #90. The lorazepam prescription had the date of 3/8/12 on it which was different from the other which had the 3/7/12 date. 4/2/12 The patient returned and was noted by Dr. Wilson to be satisfied with her current regimen and he was going to write for the same meds. The triage note documents that patient "may have took 1/2 Klonopin". The chart contains what appear to be copies of prescriptions issued on this visit but there is confusion. The chart does not appear to contain all copies of prescriptions issued. The KASPER lists Lorazepam #60 filled on 4/2, oxycodone 30mg #90 filled on 4/2/12 and Nucynta 100mg #150 filled on 4/2/12 and oxycodone 10mg #90 filled on 4/12/12. It is unclear what prescriptions the patient was issued in the office visit of 4/2/12. The last visit documented in the chart was on 4/30/12. Dr. Wilson notes the patient as doing well and to write the same meds. Prescriptions were issued for Lorazepam 1mg #56, oxycodone 10mg #84, oxycodone 30mg #84, Nucynta 100mg #140, Ultram 100mg #112 and Paxil 30mg #84.

DIAGNOSIS , TREATMENT & RECORDS-All three categories were below minimum standards.

The patient had a diagnosis of severe stenosis at multiple levels in her spine. The chart contained an adequate history and physical upon her initial treatment by Dr. Argotte. There was no documentation that Dr. Wilson ever examined the patient. He never attempted to clarify the possible diagnosis of carpal tunnel syndrome. There was no follow up on previously ordered studies and referrals. There were no other treatments for the patient except for medications. The attempts to monitor the patients' use of controlled substances were inadequate. Though urine drug screening was utilized at each visit the decision to cancel confirmation of presumed positive substances not prescribed was concerning. The patient admitted she was taking medications not prescribed for her but to her husband. Results of another screening indicated she had taken buprenorphine and hydrocodone; neither prescribed. The buprenorphine is found in a transdermal opioid medication called Butrans. Buprenorphine is also Suboxone. The confirmations initially requested for both of these substances were cancelled for reasons that were not clear. There was no documentation that the results were reviewed and considered by Dr. Wilson. There were other confirmations that were cancelled for reasons that are not clear. The prescribing mixture was inappropriate. Dr. Wilson exceeded the maximum recommended dose for the safe prescribing tramadol. This was particularly concerning because the patient was also prescribed SSRI medication which in combination with tramadol may cause seizures etc. The records never contained any working diagnoses. The chart had divided categories of records that were confusing and often had conflicting dates. The controlled substance prescriptions never were written to the appropriate and expected standard of also including the address of the patient. KASPER tracking numbers were at times on the triage record.

OVERALL OPINION- Below minimum standards and considered to be gross ignorance and gross incompetence.

There was never any documentation of a physical examination or diagnosis rendered by Dr. Wilson. He never followed up on any prior studies requested. He appeared to ignore obvious aberrant behaviors concerning high risk medications. He ignored repeated abnormal urine drug testing results. His prescribing of medications was grossly incompetent and without apparent concern for the safety of the patient. He prescribed multiple high risk medications with inappropriate doses and combinations.

4. [REDACTED] She appeared to have received care from Commonwealth Quality Health Care in 2010. (CQH) She was treated by numerous physicians at CQH. Physicians included Najam Azmat, MD; Mary Beth Scott-Calor, DO; Alex Argotte MD; R. Greenlaw, MD and H. Dehaven MD prior to Dr. Wilson. She presented with complaints of arm, elbow, low back and neck pain. She was involved in an accident at the age of 16 or 16 or 17 and fractured her left arm; the fracture required the placement of hardware. She was involved in motor vehicle accidents in 2001-2003 and in 2009. She began to have complaints of neck and back pain in addition to the arm pain. MRI studies taken in 2009 revealed the following: cervical spine study was normal except for straightening of the normal curve suggesting an underlying muscle spasm; thoracic spine was normal and the lumbar spine demonstrated a disc bulge at L5-S1. The patient also complained of significant anxiety and insomnia. She was diagnosed in 2010 with CPS/chronic pain syndrome, myofascial pain and "probably fibromyalgia" by the initial treating physician at CQH. (It is difficult to follow the flow of patient care due to the placement of records in the chart). There were episodes of aberrant behavior documented throughout the chart prior to Dr. Wilson's care. Examples include "borrowing" medications from friends, see note per Dr. Argotte on 3/10/11; purchasing medications "off the street", see note per illegible name written on "Miscellaneous Patient Information" sheet dated 12/14/10; note written "no pot" on 1/24/11 by what appears to be ? Dr? Some attempts at pill counts were not successful, see note written on 4/7/11 by Dr. Argotte. In addition, the patient had multiple red flags with urine drug screening. For example, the urine drug test performed on 9/30/11 did not pass validity testing and the sample contained opiates in addition to the oxycodone and benzodiazepine. The sample was not sent for confirmation of the hydrocodone (opiate). She was ordered to have a physical therapy psychiatric evaluation and other diagnostic studies but was unable to go because she reported financial limitations. On 9/30/11 she was given orders to have MRI studies of the cervical, thoracic and lumbar spine and a note indicated Percocet would be added until the results of the diagnostic studies were completed. 10/31/11 Dr. Wilson began care of the patient. There is a note under the "progress notes" tab of the chart that was not signed by anyone but lists a KASPER tracking number, vital signs and various questions. Under the "RX" tab of the chart is a note written on the same day which appears to be from Dr. Wilson and states, "pt satisfied with current med regimen, will script same meds and return in 1 month". The patient was given the following medications: oxycodone 15mg #90 to take 1 every 8 hrs, Percocet 10/650 #60 to take every 12 hrs and Xanax 2mg #60 to take 1 every 12 hrs. The urine drug screen on this date did not have benzodiazepines present as should be. 11/29/11 she returned for follow up and Dr. Wilson notes the abnormal lab, he also notes that the patient requests Fioricet for her headache because she took her mother's Fioricet and it "worked". He notes other medications are working well. He wrote he would continue all other medications. The following prescriptions were given: oxycodone 15mg #90, Percocet 10/650 #60, Xanax 1mg #30 and Fioricet #30 with directions to take 1 daily prn. The patient was called in for a pill count on 12/7/11 but stated she could come on the following Monday. She came for the pill count on 12/12/11 and it appeared to be okay. She was given an additional prescription for Xanax on that day because her prior

prescription was a partial prescription. The visit of 12/22/11 has a notation from Dr. Wilson, "Calloway 11/29 OK". She was given the same prescriptions as the 11/29/11 visit and in error was given an additional Xanax prescription. 1/19/12 patient returned for follow up. Dr. Wilson made a note that the patient goes by the name [REDACTED], she was satisfied with her current regimen and all medications were to be written the same. However, there was not a prescription noted for Floricet. The Xanax continued to be off the regular schedule as the patient picked up a prescription for Xanax on 12/27/11. 2/16/12 A triage note by the nurse/staff could not be found for this date. There was a note written by Dr. Wilson stating "no complaints, plan: write meds same". She was given the same prescriptions for oxycodone, Percocet and Xanax. A urine drug test on this date indicated there was no Xanax in the urine. 3/15/12 Dr. Wilson makes a note that patient was without complaints; benzodiazepines were negative and plan to write the same meds. She was issued the same prescriptions for oxycodone, Percocet and Xanax. 4/12/12 Dr. Wilson addressed the negative benzodiazepine result from the previous visit. He wrote a lengthy note as compared to prior notes and addressed in this note the patients use of soft drinks and dental deterioration; he instructed her regarding proper dental hygiene. At this visit he writes his plan is to decrease the oxycodone by 1 pill and increase the Percocet by one and other medications to remain the same. He issued the prescriptions with changes as he described but did not explanation why. Prescriptions issued were: Oxycodone 15mg #60 with directions 1 every 12 hrs, Percocet 10/650 #90 1 every 8 hrs and Xanax 1mg #60 every 12 hrs. 5/10/12 the patients' urine drug test was again negative for benzodiazepines. The follow up triage note from the nurse/staff indicates "pt was told no more bad labs 2 -bzo in final lab, -bzo today". Dr. Wilson makes a note, "pt w/o complaints, plan: write meds same". On this visit Dr. Wilson increased the patients medications as follows and was given the following prescriptions: oxycodone 15mg #70 (with no change in directions) 1 every 12 hrs, Percocet 10/650 #105 (no change in directions) 1 every 8hrs and Xanax 1mg #70 (no change in directions) 1 every 12 hrs.

DIAGNOSIS & TREATMENT- Below minimum standard for both.

There never appeared to be a diagnosis given by Dr. Wilson. There was no documentation in the record that he ever examined the patient, reviewed prior studies or notes and followed up on prior diagnosis and plans. The diagnostic studies do not indicate the patient has a diagnosis that justified the use of the prescribed controlled substances for pain. She was treated with more than one high risk shorter acting opioid without the indications. The patient was given medications repeatedly while the record documented repeated aberrant behaviors. KASPER data reviewed indicates the patient was also given multiple early refills on her medications. Dr. Wilson never wrote any orders for consultations or referrals to diagnose pain complaints or treat her anxiety.

RECORDS - Below the minimum standard.

The organization of forms and documents in the chart was poor. The chart contains tab separators but the documents are placed throughout. An example of this is the placement of what appears to be a progress note and on a form titled, "Miscellaneous

Patient Information" in the RX tab and also appears at times in the "History and Physical" tab. There are numerous forms which do not contain any name, etc. There are notes written without any signature. As stated above there is no diagnosis by Dr. Wilson. The working diagnosis is never validated. None of the controlled substance prescriptions are written to standard; all without address, some without the year and none with the numerical quantity written out. There are tracking numbers periodically that indicate a KASPER report was obtained but rarely are the results of the report noted.

OVERALL OPINION- Clearly below the minimum standards. Grossly ignorant and grossly incompetent.

Dr. Wilson continued to prescribe high risk medications without documentation that he examined the patient or rendered a diagnosis. He prescribed these medications to a patient that did not have the indications to use them and increased them frequently. Further, he ignored obvious behaviors that indicated the patient was either diverting the medication or developing an addiction to the medications. A review of the KASPER data indicated that the patient was given significant early refills from February thru May of 2012. While the record contains tracking numbers to indicate a KASPER report was obtained it is apparent by Dr. Wilson's actions indicate that he never considered this information while treating the patient or simply chose to ignore it. He counseled the patient about proper dental hygiene but did not address bad urine drug testing results. The decision making regarding not only the choice of medication but quantities is flawed. He departed from the minimum standards to such an extent that his care of the patient is concluded to be grossly ignorant and grossly incompetent.

5. [REDACTED] Patient appears to initially present to the facility in 2010. However, from review of the chart it is not conclusive as to when he actually presented. A consent form located in the "History and Physical" section does not have a date on it because white out has been used to cover up the date written on it. This form is some type of consent and contains a patient signature in several places; both dates on the form have been covered up with white out. He complained of chronic pain as a result of a motor vehicle accident in 2006. In that accident he sustained multiple fractures; right leg, left ankle (which required surgery) and left wrist. He also complained of lower back pain that was radiating down the leg. In the patients self reported questionnaire he reported that he had an arrest for a DUI in mid 2010. On another document it notes the patient to be on probation June/July 2012. The chart contains an MRI of the lumbar spine dated 5/16/2011 which was normal and a thoracic MRI dated 5/18/11 had mild disc space narrowing as a result of a disc bulge at T10-11. The patient was treated at CQM by N. Azmat, MD; M. Scott-Calor, DO; A. Argotte, MD; R. Greenlaw, MD; H. Dehaven, MD prior to Dr. Wilson. The records contained a history and physical examination per Dr. Argotte and a psychological evaluation as requested by Dr. Argotte. It was noted by prior physicians that the patient had experienced seizures. The outcome of the psychological evaluation was noted as "guarded" and it was suggested he be referred to a substance abuse professional for evaluation and referral to a neurologist evaluation for possible prior head injury. He was also given orders to have physical therapy. It was also during the care of Dr. Argotte that the patient was given the orders for MRI studies which were done and noted as above. There did not appear to be any follow up on the recommendations. The chart also contained numerous abnormal urine drug test results to include medications not prescribed, medications prescribed that were absent and detection of marijuana use. It appeared the patient was actually dismissed from the facility for noncompliance sometime in September 2011. At the time of dismissal he was being prescribed Neurontin, Xanax, Ultram and oxycodone. Dr. Wilson began to see the patient on 11/10/11. The patient was dismissed after his September visit and given two weeks of medications at the time of dismissal. When he returned he had clonazepam, opiates, oxycodone, Xanax and THC in the urine drug test. Dr. Wilson wrote a note on the "Miscellaneous Patient Information" form that the patient stated the Neurontin and Ultram do not help and the patient was complaining of breakthrough pain and insomnia. He instructed the patient to take 25mg Benadryl at bedtime, discontinue the Neurontin and Ultram, and add oxycodone 10mg for breakthrough pain. There was no discussion of the failed urine drug test, any apparent physical examination or documentation of prior consultation notes etc. There did not appear to be a KASPER report obtained at this visit. He was issued the following prescriptions: Xanax 1mg #68 with directions of 1 pill every 12 hrs, oxycodone 15mg #130 with NO directions and oxycodone 10mg #68 with directions for 1 pill every 12 hrs. 12/12/11 the patient returned for follow-up. The urine drug test as this visit for negative for benzodiazepines which were prescribed and okay for oxycodone. Dr. Wilson made a note on this visit that the prior urine test was positive for clonazepam; he would have the patient return in 15 days for a pill count and given same prescriptions except for Xanax enough for 15 days. He was issued prescriptions Xanax 1mg #30 to take 1 every 12

hrs, oxycodone 10mg #60 to take 1 every 12 hrs and oxycodone 15mg #120 to take 1 every 6 hours. Attempts to call the patient for a pill count on 12/19/11 and 12/20/11 were unsuccessful because they could not reach the patient. A pill count was performed on 1/3/12 and the quantities were not correct, the patient stated he thought he had misplaced some of the oxycodone. 1/10/12 the patient presented for follow up and the note from Dr. Wilson reports that patient is satisfied with the current regimen but complains of insomnia, the patient is requesting Xanax for sleep and Dr. Wilson wrote; "denied". The patient reported Ambien and Benadryl not working. Plan was to write for same medications and add Elavil 25mg for sleep. A urine drug test on this date was negative again for Xanax and positive for oxycodone and opiates. The opiates are never sent for confirmation. The patient was issued the following prescriptions: Elavil 25mg #30, oxycodone 10mg #60, Xanax 1mg #30 and oxycodone 15mg #120. A pill count is noted on 1/26/12 that the pharmacy employee "Tony" counted the patients medication at the pharmacy and it is as should be. 2/7/12 he returned for follow up and Dr. Wilson notes the patient to be satisfied with the current regimen and write same meds. The patient was issued the same prescriptions as the previous month. 3/7/12 The patient is issued the same prescriptions except the Xanax is now increased back to #60 with directions every 12 hrs. Dr. Wilson makes a note that the patients anxiety has increased and he will increase the Xanax by 1 and continue other medications the same. 4/4/12 the patient returned with complaints of poor sleep. Dr. Wilson makes a note that the patient reported to him the Elavil was "too weak for sleep", Dr. Wilson's plan was to change the oxycodone 10mg to Percocet 10/650 and decrease the oxycodone 15 by 1 pill and increase elavil to 75mg and continue other medications the same. The patient was issued the following prescriptions: Elavil 75mg #30, oxycodone 15mg #90 to take 1 every 8 hours, Percocet 10/650 #90 to take 1 every 8hrs and Xanax 1mg #60 to take 1 every 12hrs. The urine drug test on this day was positive for THC, Xanax, opiates and oxycodone. Opiates were not sent for confirmation. 5/7/12 note per Dr. Wilson states the patient was without complaints, patient wants to finish GED and join the military and then to college. Plan was to continue same medications. The patient was issued the same prescriptions but with a small increase all quantities with the same prior directions without explanation. Xanax 1mg #64, Elavil 75mg #32, Percocet 10/650 #96 and oxycodone 15mg #96. The urine drug test for this date was positive for THC and negative for benzodiazepines.

DIAGNOSIS, TREATMENT & RECORDS: All three areas are clearly below the minimum standards.

There is no documentation that Dr. Wilson ever examined the patient or rendered a diagnosis. The diagnostic studies do not justify the use of the medications prescribed. There did not appear to be any follow up on the prior orders for additional studies. The patient was evaluated by psychological services and the outcome of this evaluation indicated the patient needed to be evaluated by a substance abuse specialist. The record was clear that the patient had an arrest for a DUI and was on probation. There was never any documentation that Dr. Wilson considered this information in treating the

patient. There were no other therapies used to control his pain. The patient demonstrated multiple aberrant behaviors related to use of controlled substances. There were KASPER tracking numbers in the chart but the KASPER data did not appear to be considered. The patient was given multiple early refills and he actually was given Xanax #98 in 28 days according to KASPER data. The patient had quantities of medications that were inappropriate and not justified. The combination of high dose benzodiazepines with opioid medications was inappropriate. Continued use of benzodiazepines with the knowledge the patient failed to have this medication present in the urine is not acceptable. The records did contain multiple tracking numbers for KASPER data. All controlled substance prescriptions failed to be written to standard; omitting the patients address and written numerical quantity, some did not have the year written and some lacked written directions.

OVERALL OPINION- Clearly below the minimum standards. The care of this patient was considered to be grossly incompetent, ignorant and negligent. Dr. Wilson prescribed multiple high risk opioid medications to a young patient that did not have the medical indications to be prescribed such medications. There is no explanation as to why this patient was allowed to return to the facility after he had been dismissed for aberrant behaviors. This patient was clearly demonstrating aberrant behaviors and should not have been prescribed controlled substances. This patient was most likely diverting the medications he was prescribed.

6. [REDACTED]. The initial visit appears to be either September or November of 2010; the record is not clear. The patient reportedly was involved in a motor vehicle accident in 2003 and maybe in also 2007 (again the record is not clear) he continued to have pain in his lower back radiating to his leg and trouble sleeping. He also complained of neck pain radiating down both arms and his back. MRI and CT studies in the record are all essentially normal. These studies are from 6/17/2010 and 1/7/2008. There are of the lumbar and thoracic spine. The patient was treated by all the prior Commonwealth Quality Healthcare physicians and Dr. Wilson. His initial treatment included Soma, Valium and hydrocodone and these medications continued until the patient started seeing Dr. Wilson. There are no copies of prescriptions given to the patient included in the record before 9/20/11. The patient appears to have been dismissed from the facility in 4/18/12 for "bad labs/pill count". This patients record is not in any order; it appears to have been removed from a ringed binder and placed in a yellow envelop after the patient was dismissed. 10/18/11 Dr. Wilson gave the patient the following prescriptions: Lorcet 10/650 #90 with directions to take 1 pill every 8 hrs, Soma 350mg #90 to take every 8 hrs, Valium 10mg #90 to take every 8 hrs and an order for the patient to have an MRI of the lumbar and thoracic spine because of pain with radiculopathy, possible compression with numbness and tingling. There was what appeared to be a triage note completed by "Sue" who describes left knee pain and pain in the lower back that was shooting up the spine and down the legs. He reported his meds were working but he still had pain. There is no note from Dr. Wilson or notations from him on the triage form. There was no diagnosis rendered. 11/16/11 The patient presented for follow up and the urine drug test was positive for oxycodone which was not prescribed. There are notes on the urine test form that have been covered up with white out and could not be read. The patient said he had taken his mothers Percocet. Dr. Wilson makes a note on the "Miscellaneous Patient Information" form that the patient was complaining of valium not helping and he was having breakthrough pain, his plan was to replace the valium with Xanax 1mg bid and replace the Lorcet with oxycodone 10mg 4 times per day and keep the Soma the same. He issued the following prescriptions: oxycodone 10mg #120 to take 1 pill every 6 hrs, Soma 350 #90 to take 1 every 8 hrs and Xanax 1mg #60 to take 1 every 12hrs. 12/14/11 The patient returns, reports a friend gave him an oxycodone 15mg and it worked better, ran out of medications and had to "borrow from friends and family" because his medications were stolen, "had entire safe stolen". He requested his oxycodone be raised to the 15mg. Dr. Wilson notes the patients previous urine test results and that the patient took his mothers Percocet. He noted patients complaint of the "oxy's barely" decrease pain; complaints of anxiety and plans to replace the oxycodone 10's with the 15 at #150, increase the Xanax by 1 per day and continue the soma. He issued the following prescriptions: oxycodone 15mg #150 to take 1 pill every 4-6 hrs, soma 350 #90 to take 1 every 8 hrs and Xanax 1mg #90 with directions to take 1 pill every 8 hrs. 1/12/12 he returned for follow up stating meds were working well per staff member "Follow up Triage" note per "Sue"; Dr. Wilson writes a note that the patient was complaining of breakthrough pain and anxiety and he planned to decrease soma by 1 pill, increase Xanax by 1 pill and add Percocet for breakthrough pain. He issued the following

prescriptions: Oxycodone 15mg #150 q5h, Percocet 10/650 #60 1 every 12 hrs, Soma 350mg #60 1 every 12 hrs and Xanax 1mg #120 to take 1 every 6 hrs. On 1/26/12 the pharmacy employee "Tony" called in a "pill count" which indicated all correct except he had 1 more Xanax than prescribed. 2/9/12 the patient presented and the follow up triage note by the nurse states "Pt says he will bring paperwork showing PI was dismissed". There is no documentation of explanation regarding this statement. It suggests the patient had been charged perhaps with a public intoxication offense. But it is unclear, not addressed or explained. Dr. Wilson does not mention this in his note. Dr. Wilson makes a note that states the patient is satisfied with the current regimen, and he plans to decrease the oxycodone by 1 and increase the Percocet by 1 and decrease the Soma by 1. He writes (lab e) but there is no explanation as to what he was stating. He also writes other meds same and "pt is maxed out". He issued the following prescriptions: oxycodone 15mg #120 1 every 6 hrs, Percocet 10/650 #90 1 every 8hrs, Soma 350mg #30 1 every day and Xanax 1mg #120 to take 1 every 6 hrs. 3/8/12 he returned and said his medications were helping as noted per the triage note from "Sue". Dr. Wilson makes a note that the patient was complaining of increased pain, he planned to add 1 Percocet, other meds same, he will let the patient continue Soma because he has been cut back from #120 pills. He gives the patient the following diagnoses: acrophobia, agoraphobia and claustrophobia. He issued the following prescriptions: oxycodone 15mg #120, Percocet 10/650 #120, Xanax 1mg #120 and Soma 350 #30. 4/4/12 the triage note states meds are helping, Dr. Wilson makes a note that the patient requested an increase in the oxycodone which was denied and all medications to stay the same. He issued the same prescriptions as the preceding month.

DIAGNOSIS, TREATMENT & RECORDS: All three are below the minimum standards.

There is no justifiable diagnosis in which to use scheduled 2 controlled substances. There is no history and physical in the record. There was no record of any follow up on diagnostic studies that were ordered. There were no other treatments or evaluations for this patient. There was no apparent follow up on the notation of public intoxication and illegal behavior related to controlled substances. The record included what appeared to be a printout from a local newspaper that listed the patient as being arrested for public intoxication with Dr. Wilson made the diagnoses of phobias as described above without any documentation as how he came to those conclusions. Treatment for the psychiatric diagnoses was not appropriate. Dr. Wilson prescribed high dose medications in its most abusable form to an individual that presented without the diagnoses to warrant such prescribing. Further, he continually increased the benzodiazepine, continued another sedating drug (soma) and in combination with high dose opioids. While there were frequent abnormal urine drug test results, the patient was continued on the same dangerous medications without justification. KASPER tracking numbers appeared consistently throughout the record but Dr. Wilson never made note of the information. The patient was given early refills on medications frequently; 2-4 days early. The patient demonstrated aberrant behaviors. The pill count phoned in from the pharmacy employee was highly suspect. It is also noted by this reviewer that the patient

Chester Dorton has the same pill count phoned in. The records were disorganized and incomplete. None of the controlled substances prescriptions had the patients address on them.

OVERALL OPINION – Clearly below minimum standards. Gross ignorance, negligence and incompetence.

Dr. Wilson prescribed high risk medications for many months on this patient while ignoring aberrant behaviors. He prescribed medications to this patient who did not have a diagnosis.

7. [REDACTED] This patient appeared to present on 7/28/11. He was dismissed in April 2012 for having cocaine in a urine drug test. (The records have been removed from a chart binder and placed into a yellow envelope. The contents are disorganized and it difficult to determine flow of care as the complete date is often not on the documents). He complained of lower back pain that radiated to his left leg. He reported to have had two prior back surgeries and the problem was precipitated by a motor vehicle accident in 2001. He also reported he had 2 prior knee surgeries. He had been a patient of another pain management center, "Care More" but stated he left because he was not happy with the physician. He reported the Percocet's and Lorcet were no longer helping him. Included in the record were several MRI reports. An MRI of the lumbar spine dated 12/9/2002 notes postoperative changes at L5-S1 consistent with a laminectomy on the left and fibrosis, disc degeneration and spondylosis at L4-5, minimal retrolisthesis of L5-S1; he reported some type of trauma in 7/11 and had MRI studies of the cervical spine dated 7/17/11 was normal, MRI of the thoracic spine dated 7/17/11 demonstrated a mild curvature of the upper spine but was otherwise normal; an MRI of the lumbar spine dated 7/17/11 demonstrated degenerative disc disease with acquired central canal and neural foraminal narrowing. Following a motor vehicle accident in 1/2012 he had an MRI of the lumbar spine dated 1/03/12 which demonstrated a minimal central disc bulge at L4-5, central and left paracentral disc bulge at L5-S1 on the left creating left neural foraminal stenosis and slightly displacing the S1 left nerve root sleeve and an MRI of the cervical spine on the same date (1/03/12) showed small diameter of the spinal canal probably due to congenitally short pedicles otherwise the study was normal.. The patient had considered additional surgery and/or placement of a "nerve stimulator pump". The patient also reported he had a back brace. Prior to Dr. Wilson he was prescribed Neurontin for approximately 1 month, Xanax 1mg twice per day, oxycodone in various strengths including Percocet's and approximately one month of nortriptyline. 10/18/11 Dr. Wilson began seeing the patient. A note for the same date written on the "Miscellaneous Patient Information" form documents that patient not having any new complaints or injuries and his treatment plan will continue; the initials "Ya" appear on this note. Beneath that note Dr. Wilson wrote, Percocet 10/650 q8h #90, oxycodone 30mg q6h #120 and Xanax 1mg bid. He issued those prescriptions to the patient. 11/16/11 the patient returned for follow up and the follow up triage note reported the patient to have left knee pain, weather was intensifying his pain and a rock had fallen on him while working underground. He also complained of the Percocet's upsetting his stomach and not offering much relief. This note was not signed. Dr. Wilson makes a note that the patient complained of increased pain, Percocet's were upsetting his stomach, relief and he would replace the Percocet with oxy 15 and continue other medications the same. He issued the following prescriptions: oxycodone 15mg #93 with directions to take 1 pill every 8 hrs, oxycodone 30mg #124 to take 1 pill every 6 hrs and Xanax 1mg #62 to take 1 pill every 12 hrs. 12/15/11 The patient returned and complained of new pain in his neck and mid back as a result of a motor vehicle accident December 5th. The patient went to the ER for care following the accident. There is no signature or initials on the follow up triage note. Dr. Wilson makes a note on the "Miscellaneous Patient Information" form that the Calloway lab from 11/16/11 was okay;

a urine drug test was performed on this date and abnormal with amphetamines, THC and opiates in the screen in addition to the Xanax and oxycodone. The Xanax and oxycodone were expected to be in the urine. For unknown reasoning the amphetamines and opiates were not confirmed. There was no documentation by Dr. Wilson that he reviewed these results on the day the patient was present. The patient complained of more pain because he had been in a prior motor vehicle accident with the vehicle flipping over 3 times. Dr. Wilson planned to increase the oxy 15 by one and continue other meds the same, he made a note that the patient had "plateaued w/ox". He issued the following prescriptions: oxycodone 15mg #132 with directions to take 1 every 6hrs, oxycodone 30mg #132 to take 1 every 6 hrs and Xanax 1mg #66 to take 1 every 12 hrs. There appeared to be a pill count performed on 12/21/11 which for the most part was acceptable. 1/16/12 it appeared the patient was asked about the results from the previous month's urine drug test. The patient reported he had been a patient at a weight loss clinic for several months and received "Adipex". He also reported he took Fioricet from his wife for a headache and had been around friends who were smoking THC. The follow up triage note states the patient understands he can be dismissed. This note is signed by L Kidd, RN. Dr. Wilson makes a note that the patient was satisfied with the current regimen and his plan was to continue the same meds. He issued the patient the following prescriptions: oxycodone 15mg #120, oxycodone 30mg #120 and Xanax 1mg #60. 2/13/12 the patient did not have any new complaints, the triage note circles yes to the question if the patient had visited another medical facility since the last visit and a notation is made, "neurologist-pt says he did not take anything". A urine drug test was again abnormal and contained THC. Dr. Wilson makes a note that the patient is satisfied with the current treatment regimen and he will decrease the oxycodone 30 by 1. He issued the following prescriptions: oxycodone 30mg #90, oxycodone 15mg #120 and Xanax 1mg #60. 3/12/12 The triage follow up notes patient to describe increased pain since the Dec motor vehicle accident, left knee and mid back pain. Dr. Wilson makes a note that the patient is without complaints and he plans to decrease the oxycodone 30mg by 1 and other medications to stay the same. He issues the following prescriptions: oxycodone 15mg #120, oxycodone 30mg #60 and Xanax 1mg #60. The urine drug test on this day was again abnormal; positive on screen for opiates and THC. 4/9/12 the patient returned and cocaine was in his urine. He was given a dismissal letter and prescriptions for 2 weeks of his medications. He was issued the following prescriptions: oxycodone 15mg #60, oxycodone 30mg #30 and Xanax 1mg #30. The patient dismissal letter included a note that if the final labs "come back - (negative) cocaine will call you and will be a pt again".

DIAGNOSIS & TREATMENT -Below the minimum standards for both.

The patient appeared to have proper diagnostic studies for his back complaints. It would appear the patient had a lumbar spine condition that did cause pain. There was discrepancy in the diagnostic studies; one diagnostic study did not indicate the prior back surgery and one did. If the patient had back surgery he would have been very young and this age would be approximately 15-17 years old. There were also no records from the prior pain management care. There were no physical examination

notes to indicate the patient had lumbar scarring. The patient never appeared to have any diagnostic studies of his left knee indicating the cause of his pain complaints. There never appeared to be any physical examination of the patient by anyone. There no notes to indicate that Dr. Wilson ever examined the patient or rendered a diagnosis other than for pain and anxiety. The patient was treated with 2 short acting opioid medications with multiple doses in combination with high dose benzodiazepines. There were no other adjunctive therapies utilized or referrals. If the patient had anxiety problems that required benzodiazepines he should have been referred to a psychiatrist for evaluation of this problem and proper treatment. The patient was ultimately dismissed when he used cocaine. However, he was treated for approximately 8 months by Dr. Wilson while he obviously ignored the indicators of aberrant behavior.

RECORDS – Below the minimum standards.

There was no history and physical, follow up evaluations lack appropriate content, the controlled substance prescriptions were never written to standard. The records contain multiple urine drug testing results but appeared to be ignored. The record contained triage follow up notes that did not correlate to notations made by Dr. Wilson. The triage notes often did not have any signatures. The records contained multiple tracking numbers for the KASPER data but this too appeared to be ignored. In review of KASPER data for this patient, he was given multiple early refills of controlled substances without explanation.

OVERALL OPINION – below the minimum standards and gross ignorance, negligence and incompetence.

Dr. Wilson demonstrated incompetence and lack of knowledge in treating pain and prescribing medications to treat pain. He failed to adequately prevent probable fraud and abuse of high risk controlled substances. Dr. Wilson failed to practice the most fundamental and basic component of medicine; conducting a physical examination and formulating a diagnosis. There was no indication that he did either one.

8. [REDACTED] 12/22/11 the patient initiated care with Commonwealth Quality Health Care/Dr. Wilson. He had been under the care of another pain specialist/Kentucky Pain Physicians in Pikeville, Kentucky; Robert Windsor, MD. He reported leaving that facility because "the medication wasn't helping and the Dr. wouldn't listen." He said he had back pain for approximately 3 years. He reported that he had used a heating pad and a back brace. He also reported that he was disabled due to "bad" nerves. He stated he was previously under the care of a psychiatrist for depression and anxiety. Dr. Wilson makes a note on the "Miscellaneous Patient Information" form that the patient presented to be "evaluated with complaint of chronic pain lower back". The plan was "ox 10's #120, Klonopin 1mg #60. The patient reported he was on hydrocodone 7.5, clonazepam 1mg and tizanadine 4mg. A urine drug test was performed on this initial visit and abnormal for multiple benzodiazepines, oxycodone and opiates. Records were obtained from the prior pain management physician and these included office visit notes and diagnostic studies. An MRI of the lumbar spine was essentially normal except for mild disc bulging at L4-5 and L5-S1. A nerve conduction and EMG study was performed on 8/9/11 and the result was normal. Dr. Wilson issued the patient the following prescriptions: oxycodone 10mg #120 to take 1 every 6 hrs and Klonopin 1mg #60 to take 1 pill every 12 hrs. 1/23/12 the patient returned for follow up and stated he was involved in a motor vehicle accident on January 3rd. He reported was seen in the ER and said everything was fine but he was having increased pain. This information is written on the "Miscellaneous Patient Information" form by L. Kidd, RN. The follow up triage note for the same day also completed by Kidd, RN notes the patient reporting the Klonopin is not strong enough, there were no new complaints, he may have taken a Xanax at his uncle's funeral. Dr. Wilson makes a note that the patient is complaining that the oxy's are too weak, Klonopin does not work and plans to replace the oxy 10's with 15's and replace the Klonopin with Xanax. He issues the following prescriptions: oxycodone 15mg #120 to take 1 every 6hrs and Xanax 1mg #60 to take 1 every 12 hrs. The urine drug test on this date is positive for barbiturates, no benzodiazepines, opiates and oxycodone; the confirmation testing was negative for benzos and oxycodone but is not conclusive. 2/20/12 the follow up triage note reports pts meds are working good, he reported he was seen in the ER for a cold. Dr. Wilson writes the patient is without complaints and to write the same meds. The urine drug test on this date was positive for multiple benzodiazepines, opiates and oxycodone. The patient was issued the same prescriptions as the preceding month. 3/19/12 the follow up triage note says the pain had increased in his lower back and he was asking for break thru pain medication, he was warned about previous lab results, the note was signed by L. Kidd, RN. The urine drug test was negative for benzodiazepines. Dr. Wilson makes a note that the patient was asking for breakthrough, "benz labs are a concern. Plan to increase oxy 15 by 1 and other meds same, trend labs closely". Dr. Wilson continued the Xanax 1mg #60 to take every 12 hrs and was given an increase in his oxycodone 15mg to every 5 hr #150. 4/16/12 he returned for follow up and did not have any new complaints was warned about inconsistent labs and asked for an increase in Xanax due to difficulty sleeping and "stays aggravated". This note again per L. Kidd, RN. A urine drug test for this date was again negative for Xanax, tramadol, opiates and

oxycodone. There was no documentation or notes from Dr. Wilson but he issued the following prescriptions: Xanax 1mg #60, oxycodone 15mg #120 and Percocet 10/650 #60. Percocet was added to the mixture on this visit with no explanation. 5/14/12 the patient was dismissed from the facility and given 15 day prescriptions. There is no note or documentation from Dr. Wilson. He issued the following prescriptions: Xanax 1mg #30, oxycodone 15mg #60 and Percocet 10/650 #60.

There were 3 attempts at pill counts; 2 the patient was unable to either be reached or he could not come in and one pill count appeared to be okay basically ok.

DIAGNOSIS & TREATMENT- Below minimum standards for both.

This patient did not have a diagnosis that warranted the use of the opioid medications prescribed. Dr. Wilson never obtained a history and physical. There was no documentation that he examined this patient. Dr. Wilson frequently increased the medications without any written explanation for his actions.

RECORDS- (The record contains a document that the Kirk Law Firm is representing the patient for an injury claim from the motor vehicle accident of 1/3/2012 and related release of information forms). There was no physical examination. There were no follow up notes.

OVERALL OPINION- Below minimum standards. Gross negligence, ignorance and incompetent.

Dr. Wilson prescribed high risk opioid medications to a patient without a diagnosis and with indication that the medication would most probably be diverted.

9. [REDACTED] Initially presented on 3/28/11 with complaints of pain that began after multiple car accidents at the age of 18; approximately 2005. She was treated at a prior pain management clinic and was under the care of "Dr. Albert" who prescribed Soma, Xanax, Percocet, Lorcet and stomach medications. She complained of upper back and neck pain shooting down her spine into her lower back and making her right leg numb. She indicated she was presenting for pain medications and informed that prior treatment included physical therapy and the use of a heating pad. MRI studies were in the chart and on 6/24/2010 the cervical spine results indicated mild disc bulging from C4-5 thru C7-T1 with congenital narrowing of the spinal canal due to short pedicles and a muscle spasm at the time of the study; lumbar and thoracic study on the same date demonstrated multilevel disc bulging with a right paracentral posterior disc herniation an associated radial tear at T11-12, there was also bilateral facet hypertrophy at the L5-S1 level with moderate impingement upon the bilateral lateral recesses. A. Argotte, MD did the initial evaluation which included a physical examination and history. He referred the patient to a spine surgeon, physical therapy, orders for lab work and a psychological evaluation. He issued the following prescriptions: Percocet 7.5/500mg #60 with directions to take 1 q12hr prn, Soma 350mg #30 to take q24hrs prn, Lorcet #120 to take 1 every 6hrs prn and Xanax 1mg #30 to take 1 every 24hrs prn. The patient was unable to keep her follow up appointment because of family surgery. She returned on 5/18/11 she had the requested lab work performed. Her urine drug screen was questionable. She reported her medications were working well. It was not explained why the patients medications lasted beyond 30 days. She reported symptoms of depression and stated she was in the process of going through a divorce. The psychiatric/psychological evaluation was scheduled. The patient was issued prescriptions for soma #30, Lorcet #120, Paxil 10mg #30, ibuprofen 600mh #90, Neurontin 100mg #60, Percocet 7.5/500 #60 and Xanax 1mg #30. 6/15/11 Pt reported the medications were helping. She thought Paxil was causing itching. She was issued the following prescriptions: Soma #30, Paxil was increased to 20mg #30, Neurontin was changed to 200mg bid #60, Lorcet #120 and ibuprofen 600mg #90. He made note that he eliminated the Xanax because it was not in the urine. Percocet also appeared to be eliminated. 7/7/11 the facility doctor was now Dr. Greenlaw who issues the following prescriptions: Neurontin 300mg #60, ibuprofen 600mg #90, Soma 350 #30, Lorcet #60, Percocet 7.5/500 #90 and Xanax .5mg #30. Paxil and ibuprofen were not longer prescribed for the patient. She reported on this visit she had to double up on her Lorcet because she was not prescribed the Percocet on the prior visit. Visits from 8/4/11 thru 9/28/11 were conducted by Dr. Dehaven. The patient reported overall her medications were working. The September urine drug screen was not as it should have been. Prior to her first visit with Dr. Wilson she had increases in Xanax, Percocet and Neurontin. 10/26/11 Dr. Wilson begins to see the patient. The triage note per "Yavonda" notes patients medications are working. Dr. Wilson writes a note that "pt Calloway shows essentially no narcs in system other meds ok" and plan is to order 15 days of narc and have pill count. The lab results are not as Dr. Wilson thought. Oxycodone and Xanax were in the urine. He issues the following prescriptions: Xanax 1mg #60, Neurontin 300mg #90, Percocet 10/650 #45 and Lorcet 10/650 #30. A pill count attempt on

11/4/11 could not be done because the patient could not be reached. On 11/9/11 the patient was issued 15 days of the Lorcet and Percocet. It is not clear if she had the pill count or not. 11/23/11 she returned and reported her meds were working good per follow up triage note; this note is not signed by any staff member nor Dr. Wilson. Dr. Wilson makes a note that "Calloway okay", the patient requested one more "perc" and he planned to replace the Percocet with oxy 10's #120 and other meds to remain the same. He issued the following prescriptions: oxycodone 10mg #130 with directions to take 1 every 6 hrs, Xanax 1mg #68 with directions to take 1 every 12hrs, Lorcet 10/650 #68 to take 1 every 12hrs and Neurontin 300mg #102 to take every 8 hrs. There appeared to be a pill count request that was unsuccessful on 12/23/11 because the patient could not be contacted. 12/27/11 the patient returned stating her meds were helping but the oxycodone made her feel funny. The triage note was not signed. Dr. Wilson makes a note stating the oxy made patient feel dizzy, she was taking them on an empty stomach he instructed her to take them with meals and otherwise she is satisfied with her regimen and he planned to continue the same medications. He issued prescriptions for the same medications except he changed the quantity to 30 day supply. 1/24/12 she reported she was not sleeping well, the oxycodone made her feel dizzy and high and had new right leg numbness. She also reported she didn't need as many Neurontin. This triage note is signed by L. Kidd, RN. Dr. Wilson writes a note that the oxycodone doesn't work as well as the Percocet, he plans to replace the oxycodone with Percocet and increase the Lorcet by 1 pill and continue all other meds. He issued the following prescriptions: Percocet 10/650 #90, Lorcet 10/325 #90, Xanax 1mg #60 and Neurontin 300mg. 2/21/12 there were no new complaints noted on the follow up triage note, the entire physical assessment note including a nursing diagnosis with suggestion to send the patient for a psych evaluation, was completed by L. Kidd, RN. Dr. Wilson makes a note that the patient was without complaints and plan is to write the same meds. He issues the same prescriptions as per previous month. 3/20/12 follow up triage note reports no new complaints but states "Norco" gives her a headache and she had sleep deprivation. Pt also reported on this visit that she had a visit with another provider for a breast exam. Dr. Wilson makes a note that the patient is without complaints and he plans to write the same medications. He issues the same medications as the preceding month. 4/17/12 triage note indicates the patient is having right arm and right leg numbness and is being evaluated for masses in her breast and stomach, this form is completed by Butcher, (SMA). Dr. Wilson makes a note that the patient is without complaints, a left breast mass and right lower quadrant mass requiring surgery for diagnosis, plan is to write for same meds and a general surgery referral. He issues the same prescriptions as the preceding month. 5/14/12 the triage note indicates the meds are helping, the report on her breast and stomach are "good". Dr. Wilson notes the patient is without complaints and plans to write for the same meds. He issues the same prescriptions but increases the quantities on all slightly without any explanation.

DIAGNOSIS- &TREATMENT- Below minimum standards

This patient had a diagnosis that did warrant the use of opioids to treat pain. However, there did not appear to be any physical examination by Dr. Wilson. There was an adequate history and physical examination on the chart as obtained by Dr. Argotte. There was no documentation to suggest that Dr. Wilson reviewed the prior diagnostic studies. Dr. Wilson never rendered a diagnosis. The patient had various complaints as noted on the follow up triage note by staff members; but Dr. Wilson's notes often were contradictory; "no complaints" etc. There were no other treatments utilized. The previously requested studies and evaluations were never followed up on. There were regular urine drug tests and tracking numbers to indicate KASPER data was obtained. The controlled substance prescriptions were consistently written without the patients address. There was no indication for the prescribing of Xanax. The notes by Dr. Wilson do not reflect the data written in the triage notes.

RECORDS – Borderline

OVERALL OPINION – Below minimum standards.

The prescribing was inappropriate; the physician demonstrated gross ignorance and gross negligence.

10. [REDACTED] Initial visit to the Commonwealth Quality Health Care was on 7/13/11. She complained of pain in her feet, lower back, legs and knees. She reported to have been in a 4-wheeler accident and this caused pain. She also reported after giving birth to twins she had more pain. She had been to a pain management physician and reported the medications he gave her worked but he retired. She also reported that use of a heating pad helped and putting a board under her mattress helped. She reported her last pain medications to be in 2/11. The urine drug test on the initial visit was negative for any medications but positive for THC. It was noted that a test for the integrity of the urine sample was out of range. An MRI study of the lumbar spine from 10/5/2010 was on the chart and results were normal. She reported that she had been taking Lorcet 10/650 #120, Percocet 10/650 #30, Soma 350 #60, Xanax 2mg #30 and Fioricet #30. Dr. Greenlaw was physician in the facility at that time and issued the following prescriptions: Xanax 1mg #60 with directions to take 1 pill every 12 hrs, Baclofen 20mg #90 1 every 8hrs, Lorcet 7.5/500 #120 1 every 6hrs and Fioricet #30 1 every 24 hrs prn. She returned on 8/10/11 and reported her medications were working but asked to have the Lorcet 10 and said the Baclofen made her sick; "soured stomach". There was no signature of the person who actually wrote this note but H. Dehaven did sign at the bottom and date it 8/10/11. There appears to be an additional note intended for 8/10/11 but it has the date 8/11/11 on this note but is also signed by H. Dehaven and dated 8/10/11. The urine drug test was again positive for THC. Dr. Dehaven now appeared to be the practicing physician and issued the following prescriptions: Xanax 1mg #60, Lorcet 10/325 #120 and Fioricet #30. 9/9/11 the patient is complaining of pain in both feet and Dr. Dehaven plans to refer her to a podiatrist. The urine drug test is again positive for THC. There is an additional note for this same day under the "RX" tab of the chart and states the patient requested to have Lorcet 10/650 instead of 10/325. The same prescriptions were issued but the Lorcet was changed to 10/650 #120. 10/10/11 **Dr. Wilson** begins care of the patient. The triage note states the patient was having tingling in her neck and sharp pain in her left and right shoulder, left and right shooting, sharp leg pain and left knee pain and sharp back pain. Meds were working. The urine drug test was positive for THC now x4. Someone wrote of note on the "Miscellaneous Patient Information" form that appeared to be the handwriting of "Yavonda" but it was signed by Dr. Wilson. This note reports the patient to have toothaches from exposed nerve endings, increase pain symptoms at times and having muscle spasms. The patient asked for Soma. She was issued the same prescriptions as the preceding month except the Lorcet was changed back to 10/325mg. There was no documentation of examination or other diagnostic studies. 11/7/11 repeat urine drug testing indicated THC was in the urine now for the 5th time in a row. The patient reported meds were helping but sometimes she needed an extra Xanax. Dr. Wilson makes a note that the patient reports her pain to return early after each dose and other meds were okay. His plan is to increase the Lorcet back to the 10/650 and continue other meds the same. He issued the following prescriptions: Xanax 1mg #64 to take 1 pill every 12hrs, Lorcet 10/650 #160 to take 1 every 4-6 hrs and Fioricet #32 to take 1 daily. 12/7/11 the urine drug test for this visit was again positive for THC-6th time; the specimen did not pass integrity testing by having the oxidant screen out of range. The patient reported her meds were

working well but on some days she may have some extra pain. Dr. Wilson writes a note that the patient was complaining of breakthrough pain and he planned to add oxycodone 10 #60 and continue all other medications. She was issued the following prescriptions: Xanax 1mg #60, Fioricet #30, Lorcet 10/650 now #150 and oxycodone 10mg #60 to take 1 every 12 hrs. 1/5/12 follow up triage note reports pain has gotten better with meds and the oxycodone 10 "really worked". Dr. Wilson makes a note that the patient is satisfied with current regimen and plans to write the same meds. He issued the same prescriptions as the preceding month. 2/2/12 the triage note indicates the meds are working and patient is having left knee pain. Dr. Wilson notes the patient is requesting an increase in the oxy quantity or strength and he writes denied, otherwise no complaints. He informs the patient the Lorcet will be "leveled off" at #90 and plans to decrease this by 1 pill and continue all other medications. He issues the same prescriptions except the Lorcet 10/650 is #120 now. 3/1 or 3/2/12 one note lists follow up as 3/2. The urine drug test on this date is now negative for THC but fails the integrity test. She reports her medications to be working. There is no note from Dr. Wilson on this date and he issues the same prescriptions as the preceding month. She returns on 3/29/12 the triage note indicates meds are working well, Dr. Wilson makes a note that she is without complaints, and his plan is to decrease her Lorcet by 1 pill and increase her oxycodone by 1 pill and leave the other medications the same. A urine drug test on this date is again positive for THC. He issues the prescriptions as planned. 4/26/12 the patients' urine drug test is conflicting, she denies use of THC, she states her medications are working, Dr. Wilson makes a note that the patient is requesting an increase in Xanax which he plans to deny and otherwise patient is satisfied with her medications; he issues all medications the same as the previous month. 5/23/12 documentation on the triage follow up note per staff Belcher notes the patient reports her pain has increased because of gardening, her urine drug test was positive for THC, she reports occasional smoking of THC to help with pain and she was counseled regarding possible dismissal for THC use. The note from Dr. Wilson notes the patients request for increase in pain medications because of gardening; he plans to increase the oxycodone 10mg to 15mg and leave other medications the same. He increases all medications and issues the following prescriptions: oxycodone 15mg #105 with directions to take 1 every 8 hrs, Lorcet 10/650 #140 to take 1 every 6 hrs, Fioricet #35 to take 1 daily, and Xanax 1mg #70 to take 1 pill every 12 hrs.

DIAGNOSIS, TREATMENT & RECORD- Below the minimum standards for all three. There was no diagnosis established that indicated the patient should be treated with high risk opioid medications. There was no documentation that Dr. Wilson ever examined the patient. There was no follow up for further investigation of her pain complaints. There was no working diagnosis. The repeated aberrant behaviors regarding illegal drug use and repeated questionable adulterated urine test results were ignored. The patient was continued on high risk medications.

OVERALL OPINION – Below minimum standards.

The care provided by Dr. Wilson indicated not only gross ignorance but also negligence and incompetence. This patient should not have been prescribed this combination of medications. This patient did not have any pathology that warranted opioid medications. There was no history and physical examination.

11. [REDACTED] (This patient was also an employee of Commonwealth Quality Medical Care). It appeared the patient presented in March 2011. The initial consents and forms have conflicting dates; some data filled out in pencil and some with signatures in pencil. Dr. Argotte initially evaluated the patient on 3/10/11. She complained of chronic right hip pain as a result of a 2004 stress fracture while in military service. She also reported being in multiple motor vehicle accidents in 2003, 2004 and 2005. She denied any hospital care following the motor vehicle accidents. She described ongoing and chronic pain in her lower back and right hip. She also reported a history of a tibia and foot fracture that occurred in approximately 2004. She complained of headaches. She reported she had spinal steroid injections in 2006/2007 and physical therapy in 2007. She also reported begin treated in 2010 for anxiety and depression. MRI studies of the lumbar spine dated 9/13/08 note the patient to have L5-S1 disc desiccation with an annular tear and a small left paracentral disc protrusion. Cervical x-rays dated 10/09/08 are normal. An MRI/MRA of the brain was normal on 5/15/2008. X-rays of the pelvis were normal except for the presence of surgical clips in the left pelvis. X-rays of the SI joints were normal on 10/0/08. Bone density study of the left hip and lumbar spine on 8/25/08 was normal. (Prior records from 12/9/08 describe concerns regarding the patients use of large amount of controlled substances while in the military, screening questionnaires at that time were suggestive of substance abuse but not diagnostic, and presentation on physical exam at that time suggested opioid withdrawal. The conclusion of the physician who provided pain management at that time, at another facility, stated, "All of this information together suggests some degree of substance abuse or concerns thereof"). Dr. Argotte diagnosed the patient with lumbar disc bulging and requested a new MRI. He resumed prescribing of medications and gave orders for MRI studies, physical therapy evaluation, psychiatric evaluation and lab work. He issued prescriptions for Percocet 10/325 #120, Lorcet 10/325 #30, Ambien 10mg #30 and Xanax 1mg #60. The prescriptions written by Dr. Argotte from March 2011 until June of 2011 were concerning. There were prescriptions without the name of the patient but signed in the chart from Dr. Argotte. From March until June, the patient requested more medications, denied use of cocaine, failed a urine drug test once by not having Percocet in the urine when prescribed and failed another urine drug test for not having Xanax present in the urine when it was prescribed, used more Xanax than prescribed and did not have any of the testing or referrals done as ordered. In July, August and September of 2011 Dr. Greenlaw and then Dr. Dehaven saw the patient. There are concerning prescription copies that appear without a name but signed by the physician. The patient was now receiving Tylox, Oxycodone 15mg, Klonopin 1mg and Ambien 10mg. In September she failed another urine drug test by having medication not prescribed for her in the urine; hydrocodone and the Klonopin was not in the urine but prescribed. On this same visit she requested additional doses of medication for anxiety. 10/10/11 Dr. Wilson issued prescriptions for the patient for the first time. There was no note from Dr. Wilson. A note written on the "Miscellaneous Patient Information" form for that date appears to be written by a staff member. Dr. Wilson issued the following prescriptions to the patient: Tylox 5mg #120, Oxycodone 15mg #120, Ambien 10mg #30 and Klonopin .5mg to take 1/2 tab #15. 10/31/11 the patient returned and a note written by Dr. Wilson

reported her to be complaining of a sore throat, she was satisfied with her current med regimen; he would write for a Z-pack and continue other meds. The urine drug test was negative for the prescribed Klonopin. He issued oxycodone 15mg #120, Tylox 5/500 #120, Ambien 10mg #30 and Klonopin 1mg #60. He issued these prescriptions within 21 days from the previous prescriptions without explanation. 11/28/11 The patient presented for follow up; Dr. Wilson made a note that the patient was satisfied with her current regimen and continue to write for the same medications. 12/12/11 The patient presented again early for an appointment but at this appointment stated on 11/30/11 her medications were stolen. A statement written by the patient on the form titled, "Miscellaneous Patient Information" and dated 12/12 stated she had arrived home from work on 11/30/11 and was met by social services and the police. She was told they received a complaint that she was selling her pain medications. They requested to see her medications and she learned at that time that all of her oxycodone 15mg was gone (filled #120 on 11/28/11) and #68 of her Tylox was remaining from the #120 she filled on 11/28/11. She wrote that this appeared to be an "obvious set up" from the neighbors who were in a property dispute with her. She also reported that she went to the hospital the next day and took a drug test to prove she had been taking her medications. Dr. Wilson's plan was to have a pill count and issued prescriptions for the same medications. There was no documentation that the patient went for the urine drug test as she claimed. 1/3/12 At this follow up visit Dr. Wilson notes the patient to be complaining of increased pain due to cold weather and he plans to increase her oxycodone 15mg by one. He issued the prescriptions for: Oxycodone 15mg #150, Tylox #120, Klonopin 1mg #60 and Ambien 10mg #30. The next two follow up visits appear to have the dates altered. There are prescriptions written for 2/20/12 but a 2 is written over a 1. These prescriptions appear to be written on 1/26/12 but were clearly altered to be 2/20/12. The record contains a note written by Dr. Wilson on 2/20/12 that states the patient was satisfied with her current regimen and he issued the same prescriptions. These are the prescriptions that have the 2 written over the 1 on the date. There is an unsigned "Follow up Triage" note that indicates the current medical regimen will continue. There is a prescription issued by Dr. Wilson for blood pressure medication with what appears to be written 1/20/12 or 1/26/12; this date has been altered and there are no notes corresponding to either date. There is no documentation for a March visit but there are prescription copies in the record for 3/8/12. The 8 on the prescriptions appears to have been written over the top of another number. The prescriptions were: Lisinopril 5mg # 30, oxycodone 15mg #150, Ambien 10mg #30 and Percocet 10/325 #120. 4/5/12 Dr. Wilson makes a note that the patient is without complaint and he will decrease the oxycodone by one. The prescriptions were issued for Ambien 10mg #30, Klonopin 1mg #60, Oxycodone 15mg #120 and Percocet 10/325 #120. 5/15/12 a follow up triage form is used but not signed by anyone; this form indicates the current medical regimen will continue. There is a note by Dr. Wilson that reports the patient was without complaint and he will write for the same medications. He issued the same prescriptions as the preceding month.

DIAGNOSIS-Below minimum standards.

The patient did have a diagnosis that may cause pain but did not warrant the medications prescribed. Dr. Wilson never appeared to render a diagnosis. There was no use of the acceptable methods of establishing a patient diagnosis such as a physical examination, use of additional laboratory and radiographic studies. Dr. Wilson never requested any other testing or studies. Incidentally, Dr. Wilson also prescribed blood pressure medications to this patient without the proper standards being taken.

TREATMENT- Below minimum standards.

The patient had records that described prior concerns about the patient displaying substance abuse behaviors; there was no documentation that these records were reviewed by Dr. Wilson. It never appeared that Dr. Wilson examined the patient. There was no follow up on referrals or diagnostic studies requested by other physicians at the same facility prior to Dr. Wilson's arrival. The patient continued to be prescribed high risk medications regardless of her urine drug test results. The use of controlled substances did not appear to be monitored. There was no KASPER data, no follow up on abnormal urine drug screens. There was no explanation for the increase in medications from Tylox 5mg to Percocet 10/325. There were no other therapies used to treat this patient.

RECORDS- Below minimum standards.

The chart contained numerous forms that were filled out in pencil, forms had conflicting date/years on them, the controlled substance prescriptions were not written to standard and many did not have the name of the patient written on the prescription itself. None of the controlled substance prescriptions had the address of the patient written on the prescription. There were prescriptions that were signed but the left blank. There are prescriptions that appear to have the dates altered. There is no mention of KASPER data being obtained except when under the care of Dr. Argotte.

OVERALL OPINION- Below minimum standards. Grossly incompetent, grossly ignorant and grossly incomp.

Did Dr. Wilson sign prescriptions in advance? The prescriptions written in January and February appeared to be in his handwriting but they were obviously altered. Did the patient who was also an employee alter the existing record? The KASPER data obtained for the dates of the patient prescriptions with Dr. Wilson for the consultant to review clearly indicate conflicting prescriptions when compared to the chart. Had a KASPER report been obtained and reviewed by Dr. Wilson he could have stopped the behavior. It appears he did not monitor the patient in any way regarding these high risk medications. The one time he planned for a pill count it never was mentioned thereafter. Another concern is that he prescribed controlled substance to his fellow employee. Prescribing to an employee or fellow employee constitutes unethical behavior. Dr. Wilson prescribed high risk medications that most probably were being diverted and he was completely negligent in taking the proper precautions to prevent such behaviors. In summary, this patient was prescribed medications that were excessive and Dr. Wilson's behavior was unethical and grossly negligent.

KASPER data for this patient does not correspond to the prescription copies that were in the record. Prescriptions were filled on 10/10/11, 10/31/11, 11/02/11, 11/22/11, 11/28/11, 12/12/11, 1/3/12, 1/26/12, 2/20/12, 3/12/12, 4/13/12. This patient was using 3 different pharmacies and her husband was also a patient of Dr. Wilson's receiving similar medications.

12 [REDACTED] (Husband of employee [REDACTED]) Presented to facility 4/20/11 referred by his spouse who was an employee and a patient of the facility. He complained of lower back pain that originated after a motor vehicle accident in either 2003 or 2004. He provided an MRI report from Florida dated 2/12/09 which reported bulging of the annulus fibrosus at L4-5 and L5-S1 and partial dehydration of the L4-5 disc. He reported having physical therapy in 2004 which did not help. He did not have any other therapies or consultations.

Pt acknowledged he "borrowed" his mother's Percocet. His pharmacy printout indicated he had been prescribed hydrocodone and filled this on 3/29/11. His initial urine drug test was confirmed positive for morphine sulfate, hydrocodone and oxycodone/oxymorphone. Dr. Argotte prescribed Lorcet 10/650 #120 and ibuprofen 800 mg #90. He was also given orders to be evaluated by physical therapy and psychiatry. He presents again on 5/1/11 and reports the Lorcet is not helping but he did not want more pain medication but needed something for sleep, he was unemployed but was able to cut grass and performs weight lifting exercises. An MRI of the spine was ordered on this visit. He was issued Ambien 10mg #30, Lorcet 10mg #135 which was 11 days from the last RX, and ibuprofen. The chart follow up notes are confusing as to dates. There is a Calloway lab record with the date of a urine specimen collected on 5/11/11; there is no other record found in the chart that the patient was seen on that date. The next visit of 6/1/11 noted pt did not have the MRI studies done as ordered, the Lorcet was decreased to #120 and other medications continued. 7/20/11 is the next visit, he complained the pain was not controlled by the medication and he requests breakthrough medications and something to treat his anxiety. Dr. Greenlaw is now taking care of him and again MRI studies are ordered, he is issued Ultram 50mg #120, Lorcet 1/65 #120 and ibuprofen. On 8/17/11 he is now seen by Dr. Dehaven and the patient reports meds are not working at all. He is issued Percocet 7.5/325 #60, oxycodone 15mg #60, Percocet 10/325 #120 and Ambien 10mg #30. There is no note from the physician. The same prescriptions were issued for 9/26/11 by Dr. Dehaven. 10/24/11 Dr. Wilson sees the patient for the first time. A note made by a staff member indicates meds are working great for the patient but he has had "several spells with groin and side pain...treated by urologist previously, no conclusive findings". Dr. Wilson makes a note that the patient requests the Percocet be discontinued because of expense and is asking for an increase in the oxy 15 to #155. Dr. Wilson writes his plan is to discontinue the Percocet and increase the oxycodone 15 to #155, continue Ambien he makes a note that the patient requests weaning off opioids after? (Cannot read the word). Dr. Wilson did not do as he planned; he issued the following prescriptions for the patient: Percocet 10/325 #120, oxycodone 15mg #60 and Ambien 10mg #30. He also wrote an order for the patient to have an MRI without contrast of the c-spine. A urine drug test was performed on this visit and was noted to be positive for hydrocodone and oxycodone. A note on the lab form stated patient took hydrocodone from an old script. There are no visit notes for 11/14/11 however a urine drug test was positive for alcohol in addition to opiates and oxycodone. 12/5/11 he returned and Dr. Wilson makes a note that the patient was satisfied with the current regimen and plans to continue same. On this visit he is issued the following prescriptions: oxycodone 15mg #150 and Ambien 10mg #30. There is no discussion

of the changes made. 1/16/12 Dr. Wilson makes a note that the patient is satisfied with his current regimen, had a head and chest cold and pt requested an antibiotic. He wrote that he would continue the same meds and give a Z-pack. The prescriptions issued were not the same as the previous month and he was issued the following prescriptions: Percocet 10/325 #60, oxycodone 15mg #150, Ambien 10mg #30 and a Z-pack. 2/13/12 Dr. Wilson makes a note that the patients was without complaints and continue same meds. A note written by a staff member on a form titled, "Follow-Up Triage" notes the patient went to the urologist who prescribed him Opana but the notation stated the patient did not fill the Opana. Dr. Wilson issued the same prescriptions as the preceding month. 3/26/12 Dr. Wilson makes a note that the patient was without complaints and write for the same meds. However, he issued the same medications but increased the Percocet 10/325 to #90, oxycodone 15mg remained #150 and the Ambien was #30. There was no explanation for the change. 5/21/12 is the last record for the patient. A follow up triage note is not completed and not signed. Dr. Wilson makes a note that the patient is satisfied with the current regimen and continue same meds. Again, he issues the prescription of Percocet with an increase now to #120 and the oxycodone 15mg remains #120.

DIAGNOSIS & TREATMENT- Both are below minimum standards.

Dr. Wilson never renders a diagnosis. The diagnosis indicated by the MRI study from 2009 does not justify the medications prescribed for this patient. The MRI findings are essentially normal and do not suggest severe, chronic back pain. There is no indication that Dr. Wilson ever examined the patient; no initial or follow up examinations. When he makes a note that the patient would like to wean off opioids he does not demonstrate any action toward that goal. In fact, he increases the high risk opioid medication for the patient. There was never any follow up on the abnormal urine drug tests, requests for imaging studies or other referrals. There were no other treatments or adjuncts used. There were no precautions regarding the use of the high risk medications prescribed. There were no KASPER reports noted. The visit history was not clear. It appeared the patient presented for an appointment and failed a urine drug test but there was no documentation or follow up for these results.

RECORDS- Below minimum standards.

Many of the forms were not signed by the patient or a staff member. Many of the forms had conflicting dates. The controlled substance prescriptions were not written to standard. There was no working diagnosis. The follow up notes were inadequate. The only examination was the history and physical performed by Dr. Argotte.

OVERALL OPINION- Below minimum standards. Gross ignorance, negligence and incompetence.

Dr. Wilson prescribed excessive amounts and high risk medications to a patient without a diagnosis that justified the use of these medications. He continued to prescribe to this patient who demonstrated aberrant behaviors. He ignored the patients request to stop opioid medications. He did not appear to have any plan other than to continue the same

medications yet he increased them repeatedly. There was no monitoring of this patient and his controlled substance prescriptions. A KASPER report may have alerted Dr. Wilson to possible prescription fraud.

KASPER data does not match the prescription history in the chart. There are copies of prescriptions in the chart for 10/24/11, 12/5/11, 1/16/12, 2/13/12, 3/5/12 and 5/21/12. The KASPER data indicates that prescriptions were also filled for 11/14/11, 12/27/11, 3/5/12 and 4/16/12 in addition but there are no records in the patients' chart that correspond to these prescriptions.

(The patients spouse, an employee and patient of the facility, also had suspicious prescriptions in her chart as well as concerning KASPER data.)

13. [REDACTED] This patient was treated at Commonwealth Quality Healthcare by 4 physicians prior to Dr. Wilson. There was no history and physical under the designated "History /Physical" tab in the chart. The section of the chart labeled, "Progress Notes" appears to contain the only history and physical examination of the patient and this was conducted by Dr. Argotte on 3/7/11. The patient had a long history of chronic pain with initial traumatic injuries as a child; shoulder and clavicle fractures. IN 1991 he sustained injuries to his lower back and neck. He reported that he had right carpal tunnel disorder but refused surgery. Additionally he complained of severe bilateral knee pain and was going to have a total knee replacement. He reportedly had prior arthroscopic knee surgeries. He had psychiatric issues of anxiety and depression and had previously been under a psychiatrist care in 2010. Diagnostic studies included in the chart included: Whole body bone scan of 10/15/09 which was positive for prior rib fractures, and knee disease; MRI of the lumbar spine 2/1/2010 positive for mild to moderate L4-5 spinal stenosis as a result of disc bulging, osteophytes and congenitally short pedicles and bulging of the disc at L5-S1; MRI of the cervical spine on 2/1/2010 C5-6 and C6-7 disc bulging with bilateral and neural foraminal encroachment and hypertrophic facet joint change; radiographs of the knees 6/9/11 demonstrated moderately advanced degenerative disease of the right knee and mild on the left; MRI of the right knee demonstrated a bone contusion of the medial tibial plateau and an incomplete tear of the anterior cruciate ligament; the left knee had moderate degenerative changes and an MRI of the left ankle on 12/01/2010 demonstrated severe degenerative changes. His plan of care at that time included continuation of current medications which were oxycodone 30mg bid and oxycodone 15mg bid for breakthrough pain, soma 350 for muscle spasms, elavil 10mg at bedtime, referral to physical therapy and attempts to obtain prior psychiatric records. The patient had a urine drug test on this visit and was positive for marijuana and he indicated he would stop. He was diagnosed with chronic low back pain with spinal stenosis, cervical disc bulging with foraminal stenosis and facet hypertrophy and severe osteoarthritis of the knees needing a right total knee replacement. Dr. Argotte planned to wean the patient off oxycodone and change to Percocet, add an arthritis medication and address depression and anxiety. The patient had Valium in the urine at the June visit which was not prescribed. At the July, August and September visits his care was provided by Dr. Greenlaw and Dr. Dehaven. His medications now included Celexa 20mg, Xanax 1mg #90, Ultram # 90, Neurontin 800mg #90, Norflex 100mg #30 and oxycodone 30mg #120. 10/10/11 Dr. Wilson initiates care of the patient. A note written on the "Miscellaneous Patient Information" sheet by a staff member lists the medications he is taking and that he will have a total knee replacement. He is issued the same prescriptions of celexa 20mg, oxycodone 30mg #120, Xanax 1mg #90, Neurontin 800mg #90, Norflex 100mg #30, and Ultram 50mg #90. 11/7/11 Pt returned for follow up, Dr. Wilson makes a note that the patient was scheduled for knee replacement surgery in 8 days and he would increase pain medications by increasing the oxycodone 30mg to #150 and adding oxycodone 15mg #60. He gave the patient the increased medications as planned and continued all other medications. 12/5/11 he returned for follow up after having his knee surgery. The patient was having increased pain. Dr. Wilson issued all the same medications as the

previous visit except he increased the oxycodone 15 mg to #90. 1/3/12 the patient was issued the same prescriptions as the preceding month but the oxycodone 15mg was reduced to #60. There was no note or documentation that correlates to this date. 2/9/12 There are prescriptions issued to the patient for this date of oxycodone 15mg #30, Ultram 50mg #45, oxycodone 30mg #75, Neurontin 800mg #45, xanax 1mg #45 and celexa 20mg #15. 2/28/12 Dr. Wilson makes a note that the patient was doing well and he would decrease the oxycodone 30mg by one and increase the oxycodone by one and continue all other medications. 3/27/12 Dr. Wilson makes a note that the patient was doing well, warned about bad lab results and issued all medications the same except for a decrease in Xanax by 1 pill. While he makes a note of the changes planned, he did not decrease the Xanax and the oxycodone 15mg and oxycodone 30mg were issued with quantity of #90 and #120. 4/23/12 The patient returned for follow up and a note written by "Whitney" on the "Miscellaneous Patient Information" sheet states the patient would need to find another clinic because he could not function on the amount of medication he was getting. He could not handle the decrease in oxycodone. The note further states, "Pt will not ever be taken back as a patient due to his constant drug seeking behavior". At the bottom of this same paper it appears Dr. Wilson made a note, "oxy 30/60, 15/120, will be no more than this". However, the patient was issued prescriptions that do not correspond to his plan. He was issued the following prescriptions: oxycodone 15mg #90, oxycodone 30mg #120, Xanax 1mg #90, celexa 20mg #30, Ultram 50g #90, Neurontin 800mg #90 and Norflex 100mg #30. 5/21/12 a follow up triage note states the patient was adjusting to his medications. Dr. Wilson makes a note that the patient is complaining of persistent pain and he will decrease the oxy 30 by 1 and make other adjustments next month by decreasing the oxycodone 30 mg and increasing the oxycodone 15mg. The patient was issued the following prescriptions: oxycodone 30mg #90, oxycodone 15mg #90, celexa 20mg #32, Neurontin 800mg #90, Xanax 1mg #90, Norflex 100mg #32 and Ultram 50mg #90.

DIAGNOSIS- Within minimum standards.

This patient had a diagnosis that justified the use of controlled substances to treat his pain. There were never any documentations that Dr. Wilson examined the patient or rendered a diagnosis.

TREATMENT- Within minimum standards.

The patient had regular follow up visits to evaluate his need for controlled substances. He had urine drug testing. There were KASPER tracking numbers occasionally noted in the chart. Combining Xanax with the opioids in the doses prescribed was concerning.

RECORDS- Below minimum standards.

There is one physical examination in the record. There was no documentation that Dr. Wilson ever examined the patient. The follow up notes were not acceptable. The controlled substance prescriptions were not written to standard. There were no records of the hospitalization describing the total knee replacement; no physical therapy notes.

OVERALL OPINION-Below minimum standards.

The combination of high dose opioid medication with large quantities of benzodiazepines is dangerous; Dr. Wilson prescribes this combination as though there are no consequences. There were no other treatment options offered for this patient. There were no referrals to psychiatry or other specialists. The fact that no documentation was found to show that Dr. Wilson examined the patient is concerning.

14. [REDACTED] (Former owner of Commonwealth Quality Healthcare). Pt complained of chronic pain that began after having a motor cycle accident in 2002 and ATV accident in 2004. The chart lists several dates for these accidents and it is unclear when they actually occurred. She reported that she sustained a pelvic and clavicle fracture. She complained of chronic lower back, neck pain and headaches. The only physical examination documented in the chart is per Dr. Argotte on 3/1/11. diagnostic studies on the chart included an MRI of the lumbar spine dated 8/19/2011 from Missouri which was positive for a posterior broad based disc bulge and a left paracentral protrusion causing stenosis at L4-5 and facet hypertrophy at L5-S1; an MRI of the cervical spine dated 8/3/2009 positive for foraminal narrowing at C3-4 and C4-5. (This patient had radiograph reports from Tampa Florida, Missouri and Kentucky in her chart). She reported she was taking oxycodone 15mg #120, soma 350mg qd prn, Xanax 1 mg, valium 5mg qd and Fioricet. She denied having physical therapy. Dr. Argotte wrote orders for her to be evaluated by psychiatry for anxiety, depression and chronic pain and physical therapy for muscle strengthening and increasing range of motion. He issued the following prescriptions: oxycodone 15mg #120, Xanax 1mg #30, Imitrex and flonase. Over the next several months Dr. Argotte attempted adjunctive therapies such as ibuprofen and continued the same medications. There were no patient visits for the next several months because the patient had taken a job in Oklahoma. 11/10/11 Dr. Wilson issued prescriptions for the patient. A note written for this date states there are no copies of these prescriptions in the chart because they accidentally got shredded. The prescriptions were written for the patient because she was in Oklahoma working. 11/22/11 Dr. Wilson made a note in the chart that the patient complained of chronic pelvic pain due to a 4-wheeler accident, continue oxycodone 15mg #120. A notation on the same form states patient is out of town working and she stopped by to get script, will not fill until due. He issued the following prescriptions to the patient: oxycodone 15mg #120 and Xanax 1mg #15. There is a follow up triage note that is confusing with date 12/08/11 stating no side effects from medications, continue same plan and no changes; this note is signed by Andrea Kennedy. There are no prescriptions with the 12/9/11 date on them. 12/14/11 Dr. Wilson issues prescriptions for oxycodone 15mg #120 and Xanax 1mg #30. It appears the patient was not seen but had prescriptions sent by mail. 1/12/12 note written on the "Miscellaneous Patient Information" form states, [REDACTED] is still in Oka working! Meds working well! There is no signature on this form and does not appear to be in Dr. Wilson's handwriting. 2/8/12 Prescriptions were issued for oxycodone 15mg #120 and Xanax 1mg #30. It does not appear that the patient was seen by Dr. Wilson on this day. 3/5/12 Dr. Wilson makes a note that the patient is satisfied with her current regimen and the plan is to continue the same medications. He issues the same prescriptions as the preceding month. 4/5/12 Dr. Wilson writes the same note as the preceding month that the patient was satisfied with her regimen; he would continue the same prescriptions and issues the same prescriptions. However, on 4/5/12 the patient was not seen and there were notes initialed by "JC", that the "patient could not get a flight but will be here in the morning". So it appears the patient was not seen on 4/5/12 by Dr. Wilson but he wrote a note indicating he had seen her as noted above. 5/3/12 Dr. Wilson makes a note, "pt without

complaints, continue same meds". However, he issued both prescriptions with increased quantities and no explanation. Prescriptions were for oxycodone 15mg #140 and Xanax 1mg #35.

DIAGNOSIS – Below minimum standards.

There appeared to be justification for controlled substances per the imaging studies. However, there were no physical examination notes per Dr. Wilson, no additional testing obtained.

TREATMENT- Below minimum standards.

There were no other treatment options or modalities for this patient. There was no follow up on the referrals to psychiatry or physical therapy. There were indications that the patient was continued on high risk medication without being evaluated. There was no explanation for the increase in the benzodiazepine. This patient was not being monitored for her controlled substance use. She was not evaluated regularly.

RECORDS- Below minimum standards.

There were no physical examination notes or adequate progress notes by Dr. Wilson. The record appears to indicate he wrote notes when the patient was not present. A KASPER report appeared to have been requested twice. The controlled substance prescriptions were not written to the required standard.

OVERALL OPINION- Below minimum standards. Gross negligence.

It is grossly negligent to prescribe controlled substances for a patient that you have not met or examined. The combination of high dose opioid and benzodiazepine is unsafe.

15. [REDACTED] (This patient is an employee of Commonwealth Quality Healthcare). She complained of chronic lower back pain that radiated down her legs for approximately 2 yrs. The pain began after caring for her husband by lifting etc. She had prior treatment by Dr. Azmat and Mary Beth Calor, DO. Dr. Calor also treated the patient's hypertension and thyroid disorder. There were few records in the chart and of the records they are in a disheveled fashion with many pages being blank. A copy of an MRI of the lumbar spine report appears in the record dated 10/27/2008. It is positive for a mild posterior disk bulge at L3-4, probable L3-4 radial tear, bilateral facet hypertrophy and right neural foraminal stenosis, a midline disk herniation at L4-5 with bilateral facet hypertrophy and moderate to severe impingement upon the right lateral recess and mild disk bulging at L5-S1. The only documented physical examination was per Dr. Argotte on 4/6/11. On 4/4/11 the chart contains a document that appears to be completed by the patient. This form is one that is utilized by the medical provider to ascertain information about the pain complaint along with vital signs. Dr. Argotte ordered the patient to have MRI studies of her cervical, thoracic and lumbar spine, physical therapy evaluation for muscle strengthening and improve range of motion; and a psychiatric evaluation for anxiety, depression and chronic pain. He issued prescriptions for Percocet 10/650 #120, Neurontin 200mg #60 and ibuprofen 800mg #90. A urine drug test performed on 4/6/11 was negative for any substances. A notation dated 6/6/11 per Dr. Argotte states he will no longer see the patient for pain management. There is no explanation. A urine drug test dated 6/27/11 is noted in the record and positive only for hydrocodone; at this time the patient was being treated with Percocet. 11/23/11 Dr. Wilson makes his first note on the patient. This note appears to be with some corrections or white out marks, it is unclear what happened to the note. In his note he writes the patient complains of neck and lower back pain, the present MRI's were verified but were greater than 5 years old and his plan was to get new MRI studies of the spine. He also writes that his plan will be for Tylox 5/500 bid, Percocet 10/325 qid and ox 10 one daily. The date on this note appears to be altered. The KASPER data obtained by the consultant indicates for this date the patient filled oxycodone 5/500#60, phentermine 37.5mg #60, and Endocet 10/325 #150. The chart contains copies of prescriptions that do not match the notation date. Also included in the chart are copies of prescriptions dated 10/18/11 for Percocet 10/325 #150, Adipex 37.4mg #60, Neurontin 100mg #120 and Norvasc 10mg #30. There was one prescription copy dated 11/18/11 for Tylox 5/500 #60 and has #3 of 4 at the top; the other copies are not found in the record. There were no other prescription copies for this date. The next note appears to be written on 12/23/11 but this date also looks to be altered somewhat. Dr. Wilson notes something about Calloway lab, it is unclear whether the lab was okay or not, the patient was requesting Percocet in place of Lorcet and his plan was to add Percocet 10/325 #120. (He had not prescribed Lorcet for the patient according to the chart). A follow up triage note dated 12/22/11 is in the chart but does not have the patients name or any other signature. There are no copies of prescriptions for either of these dates in the chart. 1/11/12 again there is a follow up triage note that does not have the patients name or other signatures; it appears in the same handwriting and appears to be the patients' handwriting. Dr. Wilson has a note for this date but this date too has been

altered by writing over it. He writes the patient is satisfied with her current regimen. The remainder of his note is not legible. It appeared to state something about a weight loss drug and he planned to write for the same medications. There are no copies of prescriptions in the chart from this date. On 2/9/12 a follow up triage form is in the chart but does not have any name or identification. There are no notes from Dr. Wilson.

DIAGNOSIS- Below minimum standards.

MRI studies indicate the patient had a condition which could cause pain. However, Dr. Wilson never rendered a diagnosis. There was no documentation that he ever examined the patient. There did not appear to be any attempt to obtain previously ordered MRI studies.

TREATMENT- Below minimum standards.

The use of multiple controlled substances to treat this patient's pain was inappropriate. There was no follow up on previously ordered diagnostic studies by other physicians nor Dr. Wilson. There was only one KASPER data notation. The urine drug testing was not as it should have been and these results were never addressed. There were no other treatments or therapies ordered. A treatment plan was not followed.

RECORDS- Below minimum standards.

There were no physical examinations, no working diagnoses. The notes were grossly inadequate. The chart contained forms/documents that were either blank, not marked appropriately with identifiers or not signed by anyone. It was obvious often the patient who was also an employee filled out some of her follow up forms. There were obvious discrepancies in dates on both follow up forms and prescriptions. It appeared Dr. Wilson tried to make his notes match his prescribing upon 2 occasions after the fact.

OVERALL OPINION- Below minimum standards. Grossly negligent.

It is unethical to prescribe controlled substances for an employee/fellow employee. The treatment was inappropriate. There was no examination or medical diagnosis rendered.

16. [REDACTED] This patient had lower back and left lower extremity pain that began approximately 17yrs prior, following a crushing injury by a heavy piece of equipment called a dozer. He also complained of pain in his neck and shoulders for approximately 10yrs following a motor vehicle accident. He had been to a physician for pain management but that physician was "shut down" according to the patient. He presented to Commonwealth Quality Healthcare in 3/11. The mainstay of his pain management treatment had been with hydrocodone, soma, Xanax and tramadol. Dr. Argotte initially evaluated the patient conducting a history and physical and found him to be reliable. He discontinued the soma; continued Xanax at 1mg every 12 hrs as needed, increased his tramadol and resumed hydrocodone, (Lorcet 10/650 #120). He ordered physical therapy, a left shoulder x-ray, MRI of the cervical and lumbar spine and psychological evaluation. He was also to return to his internist/family physician for blood pressure and diabetes management. An existing MRI report of the lumbar spine was obtained dated 9/12/05 and results indicated severe L4-5 facet degenerative disease causing bilateral foraminal narrowing and an anterolisthesis of L4 on L5 and a large left L5-S1 paracentral disc extrusion affecting the left S1 nerve root with degenerative disc disease also at that level. An MRI of the left lower extremity for the same date indicated degenerative changes involving the third and fourth MTP joints consistent with osteochondrosis. He returned the following month doing well with medications; Dr. Argotte began Elavil 25mg at bedtime and Neurontin 600mg every 24hrs and continued the other medications for pain. It was also noted on this visit Dr. Argotte prescribed blood pressure medications. The patient went for the psychological evaluation on 4/26/11 and the resulting report sent to Dr. Argotte concluded the patient was determined not to pose any risk to self or others, was currently doing okay managing pain and stress and the patient was not interested in receiving any services at that time. The patient also went for the physical therapy evaluation on 3/30/11 and a treatment plan was developed to improve range of motion and reduce pain. The patient had the MRI of the lumbar spine performed on 8/30/11 and was noted for moderate degenerative disc disease, neural foraminal narrowing, grade 1 spondylolisthesis at L4-5 and a large left and central disc herniation at L5-S1. Dr. Greenlaw began care of the patient in July 2011, medications continued except he added oxycodone 15mg instead of the Lorcet. Neurontin had been discontinued because it gave him a rash but was prescribed again at a lower dose. 10/26/11 Dr. Wilson begins care of the patient. He made the following notes; patient was having breakthrough pain and tramadol wasn't helping, Calloway lab was ok, Kasper was ok, increase the oxy to 30mg to tid and tramadol tid. He issued the following prescriptions to the patient: Ultram 50mg #90, oxycodone 30mg #90 (the patient had been on oxycodone 15mg #100 the previous month from the previous physician), Xanax 1mg #60 and Elavil 25mg #30. 11/23/11 note per Dr. Wilson states the patient was satisfied with his current regimen and his plan was to continue the same medications. He issued the same prescriptions as the preceding month. There was a form that indicated attempts were made to phone the patient for a pill count but the phone was never answered. 12/22/11 Dr. Wilson makes a note that the patient was satisfied with the current regimen, plan was to continue same medications and Calloway "Ok'd by nurses". He issued the same prescriptions as the preceding month. 1/19/12

Follow up triage note by staff describes patient to be doing well on meds but needs new sleeping med. Urine drug testing demonstrated high levels of opiates but was never sent for confirmation after the patient was no longer being prescribed hydrocodone. Dr. Wilson makes a note that the patient was satisfied with his current regimen but Elavil was not helping with sleep and he would replace Elavil with Ambien. He was issued the same prescriptions except no Elavil which was replaced by the Ambien as planned; 10mg #30. 2/16/12 the follow up triage note reported the patient to be complaining of more shoulder pain in the previous weeks; a form titled, "FOLLOW-UP PATIENT" was completed by Kidd, RN. This appeared to be a physical examination form. Dr. Wilson makes a note that the patient was without complaints, he planned to decrease the oxy 30 and add oxy 15, the remainder of his note is not clear as to the meaning, "Plan: Leave last 30". He issued the following prescriptions to the patient: oxycodone 15mg #30, oxycodone 30mg #60, Ultram 50mg #90, Xanax 1mg #60 and Ambien 10mg #30. 3/15/12 patient returned for follow up and was reporting numbness in his right arm, Dr. Wilson makes a note that the patient was warned about a pill count, that he was complaining of shooting pain and tingling, plan was to continue the oxy 30 and increase the oxy 15 and add Neurontin 600mg #60 and continue all other medications. He issued the following prescriptions: oxycodone 15mg #90, oxycodone 30mg #30, Neurontin 600mg #60, tramadol 50mg #90, Xanax 1mg #60 and Ambien 10mg #30. 4/12/12 the patient returned and reported doing well. Dr. Wilson makes a note the patient was without complaints, plan was to replace the oxy 30 with Percocet 10 #90, continue all other medications and the following month to discontinue the tramadol. He issued the following prescriptions: oxycodone 15mg #90, Percocet 10/650 #90, tramadol 50mg #90, Xanax 1mg #60, Ambien 10mg #30 and Neurontin 600mg #60. 5/10/12 The follow up triage note per staff reports that patient without any new complains, Dr. Wilson makes a note that the patient was without complaints and plans to write the same medications. However, he issued prescriptions without the changes he planned from the previous month and with no change in directions but also increased the quantities of each. He issued the following prescriptions to the patient: oxycodone 15mg #105, Percocet 10/650 #105, tramadol 50mg #105, Xanax 1mg #70, Ambien 10mg #35 and Neurontin 600mg #70.

DIAGNOSIS- Below minimum.

There was no documentation that Dr. Wilson examined the patient as a means to make an evaluation and render a diagnosis. The patient clearly had lumbar pathology that could result in the pain he described. There was never any diagnosis of his shoulder and neck pain. There was never any diagnosis rendered regarding his left foot pain and study results. Dr. Wilson never documented a diagnosis of any kind.

TREATMENT- Below minimum.

The use of controlled substances as part of this patients overall treatment plan was appropriate. It is also concerning that the patient had a previous problem tolerating Neurontin at low doses yet it was prescribed again at a higher dose. Neurontin was

prescribing again in response to the patients shoulder complaints. When the patient complained of shoulder pain, numbness and tingling there did not appear to be any physical examination by Dr. Wilson. Dr. Argotte originally ordered a shoulder x-ray and a cervical MRI; there was neither documentation of follow up on those previously ordered studies or documentation of ordering any studies to evaluate the patients' complaints. The patient was evaluated by physical therapy when he saw Dr. Argotte. There were never any additional records or discussions regarding physical therapy following that initial evaluation. There were no other adjunctive therapies suggested such as interventional injections therapies. There were no other referrals made such as to the orthopedist or spine specialist. The only other prior adjunct used for the patient per documentation was a back brace. The patient did have urine drug testing and occasional KASPER data notations. When the patient had high levels of opiates in his urine drug screening it was never sent for confirmation.

RECORDS-Below minimum.

The records contained acceptable urine drug testing documentation. The controlled substance prescriptions were not written to standard. The record contained 2 radiograph reports on another patient. There were no physical examinations by Dr. Wilson documented. There was no working diagnosis. Most of the consents have the appropriate date and signing.

OVERALL OPINION- Below minimum standards. Gross ignorance and incompetence.

Dr. Wilson never examined the patient. Appropriate testing was not obtained. Dr. Wilson demonstrates a general "disconnect" in medical decision making. He planned to decrease medication and eliminate some medication but he did the opposite; he increased and added medications. The record indicates Dr. Wilson does not appear to use rational medical decision making based upon knowledge and understanding of how to utilize these medications.

17. [REDACTED] Initial visit appears to be on 8/2/11. The patient reported he had pain in his lower back as the result of two motor vehicle accidents. He complained of constant pain that radiated down both legs. By his report this was his first visit to a pain treatment facility. He denied medications but did report he took pills from his wife and the staff notes reads, "both were white". He reported that he was disabled and unemployed and could not read or write. There was no physician history and physical; the physician providing care at this time was Dr. Dehaven. A copy of an MRI of the thoracic spine dated 9/30/2009 was in the chart. The results indicated degenerative changes in the thoracic spine with mild bilateral recess narrowing at T11-12 and minimal levoscoliosis of approximately 6 degrees. The patient was given a diagnosis (in what appears to be the handwriting of employee Yavonda Lazar) of "deg changes Tspine, scoliosis at mid Thoracic Area '09". The patient was issued the following prescriptions: Valium 5mg #30, Lorcet 10/650 #90 and Neurontin 400mg #90. The patient returned on 8/30/11. There is a note written by "Ya" on the "Miscellaneous Patient Information" form that states the patient was "informed he will be on strict probation. States he can't read or write and his wife filled out his paperwork and he wasn't clear on rules, promises he will follow the rules and comply". He further reported "got meds mixed up on accident" with his wife's meds. This note is signed by Dr. Dehaven. The record contained a urine drug test result which was positive for oxycodone; but this test result belonged to his father, [REDACTED] date of birth [REDACTED]. He was issued prescriptions for Valium 5mg #30, Hydrocodone 10/325 #90 and Neurontin 400mg #90. He returned on 9/28/11 and a note written on the "Miscellaneous Patient Information" form was in the handwriting of employee Yavonda Lazar, states patient had been under more stress and was taking an extra pain pill at night, Lorcet 10/650 was issued and increased to #120, the valium and Neurontin remained the same. A urine drug test for this date had Klonopin present per confirmation but this was not prescribed. The chart contains a note that the urine test results were ok. 10/27/11 Dr. Wilson initiates care, makes a note that the patient requests increase in Valium, pain levels ok and he will write prescriptions. There is also a triage note written by employees for the same date. A urine drug test on this date was noted not to pass one component of the validity screen; result of out of range. Dr. Wilson issued the following prescriptions and each had an increase in quantity with no change in directions: Lorcet 10/650 #128, Valium 5mg #64, and Neurontin 400mg #96. 11/28/11 The patient returned for follow up said medications were working; Dr. Wilson makes a note that the patient was satisfied with the current regimen and he planned to write the same medication. A urine drug screen for this date was positive for oxymorphone verified per confirmation which indicated either use of oxycodone that had completely metabolized to oxymorphone or oxymorphone use. He issued the following prescriptions and again with quantities that were not explained: Lorcet 10/650 #124, Valium 5mg #62 and Neurontin 400mg #93. In mid November, a pill count had been attempted but was unsuccessful due to inability to contact the patient. 12/27/11 A urine drug test again resulted positive for oxymorphone. A follow up triage note by Kidd, RN reports patient as not having any idea why his test was positive for "oxy". Dr. Wilson makes a note that the Calloway lab was positive for oxymorphone, the patient was satisfied with his current regimen and he planned a pill count in 15 days for the Lorcet and other meds the same. He issued the same prescriptions as the previous month except the quantity of the Lorcet was

not #60. There was documentation in the chart for a pill count performed on 1/9/12 which appeared to be okay and on this date he was issued another prescription for #60 Lorcet. 1/23/12 He returned and stated his wife was prescribed oxycodone and she may have gotten it mixed up with his valium. Dr. Wilson makes a note that the patient was warned about "ox" in lab; patient was satisfied with current regimen and continues same meds. He issued the following prescriptions: Lorcet 10/650 #120, Valium 5mg #60 and Neurontin 400mg #90. 2/20/12 The patient was without complaint and the same medications were issued. 3/19/12 he returned for follow up and was complaining of more pain at when lying down at night, Dr. Wilson makes a note that the patient requested one more Lorcet, he would increase the Lorcet and continue other meds the same. He issued the same prescriptions with the exception of Lorcet 10/650 which now he increased the quantity to #150. 4/17/12 the patient reported his pain had decreased Dr. Wilson makes a note that patient was without complaints and write for same meds. The same prescriptions were issued. 5/14/12 the triage follow up note states the patient was asking for an increase in Valium for sleep at night. Dr. Wilson makes a note that the patient was complaining of insomnia, otherwise without complaints and plan is to write the meds the same. However, he issued all prescriptions with increases and adds a sleeping pill: Lorcet 10/650 #160, Valium 5mg #64, Ambien 10mg #32 and Neurontin 400mg #96.

DIAGNOSIS- Below minimum standard.

This patient did not have a diagnosis that warranted the pain medication prescribed. Dr. Wilson never rendered a diagnosis. There was no apparent physical examination from Dr. Wilson or anyone. There were no additional tests obtained in which to make a diagnosis.

TREATMENT- Below minimum standard.

This patient was treated with excessive amounts of acetaminophen in combination with his opiate medication. The amount of amount medication prescribed was excessive and not indicated. When he complained of any symptom he generally had all medications increased. When he complained of sleeping difficulty he was given not only a sleeping pill in addition to the benzodiazepine he was taking but increases in the benzodiazepine, opiate and Neurontin. There were no documented attempts to use adjunctive therapies or make any referrals. There were no psychological or psychiatric referrals. There were multiple problems with urine drug studies. Utilization of urine drug testing was problematic.

RECORDS- Below minimum standard.

There was NO history and physical. The follow up notes by the physician were inadequate. The chart contained lab results that belonged to his father. The controlled substance prescriptions were never written to the expected standard. There were frequent notations that KASPER data had been obtained. Urine drug testing was performed albeit with difficulty in utilizing the results. A pill count was performed.

OVERALL OPINION- Below minimum standard. Grossly negligent, incompetent and ignorant.

Dr. Wilson did not appear to assess the patient. He noted what the patient was requesting, i.e., another pain pill, and complied regardless of the risk or indication. The addition of multiple benzodiazepines in addition to the high dose opiate was very concerning.

18. [REDACTED] The initial visit appears to be 6/8/11 and was conducted by Dr. Argotte. The patient had chronic pain for many years with the onset beginning in 1991 with a reaching type of injury. He complained of pain in his neck radiating to his left shoulder, lower back pain radiating to both legs and muscle spasms. He reported being under the care of a Dr. Karel for pain management for approximately 7 years until "Health Dept closed him". Dr. Karel referred him to Southern Ohio Pain Management, he obtained care there for approximately 3 months and then that facility was closed down. The Southern Ohio Pain Management facility reopened but the patient reportedly became frustrated with continued appointment changes so he presented to Commonwealth Quality Healthcare for treatment. He reported prior treatment with epidural injections, physical therapy, and medications. His recent history was positive for peptic ulcer disease with recent stomach bleeding stomach. His history was positive for alcoholism; he obtained rehabilitation treatment and was sober at least for 20 years. He also reported prior problems with depression requiring treatment twice. He also reported being discharged from military duty for being unfit medically; the chart contained copies of these records. At the time of his evaluation with Dr. Argotte, his driver's license was suspended due to not having insurance. Physical examination was positive for abnormalities including muscle weakness in his right lower extremity. Diagnostic studies were ordered; physical therapy and psychological evaluations were ordered. Prior imaging studies were obtained dating from 1995 until 2008/9. The updated studies performed on 6/29/11 indicated the patient had lumbar degenerative disc disease with a posterior annular tear and a right paracentral disc herniation contacting the right S1 nerve root at L5-S1, thoracic facet hypertrophy at T8-11 with small central disc protrusions at T8-9 and T9-10, and cervical spondylosis, advanced at C4-5 and 5-6, with cord compression at C5-6 and stenosis. Dr. Argotte issued the following prescriptions: Percocet 10/325 #150, Ambien 10mg #30, Wellbutrin 75mg #60, Norflex 100mg #30 and Neurontin 100mg #60. When the patient returned for follow up, Dr. Argotte was no longer practicing at the facility. Reassessment forms for this follow up date of 7/7/11 were for the most part not completed. The office visit forms/notes were confusing for the next several months and it is not clear who actually made the treatment plans. The prescriptions were per Dr. Greenlaw and Dr. Dehaven. The 7/7/11 prescriptions were for oxycodone 15mg #120, Norflex 100mg #30, Neurontin 400mg #90 and a referral to an orthopedic surgeon was also written on the same date. Prescriptions the following month were for Percocet 10/650 #60, oxycodone 30mg #120, Xanax 2mg #60 and Neurontin 400mg #90. In September the same prescriptions were issued but now included Soma 350mg #30 and Nexium 40mg #30. In September the patient was called for a pill count and he stated he was in Ohio and would be in as soon as possible. Another phone note for September documents the patient phoning to report he went to the ER for unbearable pain. The 9/29/11 prescriptions were for all the previous medications except the Soma 350 was increased to #60 and the Percocet 10/650 was increased to #90. 10/26/11 Dr. Wilson begins to see the patient and makes a note that the Calloway lab was ok and he writes the letters MRI E; it is unclear but appears to be referring to the MRI reports; he notes the patient was without complaints but writes he will increase the Nexium by 5. The directions were to take 1 Nexium 40mg every 18 hrs. The triage follow up also notes the patient to being doing well and without complaints. Dr. Wilson issues the same prescriptions as the

preceding physician but increases the quantity of the Nexium to #45. 11/23/11 he returns for follow up, the follow up triage note indicates the patient is doing well, the right knee gives out and the patient thinks he may need to change the Percocet to oxy 10 or 15mg if possible. Dr. Wilson makes a note that the patient was satisfied with the current regimen, he planned to decrease the ox 30's to #90, replace the Percocet with ox 10's, add nortriptyline and continue other medications. He issued the following prescriptions: oxycodone 10mg #90, oxycodone 30mg #90, soma 350mg #60, Xanax 1mg #120, Nexium 40mg #45 and nortriptyline 25mg #90. There is documentation that a pill count was requested on 12/1/11; the patient was left a message to call back. On 12/19/11 the patient presented for a pill count; he was short several days of oxycodone 30mg and oxycodone 10mg. 12/22/11 he presented requesting medications to be adjusted and complained of his left knee giving out. Dr. Wilson makes notes that the Calloway lab was ok, the nortriptyline was no help, muscle spasms were diminishing, the ox's were weak and his plan was to discontinue the soma and nortriptyline and replace the oxycodone 10 with oxycodone 15mg and leave other meds the same. He also makes a note that the patient is "maxed on ox's". He issues the following prescriptions: oxycodone 15mg #90, oxycodone 30mg #90, Xanax 1mg #60 and Nexium 40mg #45. 1/23/12 he returns and describes increasing pain and increasing marital stress and divorce; Dr. Wilson makes notes that the patient requested more Xanax and he would grant this and requested more oxycodone 15mg but would deny this; he would leave other medications the same except also decrease the Nexium to #30. He issued the following prescriptions; oxycodone 15mg #90, Xanax 1mg #90, oxycodone 30mg #90 and Nexium 40mg #30. 2/20/12 he reports having increased pain because of decreased medications, Dr. Wilson notes the patient is satisfied with his current regimen, complains of an upper respiratory infection and requests a Z-pack, plan is to decrease the oxy 30 by 1 and increase the oxy 15 by 1 and add a Z-pack. The following prescriptions were issued: oxycodone 15mg #120, oxycodone 30mg #609, Xanax 1mg #90, Nexium 40mg #30 and a Z-pack. 3/19/12 Dr. Wilson makes notes the complained of being dizzy, cold and clammy and bad nausea approximately 2-3 weeks prior to the appointment and writes, "suggestive of MI patient. Pt also complains of ED". Plan was to advise the patient to be "evaluated for probable MI and plateau meds". Dr. Wilson issued the same prescriptions as the preceding month. The urine drug test for this date was positive for morphine. This was addressed on the follow up visit when the patient was questioned and reported taking one of his father's meds by "accident", he said he would bring proof that his father took that medication. On the follow up visit of 4/16/12 Dr. Wilson notes the patient took his father's morphine by mistake and writes, "I give second chances". His plan was to replace the oxy 30 with Percocet 10/650 #120 and leave the other medications the same. He issued the prescriptions as follows: oxycodone 15mg #120, Percocet 10/650 #120, Xanax 1mg #90 and Nexium 40mg #30. The urine test on this day was positive for amphetamines; per confirmation it appeared to be adderall. There was a note on the front of the chart that stated "+methamphetamine", "no Calloway goes to Sue for dismissal".

DIAGNOSIS- Minimum standards.

There was a complete history and physical per Dr. Argotte and more than adequate diagnostic studies that justified the use of controlled substances. Again, concerning is the lack of documentation that Dr. Wilson examined or diagnosed the patient. He never gave any diagnoses.

TREATMENT- Below minimum standards.

The patient was never examined by Dr. Wilson. When the patient repeatedly complained about his knees Dr. Wilson never examined him. The record was clear that this patient was at higher risk for the use of controlled substances given his history of alcoholism and depression. This patient may have been most suited for long acting opioid medications; not multiple short acting medications. Further, the patient described being treated by what most probably was a pill mill in Ohio and when called for a pill count he was unable to come for the pill count because he was in Ohio. Records should have been obtained or at minimum a phone inquiry to learn if the patient was continuing to obtain pain medication from Ohio. The patient repeatedly complained of psychosocial stressors and was given increased doses of Xanax. He was never referred for supportive services such as a psychologist or psychiatrist after Dr. Argotte left. The previously requested referrals were never followed up on.

RECORDS- Within minimum.

There was an appropriate history and physical examination performed by Dr. Argotte. There diagnostic studies and multiple urine drug tests. Frequently there were tracking numbers for KASPER data. There were regular visits. Physician examinations were nonexistent after Dr. Argotte left. None of the controlled substance prescriptions were written to the required standard.

OVERALL OPINION- Below minimum standards. Gross ignorance, neglect and incompetence.

It is completely unacceptable to never examine the patient. The obvious indicators that the patient may have been treated prior at a pill mill was ignored. Dr. Wilson demonstrated a persistent "disconnect" in prescribing for this patient, his notes often did not correlate to the patient complaints. When the patient complained of persistent knee pain, there was no examination, no attempt to diagnose the problem.

19. [REDACTED] Presented to the facility on 7/27/11. He had been in a motor vehicle accident on 7/6/11. He was extradited from the vehicle initially evaluated at one hospital and transferred to another hospital. After 2 days he was discharged home with the diagnosis of a C2 avulsion fracture and a C5 fracture. The chart contains records from the hospital admission and included radiographs. The CT of the head and neck demonstrated scalp lacerations and an avulsion fracture of the C2 vertebral body and nondisplaced fractures of the left C5 pedicle and lamina with extension into the left C5 inferior articular facet and subluxation of the left C5-6 facet joint. An MRI of the cervical spine on 7/7/11 showed a C5-6 posterior central disc protrusion with annular tear and mild narrowing of the canal. Thoracic and lumbar studies were normal as were radiographs of the extremities. He complained of neck, arm lower back and leg pain. He was taking hydrocodone for pain. Documentation was on the chart that the patient was prescribed hydrocodone 5/500 #40 for 7 days, when he was discharged from the hospital and a second prescription for hydrocodone 7.5/500 #40 on 7/18/11. A urine drug test on this date was positive for hydrocodone. Dr. Dehaven was the physician at the facility, made notation of the fracture, advised the patient to wear his cervical collar at all times, no driving in any car and follow up with surgical services. There is no physical examination except as noted by staff member, "Ya". "Ya" also completed the physicians' diagnosis and orders sections which Dr. Dehaven signed. The patient was issued the following prescriptions: oxycodone 15mg #120, tramadol 50mg #90, valium 10mg #30 and baclofen 20mg #90. On the next visit, employee "Ya" again wrote what appeared to be a physician note that Dr. Dehaven signed and noted the patient was to be referred for a neurosurgical consult, he had numbness and pain in his neck, shoulders. The same prescriptions were issued but the oxycodone 15mg was increased to #150 and the Ultram was increased to #120. The oxycodone was not in the urine drug test for this date as it should have been. The next visit of 9/20/11 the patient had THC in his urine test and there was no oxycodone in his system; he was given a warning. Baclofen was discontinued and Neurontin was added, the oxycodone, Ultram and valium remained the same. There was notation that the patient had a follow appointment with another physician and a new MRI was possibly going to be done. 10/18/11 Dr. Wilson begins care of the patient. Notes were made by "Ya" on the "Miscellaneous Patient Information" form that were confusing; the Ultram did not help, Dr. Wilson signed his last name by this statement, Percocet would be added and valium would be increased. There is no explanation for the decision to use Valium. The note also states, "Pt strongly urged to consult with surgeon". There were no physical examination notes. Dr. Wilson issues the following prescriptions: oxycodone 15mg #150, Percocet 10/650 #60, Valium 10mg #60 and Neurontin 300mg #90. The urine drug test for this date was positive again for THC, absence of the valium and ultram was present. 11/15/11 Dr. Wilson makes a note that the patient was complaining of breakthrough pain and he would replace the oxy 15 with 30's, replace the valium with Klonopin, leave the Percocet the same and adjust the Neurontin. He issued the following prescriptions: oxycodone 30mg #90, Percocet 10/650 #60, Klonopin 1mg #30 and Neurontin 600mg #90. The urine drug test on this day was confirmed positive for Valium and Klonopin yet it had not been prescribed yet to the patient. 12/15/11 The patient complained of not

sleeping and spasms but the meds were helping. Dr. Wilson makes a note that Calloway lab ok for 11/15, the patient was complaining of shooting left neck pain and insomnia; plan was to increase the Neurontin and Klonopin and leave other medications the same. He issued the following prescriptions all with increases: oxycodone 30mg #99, Percocet 10/650 #66, Klonopin 1mg #66 and Neurontin 900mg #99. 1/16/12 Patient now complained of headaches and ear numbness and running out of Klonopin. Dr. Wilson makes notes that the patient was warned noncompliance could lead to dismissal and planned to write the same meds. He issued the following prescriptions: oxycodone 30mg #90, Percocet 10/650 #60, Klonopin 1mg #60 and Neurontin 800mg #90. 2/13/12 the patient was satisfied with his current regimen and he plans to adjust Klonopin, oxycodone and Percocet. He issued the following prescriptions to the patient: oxycodone 30mg #60, Percocet 10/650 #90, Klonopin 1mg #30 and Neurontin 800mg #90. 3/12/12 the patient had THC in his urine drug test, stated medications were helping, Dr. Wilson makes a note that the patient was complaining of increased pain and he planned to increase the Percocet, convert the oxy 30 to 15mg and decrease the Klonopin. He issued the following prescriptions: oxycodone 15mg #120, Percocet 10/650 #120, Klonopin .5mg #30 and Neurontin 800mg #90. 4/9/12 There is no note or documentation from Dr. Wilson but there is a dismissal letter for "bad labs". Dr. Wilson issued the following prescriptions: oxycodone 15mg #60, Percocet 10/650 #60, Klonopin .5mg #15 and Neurontin 800mg #45.

DIAGNOSIS- Below minimum standards.

This patient clearly had a diagnosis that justified the use of controlled substance to treat pain. However, his pain was from an acute injury and was anticipated to improve. There was no physical examination by anyone in the record except for the physician at the hospital who treated the patient for his initial injuries.

TREATMENT- Below minimum standards.

The rapid transition from a mild dose of a scheduled 3 narcotic to the use of more than one high dose, scheduled 2 narcotics was inappropriate. Dr. Wilson continued the same prescribing without any documented examination or attempt to obtain consultation or repeat imaging studies. The patient was treated with inappropriate doses of medications. He was given early refills and quantities that did not make sense.

RECORDS- Below minimum standards.

There was no initial history and physical documentation by the physicians at, Commonwealth Quality HealthCare. There were no follow up examination records. Follow up notes were inadequate. The controlled substance prescriptions were never written to the required standard. Urine drug testing was done and there were tracking numbers indicating KASPER data had been obtained.

OVERALL OPINION- Below minimum standards. Grossly negligent, incompetent and ignorant.

There was no documentation that Dr. Wilson ever examined this patient. He did nothing to evaluate the patient's need for continued controlled substances. The hospital discharge physicians determined the patient to need a very low dose of hydrocodone for a short period of time. Dr. Wilson escalated this patient's use of controlled substances; he took the patient from a total of 20mg of hydrocodone to 110 mg of oxycodone without any justification; without any documentation of why the patient was not improving as expected.

20. [REDACTED] He initially presented on 8/22/11 complaining of chronic neck and lower back pain that began in 2008. He reported getting hurt when working in the coal mines and also having 2 motor vehicle accidents. He reported prior treatment by a pain management facility. He listed his medications to be oxycodone 15 #120, Vicodin, Xanax #30 and Lyrica; but he reported the vicodin and Lyrica did not help with his pain. Prior treatment for pain listed per the patient included physical therapy, steroid shots in his neck and back and the use of a neck brace. Diagnostic studies in the record included an MRI report of the cervical spine dated 11/27/2008. This report noted a right deep cervical lymph node at the level of carotid bifurcation, moderate degenerative changes and a C6-7 disc herniation with moderate central canal and moderate bilateral foraminal narrowing; and MRI of the lumbar spine dated 9/19/2009 was noted for L4-5 bilateral neural foraminal narrowing due to significant facet hypertrophy and a synovial cyst; other levels had mild bulging. A staff member makes notations on a triage form and this is signed by Dr. Dehaven. There is no history and physical in the chart. There is no documentation that Dr. Dehaven examined this patient. The patient reported poor sleep, sharp pain when turning his head, constant lower back pain with radiating right leg pain. There were no copies of prescriptions noted from Dr. Dehaven. There is a patient phone in note from the patient for 9/1/11; the patient called to report he could not take the Neurontin. 10/18/11 Dr. Wilson begins care of the patient. The triage note per "Sue" notes the patient to be complaining of neck, upper back to low back, numbness in right hand and arm and bilateral leg pain, meds not helping much. A note was written on the "Miscellaneous Patient Information" form by staff member "Ya" that says that patient could not take nortriptyline because it made him feel drunk and disoriented, that he was prescribed oxycodone for break thru pain and Xanax for anxiety. Dr. Wilson signed this note. He issued the patient the following prescriptions: Xanax 1mg #64, Ambien CR 10mg #32, oxycodone 30mg #90, and oxycodone 15mg #64. 11/17/11 the patient the Ambien was not helping, Dr. Wilson makes a note that the patient is satisfied with his current regimen; write same scripts except no Ambien. He issued the following prescriptions: Xanax 1mg #68, oxycodone 15mg #68 and oxycodone 30mg #102. 12/19/11 the patient reported medications were working well, Dr. Wilson notes the lab was okay, the patient was satisfied with the current regimen, complained of bronchitis for 4 days, continued same medications and gave a prescription for a Zpack. He issued the same prescriptions as the preceding month of Xanax 1mg #60, oxycodone 15mg #60 and oxycodone 30mg #90. 1/17/12 follow up triage note reports the patient doing well, Dr. Wilson makes a note that the patient is satisfied with the current regimen, continue same meds and "follow ox labs". The same prescriptions as the preceding month were issued to the patient. 1/31/12 the patient had a pill count and had extra medication for each by 3-5 pills. 2/14/12 the patient reported medications were working well but he was having headaches and took a Fioricet he had. The urine drug test was positive for barbiturates. Dr. Wilson notes the patient to be without complaints and he plans to decrease the oxycodone 30mg by 1 and increase the oxycodone 15mg by 1. He issued the same prescriptions as the preceding month with changes. 3/14/12 follow up triage note states the patient did not have any new complaints but was having increased pain due to decreased medications. Dr. Wilson writes a note that the patient complained of

persistent pain and anxiety and he would increase the Xanax and adjust the other medications. He issued the following prescriptions: Xanax 1mg #90, oxycodone 30mg #30 and oxycodone 15mg #120. 4/17/12 no new complaints, medication was not as effective because of the reduction, the urine drug test was negative for benzodiazepine, the patient had an appointment for 4/13/12 but had to reschedule to this date, Dr. Wilson makes a note that the patient was without complaints and he was going to replace the oxy 30 with Lorcet. He issued the following prescriptions to the patient: Xanax 1mg #90, oxycodone 15mg #120 and Lorcet 10/650 #90. 5/14/12 follow up triage note indicates the patient has increased pain with the changes in medications, Lorcet was not helping at all, Dr. Wilson makes a note that Lorcet was no help and the Percocet help very little, he will replace the Lorcet with oxy 10 and decrease the Xanax by 1. He issued the following prescriptions: Xanax 1mg #64, oxycodone 30mg #32 and oxycodone 15mg #128.

DIAGNOSIS – Below minimum standards.

The cervical and lumbar pathology indicated on the MRI report from 2009 could cause pain and the use of controlled substances could be justified. Both studies had pathology that indicated further investigation but this was never addressed. There was no physical examination in the record from anyone. A diagnosis was never rendered.

TREATMENT- Below minimum standards.

There were no adjunctive therapies of any kind for this patient. The patient reported he had prior physical therapy and steroid injections, but records were never obtained from the previously treating facility/provider.

RECORDS- Below minimum standards.

There was no history and physical in the record. None of the controlled substance prescriptions were written to the expected standard. There were tracking numbers indicating KASPER data had been obtained. Urine drug testing results were in the chart.

OVERALL OPINION- Below minimum standards. Gross ignorance, incompetence and neglect.

Dr. Wilson prescribed high risk medications to a patient that a history and physical was never obtained by him or anyone else. His prescribing routine is questionable; using multiple high risk opioids in combination with benzodiazepines is concerning. There was no apparent attempt to evaluate the patient with additional studies or refer. He did not practice medicine in taking care of this patient.

21. [REDACTED] She presented as a new patient to Dr. Wilson, 2/28/12. She reported she had been treated for 3 years by another pain management facility but it was now too far for her to drive to because she had moved. She reported the onset of her pain to begin after several car wrecks and a fall at a store. She complained of neck pain that caused migraine headaches, lower back pain and right knee pain. She reported prior treatment included hydrocodone, Percocet and oxycodone, Lidoderm patches and physical therapies. She also reported that she had been in a suboxone treatment program 12/6/11. An MRI of the cervical spine dated 10/6/09 noted mild disc bulging at C5-6, C6-7 and T1-2 with mild right foraminal stenosis at C6-7; an MRI of the sacrum dated 10/6/09 was normal; MRI of the right knee on 7/7/09 was normal and an MRI of the lumbar spine dated 7/7/09 was normal. The patient completed new patient questionnaires, a "detailed pain assessment and physical assessment" form was completed by Kidd, RN The nurse gave a nursing diagnosis of, "chronic pain (lb) r/t destruction of nerve tissue" There was no history, no physical examination or diagnosis rendered by Dr. Wilson. He made a note, "New pt with justified pathology, triage note and form reviewed, pt interviewed and examined. There was no documentation of his physical examination or description by Dr Wilson of the abnormal pathology or a diagnosis. He wrote his plan was to prescribe medications and he issued the following prescriptions to the patient: Percocet 10/650 #120, oxycodone 10mg #60, Xanax mg #90, Neurontin 100mg #30 and Imitrex 100mg #30. 3/27/12 the patient returned for follow up complaining of burning leg and foot pain. She was also complaining of knee pain. A urine drug test was positive for medication not prescribed but she reported having remaining hydrocodone was a prior prescription. Dr. Wilson makes a note that the patient complained her analgesics were too weak, requests stronger Neurontin; he planned to decrease the Percocet and replace the oxy 10 with 15mg and increase the Neurontin. He issued the following prescriptions: Percocet 10/650 #90, oxycodone 15mg #90, Xanax 1mg #90, Neurontin 300mg #60 and Imitrex 100mg #30. 4/24/12 Triage note indicates migraines were worsening, she was noted to have had Valium in the previous urine drug test and would be see her primary care doctor for elevated blood pressure, Dr. Wilson makes notes that Imitrex and Fioricet are not help with headaches he plans to replace Imitrex with stadol decrease the oxy 15 and increase the Percocet. He issued the following prescriptions: Percocet 10/325 #120, oxycodone 15mg #60, Xanax 1mg #90, Butorphanol nasal spray #1 bottle and Neurontin 300mg #60. 5/21/12 patient reports migraines are improving but she is not sleeping well, the urine drug test from 4/24/12 was negative for benzodiazepines and oxycodone but positive for hydrocodone, Dr. Wilson makes notes that the patient was without complaints and he plans to write for the same medications. He issued the following prescriptions to the patient: Percocet 10/325 #128, oxycodone 15mg #64, Xanax 1mg #92, Butorphanol nasal spray #1 bottle and Neurontin 300mg #64.

DIAGNOSIS- Below minimum standards.

The only diagnosis rendered for this patient was an inappropriate nursing diagnosis. While Dr. Wilson did note he reviewed the triage sheet and examined the patient there was no documentation of a history and physical examination by him. The diagnostic

studies were for the most part normal and did not justify the use of high dose controlled substances.

TREATMENT- Below minimum standards.

This patient had been in a prior pain management program for treatment. There were no records of prior treatment. The patient also reported recent treatment in a Suboxone treatment program. The use of the controlled substances to treat her pain complaints was not justified. There were no referrals to diagnostic testing ordered to further evaluate her pain complaints. Prior studies were essentially normal. The patient also had repeated urine drug test problems.

RECORDS- Below minimum standards.

The lack of physician history, physical and diagnoses was unacceptable. The controlled substance prescriptions were not written to the expected standard. Tracking numbers were documented that indicated KASPER data was obtained. Follow up physician notes were inadequate.

OVERALL OPINION- Below minimum standards. Grossly negligent, ignorant and incompetent.

Dr. Wilson failed to obtain a diagnosis or diagnoses that justified the use of the controlled substances. He not only prescribed, inappropriately, high dose, high risk opioid medications but added benzodiazepines. Further, he added Stadol which is an opioid agonist/antagonist. The prescribing of Stadol in combination with the opioids is dangerous and can precipitate opioid withdrawal. He ignored the patients' prior history of drug dependency. He treated this patient while ignoring the obvious indicators she was most probably diverting her medications.

OCT 22 2012

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1440

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY ROLAND B. WILSON, M.D., LICENSE NO. 23084,
2460 DERBY DRIVE, SHELBYVILLE, INDIANA 46176-9241

COMPLAINT

Comes now the Complainant C. William Briscoe, M.D., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel A, and on behalf of the Panel which met on October 18, 2012, states for its Complaint against the licensee, ROLAND B. WILSON, M.D., as follows:

1. At all relevant times, Roland B. Wilson, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is anesthesiology.
3. At all relevant times, the licensee practiced at Commonwealth Quality Healthcare, LLC.
4. On or about April 25, 2012, Stephen C. Johnson, Pharmacist Consultant, Office of Inspector General, Drug Enforcement and Professional Practices Branch of the Cabinet for Health and Family Services ("Drug Enforcement"), reviewed and analyzed the licensee's KASPER records (for the period October 1, 2011 through April 19, 2012) and noted several concerns, including:
 - Possible prescribing to employees;
 - Prescribing of same or similar controlled substances to persons with similar last names;
 - Use of addictive drug combinations;
 - Polypharmacy;
 - Concerns about the ages of some patients; and
 - Atypical distances traveled

Mr. Johnson identified twenty-one (21) of the licensee's patients with prescribing patterns reflective of these concerns and recommended further investigation by the Board.

5. During the course of the investigation, the Board obtained medical records for a number of employees and/or employee family members of Commonwealth Quality Healthcare, LLC. When the Board's investigator first questioned the licensee about prescribing to these persons, the licensee stated that this was improper and he did not do that. However, when confronted with patient charts, he acknowledged that he had prescribed for one employee and could not recall whether he prescribed for another.
6. A Board Consultant reviewed twenty-one (21) of the licensee's patient charts and found that the licensee failed to conform to or departed from acceptable and prevailing medical practices and that he engaged in a pattern of acts which demonstrated gross incompetence, gross ignorance and gross negligence. The Board Consultant stated

Dr. Wilson chose to practice in a facility that mirrored a "pill mill."...

The organization of the charts was difficult at best. The charts were separated by tabs but the documentation in the tabs often did not correspond to what was contained in the tabbed section. All patient charts had some type of consents for treatment albeit many were not signed appropriately; some charts lack any signature from staff or the patient. Many of these consents had the wrong year on them. There were several records that had data covered up by using "white out" liquid erasure... Some of the charts had forms completed in pencil. Often there was illegible writing by Dr. Wilson.

... Some charts had tracking numbers to indicate KASPER data had been obtained but this was very inconsistent. For most of the charts the KASPER data was not acknowledged. I found more often than not, patients were given numerous early refills on their prescriptions for both benzodiazepines and opioid medications. There was no explanation of documentation for the early refills.

All of the patient charts contained reports from Calloway Lab indicating regular urine drug testing was performed at each patient visit. However, the utilization of this information was questionable. Frequently, the results were ignored. There were many occurrences of abnormal results that should have been clarified by additional testing and this was not done. ... There were several incidents where the facility cancelled the confirmation of a urine drug test. ... Frequently amphetamine positive results were not clarified. There were many occasions in which a urine sample did not pass integrity testing. Again, this was not addressed. Nearly 100% of the twenty one charts reviewed had failed urine drug testing results and many failed urine drug testing numerous times.

...

... There were several patients that were given multiple controlled substance prescriptions repeatedly without being seen. None of the prescriptions written for controlled substances by Dr. Wilson were written to standard. ... There were some prescriptions with the dates that had obviously been altered.

It was apparent to me that Dr. Wilson demonstrated a lack of knowledge and a level of competence that would be expected of a physician practicing pain management. He acknowledged that as an anesthesiologist of twenty-eight years, he "was not familiar" with oral pain medications. Further, he never practiced as a physician providing medical management. He demonstrated a lack of ability repeatedly in prescribing as noted by the combinations of medications and the dosing of medications. While I was concerned about his general lack of knowledge, I was disturbed by his obvious neglect to the basic fundamentals of the practice of medicine and the resulting lack of appropriate and prudent medical care. ... A nursing examination cannot be substituted for the examination by the physician. A nursing diagnosis is not a medical diagnosis. A medical diagnosis is rendered after an examination by the physician. There was no initial examination or focused physical examination results documented by Dr. Wilson. None of the 21 charts contained documentation that a history and physical examination was performed by Dr. Wilson. None of the charts had documentation that he examined the patients at follow up visits regardless of their complaints. There were some charts that did not have a history of physical examination from anyone.

Dr. Wilson did nothing to establish a diagnosis or formulate a working diagnosis. Not only were his follow up evaluations lacking in any documentation of an examination but in general the follow up patient visit notes were incomplete and inconsistent. The notes were often two or three lines and most commonly stated the "patient satisfied with the current regimen" and "without complaints." These notes were

frequently the opposite of the information the patient gave to the triage nurse/staff member. There were frequent examples of the patient complaining of new symptoms or changes in symptoms. ... Again, Dr. Wilson never documented that he physically examined the area(s) of concern. He never addressed the problem except to increase either the opioid medication or the benzodiazepine. ...

Dr. Wilson not only neglected to formulate a diagnosis, he never followed up on any diagnostic testing previously ordered by the other physicians prior to his employment with the facility. Rarely did he order a diagnostic study and then he did, he never followed up on the status of the study. It was frequently unclear whether the patient actually went for the ordered study or not.

Dr. Wilson prescribed benzodiazepines regularly to his patients regardless of age and obvious risk factors associated with the use of these medications. He frequently prescribed benzodiazepines in response to a patient's complaint of increased pain. He would increase the benzodiazepine when the patient asked for additional pain medications. There were frequent occasions that a patient did not have the prescribed benzodiazepine in their urine. This did not influence his prescribing of the medication. He not only continued the prescribing of these medications but increased the dose/frequency repeatedly. ...

...
It is my opinion that Dr. Wilson did not practice medicine that was consistent with the acceptable standards and prevailing medical practice. ...in addition, he committed a pattern of acts that I determined to be grossly negligent, grossly ignorant and grossly incompetent.

...
In summary, the pattern of acts includes:

1. Prescribing high risk medication to patients without examining the patient or determining a diagnosis.
2. Prescribing opioid medications to patients without indications for their use.
3. Prescribing benzodiazepines for patients without a diagnosis that warranted the use of these medications.
4. Prescribing benzodiazepines in combination with opioid medications without any concern for the risk associated with this combination; as though there were no consequences when combining these medications.
5. Prescribing controlled substances for patients with multiple incidents of aberrant behaviors.
6. Increasing the quantities and doses of opioids and benzodiazepines in response to the patient asking for increases rather than upon investigation of the problem.

7. Repeatedly prescribing benzodiazepines and increasing the doses in response to complaints of increased pain.
8. Never referring the patient for other therapies such as a psychiatrist, interventional pain specialist, physical therapy or surgeon. ...
9. Prescribing combinations and doses of medications that exceeded recommended doses and cautions. ...
10. Prescribing medications that may cause deleterious side effects from their use. ...
11. Continued to prescribe to patients within increasing doses while noting his intentions to decrease medications.
12. Continued prescribing of high risk opioid medications and benzodiazepines without explaining any of the aberrant behaviors to include failed urine drug testing, early refills, incidents with medications, etc. Rarely a mention was made regarding the aberrant behavior but the explanation was in adequate.

(The consultant's report, including summary reviews of each individual chart, is attached hereto and incorporated herewith in its entirety.)

7. The Board Consultant also found that "Dr. Wilson's practice of pain management constitutes a danger to the health, welfare and safety of the citizens of the Commonwealth of Kentucky. He prescribed with a level of flagrant neglect and without any obvious concern for the ramifications of his actions."
8. On October 18, 2012, the Board's Inquiry Panel A determined that the licensee's practice constitutes a danger to the health, welfare and safety of his patients or the general public. As a result, the licensee was suspended from the practice of medicine in the Commonwealth of Kentucky.
9. By his conduct, the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(3) and (4). Accordingly, legal grounds exist for disciplinary action against his Kentucky medical license.

10. 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:

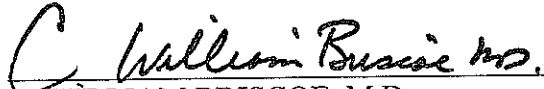
(a) His failure to respond may be taken as an admission of the charges;

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

11. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for June 4, 5 & 6, 2013, 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.

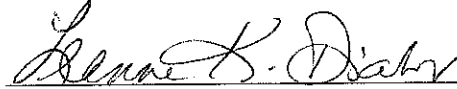
WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice medicine held by ROLAND B. WILSON, M.D.

This 22nd day of October, 2012.


C. WILLIAM BRISCOE, M.D.
CHAIRMAN, INQUIRY PANEL A

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; and a copy was mailed to: Thomas J. Hellmann, Esq., 415 West Main Street, P.O. Box 676, Frankfort, Kentucky 40602-0676 and a copy was mailed via certified mail return-receipt requested to the licensee, Roland B. Wilson, M.D., 2460 Derby Drive, Shelbyville, Indiana 46176 and at 387 Edgewood Drive, Prestonsburg, Kentucky 41653 on this 22nd day of October, 2012.



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

Pain Management Consultants, LLC

1169 Eastern Parkway, Suite 2211 Louisville, KY 40217
Phone (502) 635-2775 Fax (502) 371-0475

Jeffrey W. Berg, M.D.
Carole A. Buskirk, ARNP

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K.B.M.L.

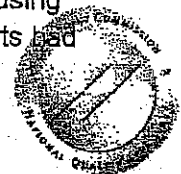
Expert Review of Roland B. Wilson, MD
Summary of Findings/Narrative Report
Consultant: Jeffrey W. Berg, MD

I have reviewed 21 patient charts of Dr. Wilson, KASPER data from January 1, 2011 thru May 1, 2012; the investigative report prepared by Doug Wilson dated 6/11/12; and the written responses by Janie Castle, Andrea Kennedy and Dr. Wilson. I also reviewed the policies and procedures for Commonwealth Quality Health Care. I understand my review is of Dr. Wilson but it is important to evaluate the facility in which he elected to practice medicine. I will occasionally make reference to a specific chart or charts to further explain and describe a particular concerning practice. However, the referenced chart is not intended to be the only example of a particular practice habit or behavior by Dr. Wilson.

I am going to begin my review with general observations and opinions of the facility, including the operating policies and procedures. The facility was problematic in regard to new patient procedures, use of MRI reports, urine drug testing and record keeping.

Dr. Wilson chose to practice in a facility that mirrored the practices of a "pill mill". To become a patient at Commonwealth Quality Healthcare, a referral from another medical provider was not required. A prospective patient had to present with a six month pharmacy printout, a copy of an MRI report, a valid Kentucky identification card or drivers license, a social security card and cash payment for an initial visit and a urine drug test. The prospective patient was questioned if they had taken suboxone, methadone, methamphetamine, fentanyl or cocaine. If these drugs were found in the patients' urine they would not be a patient. The facility indicated they would validate the MRI report brought in by the patient and obtain one from the treating facility. If this procedure was followed a patient chart should contain two MRI reports; none of the charts contained two. The policy and procedure indicated the physician would review all KASPER reports and all data obtained on the patient and then he would determine if a patient was "worthy" of treatment at the facility.

The organization of the charts was difficult at best. The charts were separated by tabs but the documentation in the tabs often did not correspond to what was contained in the tabbed section. All patient charts had some type of consents for treatment albeit many were not signed appropriately; some charts lack any signature from staff or the patient. Many of these consents had the wrong year on them. There were several records that had data covered up by using "white out" liquid erasure; an example of this is in chart summary #5. Some of the charts had forms completed in pencil. Often there was illegible writing by Dr. Wilson.



accredited by the
Joint Commission

Some charts had tracking numbers to indicate KASPER data had been obtained but his was very inconsistent. For most of the charts the KASPER data was not acknowledged. I found more often than not, patients were given numerous early refills on their prescriptions for both benzodiazepines and opioid medications. There was no explanation or documentation for the early refills.

All of the patient charts contained reports from Calloway Lab indicating regular urine drug testing was performed at each patient visit. However, the utilization of this information was questionable. Frequently, the results were ignored. There were many occurrences of abnormal results that should have been clarified by additional testing and this was not done. One chart included test results that belonged to another patient; the patient was told of these results which were abnormal for his particular treatment plan. (See chart summary #17). There were several incidents where the facility cancelled the confirmation of a urine drug test. An example of this was when the patient tested positive for buprenorphine (suboxone), the confirmation was cancelled and there was no discussion of these results (See chart summary #3). The high levels of opiates were never confirmed. Frequently, amphetamine positive results were not clarified. There were many occasions in which a urine sample did not pass integrity testing. Again, this was not addressed. Nearly 100% of the twenty one charts reviewed had failed urine drug testing results and many failed urine drug testing numerous times.

There were occasional attempts at pill counts. Of the few successful pill counts it was difficult to determine the outcome. Several charts noted the pill count was not as it should be. Many attempts at pill counts were unsuccessful as might be expected. Two charts contained pill counts that were accepted by Dr. Wilson to be okay but these were questionable. These charts had documentation of a phoned in pill count from an individual named "Tony" who was employed at the local pharmacy. "Tony" reported by phone that the patient had the correct number of pain pill remaining from their prescription. This is not an acceptable practice. Particularly concerning is the lack of the full name and title of the individual calling to report the pill count (See chart summary #5 and #6 for detail).

Most patients had regular, monthly office visits. There were several patients that were given multiple controlled substance prescriptions repeatedly without being seen. None of the prescriptions written for controlled substances by Dr. Wilson were written to standard. None of his prescriptions contained the patients address. Some of the prescriptions lacked the numerical quantity written out and some lacked dates. There were some prescriptions with the dates that had obviously been altered.

It was apparent to me that Dr. Wilson demonstrated a lack of knowledge and a level of competence that would be expected of a physician practicing pain management. He acknowledged that as an anesthesiologist of twenty eight years, he "was not familiar" with oral pain medications. Further, he never practiced as a physician providing medical management. He demonstrated his lack of ability repeatedly in prescribing as noted by the combinations of medications and the dosing of medications. While I was concerned about his general lack of knowledge, I was disturbed by his obvious neglect to the basic fundamentals of the practice of

medicine and resulting lack of appropriate and prudent medical care. Fundamental to the practice of medicine, the physician not only obtains verbal information from the patient to explore the chief complaint and history of present illness but performs an examination of the patient. Dr. Wilson informed the investigator that he examined his patients. It was specifically reported to the investigator that "all new patients are required to have a physical examination". There were physical examinations by L. Kidd, RN as documented on a new patient form that also resulted in a nursing diagnosis. (See chart summary #9 and #21). A nursing examination cannot be substituted for the examination by the physician. A nursing diagnosis is not a medical diagnosis. A medical diagnosis is rendered after evaluation by the physician. There was no initial examination or focused physical examination results documented by Dr. Wilson. None of the 21 charts contained documentation that a history and physical examination was performed by Dr. Wilson. None of the charts had documentation that he examined the patients at follow up visits regardless of their complaints. There were some charts that did not have a history or physical examination from anyone.

Dr. Wilson did nothing to establish a diagnosis or formulate a working diagnosis. Not only were his follow up evaluations lacking in any documentation of an examination but in general the follow up patient visit notes were incomplete and inconsistent. The notes often were two or three lines and most commonly stated the "patient satisfied with the current regiment" and "without complaints". These notes were frequently the opposite of the information the patient gave to the triage nurse/staff member. There were frequent examples of the patient complaining of new symptoms or changes in symptoms. For example, some of these symptoms included neck pain which was new, radicular pain which was new and new complaints of joint pain i.e., knee pain. Again, Dr. Wilson never documented that he physically examined the area(s) of concern. He never addressed the problem except to increase either the opioid medication or the benzodiazepine. A particularly concerning example is chart summary #19. This young man had an acute injury but was expected to recover. He continued with severe pain and he requested opioid medications. Dr. Wilson did nothing to investigate the cause of the continued pain. He rapidly transitioned this patient from a mild analgesic to more than three high dose opioid and benzodiazepine medications without justification or any investigation of the problem.

Dr. Wilson not only neglected to formulate a diagnosis, he never followed up on any diagnostic testing previously ordered by the other physicians prior to his employment with the facility. Rarely did he order a diagnostic study and when he did, he never followed up on the status of the study. It was frequently unclear whether the patient actually went for the ordered study or not.

Dr. Wilson prescribed benzodiazepines regularly to his patients regardless of age and obvious risk factors associated with the use of these medications. He frequently prescribed benzodiazepines in response to a patient's complaint of increased pain. He would increase the benzodiazepine when the patient asked for additional pain medications. There were frequent occasions that a patient did not have the prescribed benzodiazepine in their urine. This did not influence his prescribing of the medication. He not only continued the prescribing of these

medications but increased the dose/frequency repeatedly. In one particular patient he diagnosed the patient with multiple psychiatric disorders; acrophobia, agoraphobia and claustrophobia etc. There was no documentation as to how he made these diagnoses. He never referred the patient to a psychiatrist or psychologist despite multiple patient complaints and behaviors of anxiety and depression. He prescribed multiple sedating and high risk medications. (See chart summary #6). This patient also presented with multiple aberrant behaviors.

An example of Dr. Wilson's medical care is noted in chart summary #5. This 21 year old male patient did not have a diagnosis that warranted the prescribing of high dose opioid medications. His diagnostic studies were essentially normal. He did have some type of leg and ankle surgery in the past following a motor vehicle accident. This patient was sent for psychological evaluations per Dr. Argotte and these evaluations suggested he should be referred to a substance abuse professional. His medical history was also positive for seizures. He was prescribed high dose opioid medications in combination with benzodiazepines without justification for their use and in spite of multiple failed urine drug screens and aberrant behaviors. This patient's urine drug testing was repeatedly negative for benzodiazepines. Another example of this type of medical care by Dr. Wilson is in chart summary #6. There were times Dr. Wilson issued controlled substance prescriptions without any documentation that the patient had been seen. (See chart summary #8).

It is my opinion that Dr. Wilson did not practice medicine that was consistent with the acceptable standards and prevailing medical practice. His general prescribing of medications which includes both controlled and noncontrolled medications appeared to be disconnected. In addition, he committed a pattern of acts that I determined to be grossly negligent, grossly ignorant and grossly incompetent.

Dr. Wilson also violated ethical principles established by the American Medical Association's Code of Medical Ethics and the KRS Medical Practice Act by prescribing controlled substances to at least two of his fellow employees; Lavonda Lazar and Andrea Kennedy.

In summary, the pattern of acts includes:

1. Prescribing high risk medications to patients without examining the patient or determining a diagnosis.
2. Prescribing opioid medications to patients without indications for their use.
3. Prescribing benzodiazepines for patients without a diagnosis that warranted the use of these medications.
4. Prescribing benzodiazepines in combination with opioid medications without any concern for the risk associated with this combination; as though there were no consequences when combining these medications.
5. Prescribing controlled substances for patients with multiple incidents of aberrant behaviors.

6. Increasing the quantities and doses of opioids and benzodiazepines in response to the patient asking for increases rather than upon investigation of the problem.
7. Repeatedly prescribing benzodiazepines and increasing the doses in response to complaints of increased pain.
8. Never referring the patient for other therapies such as a psychiatrist, interventional pain specialist, physical therapy or surgeon. Dr. Wilson reported to the investigator that he referred to others when indicated. Review of the charts did not reveal this. In fact he neglected to refer.
9. Prescribing combinations and doses of medications that exceeded recommended doses and cautions. For example, high doses of acetaminophen and tramadol. High doses of tramadol; more than 400mg per day in combination with other SSRI/SNRI medications without any apparent concern for the risk of serotonin syndrome and seizure. He prescribed in this manner to a patient with a documented history of seizures.
10. Prescribing medications that may cause deleterious side effects from their use. An example includes prescribing Stadol to a patient on high dose opioid medications. The use of this medication could precipitate opioid withdrawal.
11. Continued to prescribe to patients with increasing doses while noting his intentions to decrease medications.
12. Continued prescribing of high risk opioid medications and benzodiazepines without explaining any of the aberrant behaviors to include failed urine drug testing, early refills, incidents with medications etc. Rarely a mention was made regarding the aberrant behavior but the explanation was inadequate.

Dr. Wilson's practice of pain management constitutes a danger to the health, welfare and safety of the citizens of the Commonwealth of Kentucky. He prescribed with a level of flagrant neglect and without any obvious concern for the ramifications of his actions.

Submitted: _____

Jeffrey W. Berg, MD

CHART REVIEWS

RE: Roland B. Wilson, MD

1. [REDACTED] Dr. Argotte initially evaluated this patient on 4/13/11. She reported a 20 year history of chronic pain in the back, neck and most joints; anxiety and depression. She reported that she had been under the care of a pain specialist prior but left because she did not like the doctor. She reportedly had physical therapy and injections but did not benefit from these therapies. She also reported a prior evaluation from a neurosurgeon. She was diagnosed with uncontrolled pain as a result of cervical, thoracic and lumbar pain, arthritis, anxiety and fibromyalgia. Dr. Argotte reviewed radiology studies from 3/2009 and indicated the following results; cervical degenerative disc disease with disc bulging and herniation, facet arthropathy and spinal stenosis; lumbar degenerative disc disease with herniation, facet hypertrophy and stenosis. She was prescribed an opioid analgesic for pain- Percocet 10/650 4/day; a muscle relaxer-baclofen 10mg 3/day; an AED-lyrica 75mg 3/d; an NSAID-diclofenac 50mg daily and an antidepressant-Paxil 10mg daily. The lyrica and Paxil were increased at the next visits. The last visit with Dr. Argotte appeared to be 6/9/11. The patient returned on 7/13/11 and saw Dr. Greenlaw who was now the physician for the facility. He referred the patient for a surgical consult and prescribed the following medications: Ultram 50mg 3/day, oxycodone 15mg 4/day, Xanax 1mg 2/day, diclofenac 100mg per day, lyrica 100mg 3/d, baclofen 20mg 3/day and celexa 20mg per day. This appeared to be the only visit with Dr. Greenlaw and on 8/10/11 the patient returned for follow up and was seen by Dr. Dehaven. She reported to him that she needed stronger pain medications. She was prescribed Xanax 1mg 2/d, Lorcet 10/325 2/day, oxycodone 15mg 4/day, lyrica 100mg 3/day, baclofen 20mg 3/day and celexa 20mg daily. She returned on 9/8/11 and all medications remained the same except baclofen was discontinued and soma 350mg 3/d was prescribed; Lorcet was discontinued and Percocet 10/325 3/day was initiated. Dr. Wilson began treating the patient on 10/12/11. The patient reported pain but stated meds were helping. A urine drug test was performed and negative for benzodiazepines and oxycodone but positive for amphetamine and opiates. The specimen was sent for confirmation of oxycodone which was negative. She was given the same medication prescriptions as per the previous visit prescribed by Dr. Dehaven. 11/9/11 she returned and reported she was out of soma and the other medications were not working for her. The confirmation report for the urine test of 10/12/11 was negative for oxycodone. The specimen was screened again by the confirmation lab and resulted positive for benzodiazepines and opiates but not confirmed. The level of amphetamine was not conclusive. A notation was made on the follow up triage form, "med may need to be reevaluated". She was given the following prescriptions: Percocet 10/325 #45 to take 1 every 8 hrs, oxycodone 15mg #60 to take 1 every 6 hrs, lyrica #102 to take 1 every 8 hrs, Xanax 1mg #30 to take 1 twice per day, soma 350mg #102 to take 1 every 8 hrs and celexa 20mg #34 to take 1 per day. She also had a urine drug screen which was positive for opiates, benzodiazepines and oxycodone. The sample was confirmed to be positive for benzodiazepines and oxycodone. The rescreening of the opiates was again

positive but not confirmed. The patient returned on 11/23/11 had a urine drug test was positive for opiates, benzodiazepines and oxycodone. Confirmation was performed on benzodiazepines and oxycodone which were both positive. A pill count was also performed on this visit. She returned on 12/14/11 complaining of a new shooting pain requested an increase in Percocet by one pill and other medications working ok. Dr. Wilson gave the following prescriptions: He increased the Percocet 10/325 to #120 4/day, oxycodone 15mg #120 4/day, soma 350mg #60 2/day, lyrica 100mg #90 3/day and Xanax 1mg #60 2/day. No other treatments or evaluations were requested. On the return visit of 1/12/12 no changes were made and the same prescriptions were issued. 2/9/12 she complained of poor sleep but medications were okay. She was given an increase in Percocet 10/325 #140 with directions of 1 every 6 hours, an increase in oxycodone 15mg #140 with directions of 1 every 6 hours, an increase in soma 350mg #70 with directions 1 every 12 hrs, Xanax 1mg #70 with directions every 12 hrs and Lyrica 100mg #105 one every 8 hours. It is unclear why the change in quantities except a notation was made on the follow up visit that the visit of 3/14/12 was 5 days late. On this visit the patient requested one more Xanax which was denied. Soma was to be decreased and then discontinued. The same prescriptions were issued except the soma was decreased to #30 and the quantities were the same as prescribed on 1/12/12. The follow up visit of 4/12/12 had the confirmation results from the previous visit that noted the patient to have valium or metabolite of valium in the urine which should have been positive for Xanax or its metabolites. Dr. Wilson made a note that the patient "may have been given the wrong med". The prescriptions issued were the same as previous except the oxycodone 15mg was decreased to #90. 5/10/11 the patient reported "unbearable pain the back" and "nerves shot". Notation was made by Dr. Wilson on a form titled, "Miscellaneous Patient Information" that the patient had 3 relatives dying of cancer and he refused an increase in Xanax but increased her oxycodone 15mg to #140 with the same directions of 1 every 6 hrs, Xanax 1mg was increased in quantity to #70 but the directions were the same, Percocet 10/325 was also increased to #140 with the same previous directions of 1 every 6 hrs and Lyrica was increased to #105 with the same previous directions.

DIAGNOSIS/TREATMENT- Below minimum standards for both.

The initial history and physical was complete and it was done by another physician. The diagnostic studies appeared to be valid and the diagnosis justified the use of treatment with opioid medications. MRI of the lumbar spine revealed a right L5-S1 herniated disc with bilateral neural foraminal encroachment, a central disc herniation at L4-5 with bilateral neural foraminal encroachment and mild bulging of the L3-4 disc. An MRI of the cervical spine revealed a high grade stenosis at C5-6 with associated cord edema because of a large central and right sided C5-6 disc herniation with bilateral neural foraminal encroachment, bulging at C4-5 and a central disc protrusion at C3-4. A surgical consult was ordered on 7/13/11 but never followed up on. There was no indication in the record that Dr. Wilson reviewed the initial history and physical or the MRI studies; he never rendered a diagnosis or diagnoses that could be found in the documentation. There were never any physical examination notes by Dr. Wilson. There were no other treatments or referrals for

care or follow up on the one referral that was requested by the preceding physician. Utilization of urine drug testing was included however; there were concerns. The patient had upon several occasions not tested as she should have; missing the medication prescribed (oxycodone) and having medication not prescribed, (valium and possibly amphetamines and opiates); the consistently positive result of opiates when not expected was never tested by confirmation because the level was below the lab designated cutoff. There appeared to be a pill count x1; results were unclear. The documentation included urine drug screening regularly and monthly appointments. There were occasional tracking numbers indicating a KASPER had been obtained. These medications were increased without justification. Dr. Wilson indicated he was decreasing and he did eliminate the soma but other medications were increased. The opioid medications also appeared to be increased because the patient described personal stressors and anxiety. Opioids are not indicated for anxiety and stress.

RECORDS- Below minimum standards

There were neither records nor apparent attempts to obtain prior pain management records. The records were full of forms that had missing dates and incomplete identification. There were never any working diagnoses after Dr. Wilson began. Notes pertaining to office visits were confusing; visits had a "Follow up Triage" note prepared by the nurse often without any physician comment or note. Notes written by Dr. Wilson were sparse; they were almost nonexistent. As stated above there were no notes describing physical findings by Dr. Wilson. The controlled substance prescriptions were not written to standard; none had the patients address nor spelled out the numerical quantity, and dates frequently missed the year.

OVERALL OPINION- Below minimum standards and gross incompetence and gross ignorance

There was no documentation that Dr. Wilson examined this patient. He gave no explanation for the changes he made in her medications. He prescribed increases in opioid medications in response to complaints of increased anxiety; this was inappropriate. She was prescribed not only high dose opiate medication in its most abuseable form but in combination with benzodiazepines.

2. [REDACTED] Appeared to present for initial evaluation on 1/27/2011. He complained of a work related injury that occurred in 1993 and 1996. His complaints were of upper back and shoulder pain, lower back pain that radiated down the left leg to the foot and some pain in the right leg to the back of the knee. He was seen at that time by Mary Beth Scott-Calor, DO. A physical examination was performed. It was noted that patient weighed 420 pounds. She diagnosed him with CRPS or CPS (complex pain complex regional pain syndrome or complex pain syndrome; it is unclear; CLBP (chronic low back pain), "left leg radicular pain" and what appeared to be sacroiliitis left greater than right. Her treatment plan was not entirely legible but indicated pt was to have Nucynta, tramadol and oxycodone 15mg. Copies of her prescriptions were not on the chart. Prior treatment included physical therapy and epidurals from 1997 thru 2000. The next office visit was on 3/31/11 and the physician was now Alex Argotte, MD. His treatment plan included referral for a MRI of the thoracic and lumbar spine and psychological evaluation and lab work. (A urine drug screen was sent to the confirmation lab which later returned positive for valium and soma; neither prescribed for the patient). He was given prescriptions for Ultram 50mg #120 4/day, Nucynta 100mg #150 5/day, lorazepam 1mg #90 3/day, Percocet 10/325 #120 4/day and Zoloft 100mg #30 1/day. The patient returned on 4/27/11 he complained of medications not lasting long enough and more anxiety. He reported a poor functional status. He completed a depression screening tool, lorazepam was discontinued, he was referred to an endocrinologist, orders were again written for MRI studies and a psychological evaluation. He appeared to have been questioned about the prior urine drug screen confirmation results which were not as expected and advised that he took his wife's valium and took soma that had been prescribed in years prior. Medications were the same except the lorazepam was discontinued. A urine drug screen was obtained and sent for confirmation which was again positive for soma. Visit of 5/24/11 the patient was instructed not to take medications not prescribed for him. Pt also requested to resume his lorazepam. He was given the following prescriptions; lorazepam 1mg #90 3/day was resumed and soma 350mg q12h prn #30, Nucynta 100mg was increased to #180 6/day and the Percocet and Zoloft remained the same and Ultram was increased to 8 /day. Visit of 6/20/11 patient reports medications are working. The next several visits were by Dr. Greenlaw and then Dr. Dehaven. Again diagnostic studies were ordered which also now included an MRI of the knee, referral to an internist and nutritionist and medications were adjusted. The patient complained about acetaminophen intake. Oxycodone 15mg #120 was added in place of Percocet, at the following visit this was increased to 30mg 9/19/11, Nucynta 100mg was decreased and then increased to #180 6/day, Ultram remained the same, lorazepam remained the same, Norflex 100mg #90 3/day was added for muscle spasms and Neurontin 800mg #90 3/day was added, the lorazepam was decreased to 1mg #30 1/day and all other medications remained the same. The patients urine drug testing was again in June, July, and September positive for opiates but never confirmed.

10/20/11 Dr. Wilson sees the patient for the first time. He documents on a form called, "Miscellaneous Patient Information" that the patient has chronic pain and complains of pain in the low back, Ultram does not work well and Neurontin upsets his stomach and

patient is to see an endocrinologist. The triage nurse writes that patient has pain in his upper back and radiating into mostly the right side, meds working well and no other issues. Pt was given an order for an MRI of the cervical and thoracic spine. He is given prescriptions for Ativan 1mg #30 1/day, Nucynta 100mg #150 5/day, oxycodone 30mg #120 4/day, Ultram 100mg #120 4/day, and Zoloft 100mg #30 1 day. The Norflex and the Neurontin were discontinued. The patient missed his next appointment because his mother was in the hospital. However, there was a note dated 11/-/11 with partially completed answers from the patient regarding his pain etc. He was allowed to obtain a one week supply of his medications. 11/28/11 he returned for follow up. Patient requested an additional Ativan per day and assistance obtaining a motorized scooter. Triage note from the office staff describes patient having a new complaint stating the pt thought he had ruptured another disc, problems moving his back, stated he was taking soma pm. The following prescriptions were issued to the patient: oxycodone 30mg #124 directions 1 every 6 hours, Ultram 100mg #124 to take 1 every 6 hours, Nucynta 100mg #155 to take 1 every 4-6 hours, Ativan 1mg #31 to take 1 daily and Zoloft 100mg #31 to take on every day. 12/27/11 a note written on the "Miscellaneous Patient Information" form by someone other than Dr. Wilson writes the lab ok, patient requests increase in Ativan, Plan: double Ativan, write other meds same". This note did not have a signature or appear to be written by Dr. Wilson. The patient was issued the following prescriptions: Ativan 1mg #60 which was increased, doubled to 1 pill every 12 hrs, Nucynta 100mg #150 with directions for 1 every 5 hours, Ultram 100mg #120 1 every 6 hours, oxycodone 30mg #120 1 every 6 hours and Zoloft 100mg #30 to take daily. 1/24/12 no new complaints, no changes and the same prescriptions were issued. Dr. Wilson makes a note that the patient is satisfied and will continue the same meds. The same prescriptions were issued. 2/21/11 Dr. Wilson notes, "Pt satisfied with current regimen, plan: write same meds". Prescriptions were issued. 3/20/12 Dr. Wilson makes a note, "pt without complaints, plan: write same meds." The same prescriptions were issued. 4/17/12 Dr. Wilson requests MRI of "entire spine" and issues a written order for an MRI of the cervical and thoracic spine. The staff member notes on the triage note that the patient had been out of "oxy" since Sun, and pt suspected the pharmacy to have shorted him. It was also noted on the triage note that the patient had been "self medicating" and stated "Soma and klonidine was prev prescribed by this facility". Dr. Wilson wrote to continue the same medications but he added oxycodone 15mg #120 to take 1 every 6 hours and decreased the oxycodone 30mg to #60 with directions to take 1 every 12 hours and the remainders of the prescriptions issued were the same. 5/14/12 was the last documented visit in the chart. The triage note describes the patient to be "weaker". Dr. Wilson writes that the patient is satisfied with the current regimen and continues the same medications. Prescriptions issued were for increases in quantities of all: Zoloft 100mg #32, Ultram 100mg #128, Ativan 1mg #64, oxycodone 30mg #64, oxycodone 15mg #128 and Nucynta 100mg #160; there were no direction changes in any of the prescriptions issued.

DIAGNOSIS & TREATMENT- Below minimum standards for both.

The patient had findings on an MRI from 1997 and 1994 that clearly indicated degenerative disc disease of the lumbar spine with left paracentral disc herniations at L5-S1 with displacement of the left S1 nerve root and a small annular tear and central disc bulging at L3-4 and L4-5. This pathology justified the use of some of the medications prescribed. There was never any documentation that Dr. Wilson examined the patient, he never rendered diagnoses that warranted the medications prescribed. While there were multiple orders for the patient to have updated MRI studies these were apparently never performed. Nor, was there any documentation of why the studies were not obtained. The only documentation about pain did not mention the neck; it is unclear why Dr. Wilson ordered an MRI study of the cervical spine. The choice to use two shorter acting, high risk opioids/ oxycodone was clearly inappropriate at the doses prescribed and in combination with Nucynta and Ultram. When Dr. Wilson increased doses albeit by small quantities there was no documentation as to why he was doing so. Increases in medications appeared to be in response to requests for additional Ativan. Dr. Wilson did increase the benzodiazepine; he doubled the quantity. He increased the quantity of Ativan and did not make any referral to psychiatry or psychological services. The patients' documented functional status never appeared to improve in spite of the multiple medications prescribed. The chart occasionally contained numbers that appeared to indicate tracking of a KASPER report but this was not consistent. The use of urine drug screening was noted to be marked "yes" in response to "Unanticipated urine screen". However, it is clear the urine drug screen was expected was at each visit. The patient also had several urine drug screens that included medications not prescribed and he acknowledged taking his spouses' medication. Dr. Wilson did not document any discussion regarding aberrant behaviors.

RECORDS – Below minimum standards.

The chart did contain a complete physical examination and history per Dr. Argotte. There were some prior records from the time the patient indicated he had been injured at work. There were records of a discogram and 2 prior MRI studies of the lumbar spine; dates 1998, 1997 and 1994 respectively. There was no documentation or indication that Dr. Wilson reviewed any of these records. The diagnosis of CRPS/CPS initially given to the patient was never validated or mentioned elsewhere in the chart. There was no documentation to indicate Dr. Wilson followed up on any of the prior studies or consultations ordered, including the one ordered by him. Frequently there were conflicting years on records, information written in pencil and lack of employee/physician signature. Prescriptions were not written to standard. There were never any addresses placed on the controlled substance prescriptions. The section in the chart that states "Progress Notes" does not correspond. Often what appeared to be a progress note was located in the "RX" section of the chart. There were several depression screens and tools to evaluate risk associated with the prescribing of opioid medications; these did not appear to be utilized by Dr. Wilson; the documentation indicated Dr. Argotte reviewed these.

OVERALL OPINION- Clearly below minimum standards.

Dr. Wilson never examined the patient, never documented or explained a change in medication related to the patient's condition. His decision to continue the combination of medications was clearly inappropriate. He was prescribing the maximum amounts of Tramadol to a patient also taking higher doses of an SSRI; Zoloft.

The patient was prescribed 4 controlled substances to treat his pain; 3 of which were scheduled II medications. Two of which were high dose in the most abusable form. Dr. Wilson also prescribed high dose benzodiazepine with the opioid/opiate medication which at the doses prescribed result in a dangerous and intoxicating mix. The selection of medications to treat the pain was inappropriate.

3. [REDACTED] Patient had an approximate 12 year history of chronic pain. She initially presented to Commonwealth Quality Healthcare (CQH) on 3/17/11. She was evaluated by A. Argotte, MD. She complained of "center" lumbar pain that was radiating to her anterior and lateral thigh; she stated the pain was constant and sharp. She complained of right hand numbness with activity. She had been to prior pain management physicians. She refused injections. Prior treatment consisted of opioid medications and other medications. She reported being unable to work. She would clean her home when pain levels allowed those activities. She was caring for her disabled husband who had also become a patient of CQH in 1/11. She had cervical, thoracic and lumbar MRI studies performed in 9/21/10 and 6/03/09. The cervical MRI was positive for congenital narrowing of the spinal canal because of short pedicles, multilevel disc bulging and a posterior disc herniation at C6-7 with cord compression. The thoracic MRI demonstrated multilevel disc bulging. The lumbar MRI demonstrated disc bulging from L3-4 through L5-S1 with facet hypertrophy and severe impingement upon the bilateral lateral recesses at L5-S1. She was diagnosed with muscle spasms, anxiety, chronic low back pain, depression and carpal tunnel syndrome. She was given a referral for physical therapy, an upper extremity nerve conduction study, and a psychological evaluation. She was to resume her present regimen of medications. She was given the following prescriptions: Diazepam 10mg #30 to take 1 every day, Nucynta 100mg #120 to take 1 every 6 hrs prn, Ultram 50mg #60 to take twice per day, Soma 350mg #60 to take every 12 hrs and Percocet 10/325mg #120 to take 1 every 6 hrs prn. The patient had follow up visits on 4/14/11, 5/10/11, 6/7/11 or 6/8/11, 7/6/11, 8/2/11, 8/28/11 or 8/29/11 and 9/29/11. These visits had conflicting dates recorded. They were conducted by Dr. Argotte, Dr. Greenlaw and Dr. Dehaven. There was a "Patient Pill Count Sheet" dated 4/23/11 with documentation that the patient was called in for a pill count but could not make it. Her medications prior to seeing Dr. Wilson were: Ativan 1mg #60, Nucynta 100mg #150, Soma 350mg #60, oxycodone 30mg #120, tramadol 100mg #180 and Paxil 25mg #30. On 11/3/11 Dr. Wilson saw the patient for the first time. He wrote on the "Miscellaneous Patient Information" form that "pt ok with present regimen and rewrite meds scripts same". An untitled check list type form had the date of 11/3/11 and yes/no responses to questions. The patient was given prescriptions with quantities that are confusing. Perhaps because the patients' next appointment was in more than 30 days she was given different quantities but this is not clear because there was no documentation to explain the decision. The following prescriptions were issued; Paxil 25mg #32 with directions 1 per day, Soma 350mg #64 with directions 1 every 12 hrs, oxycodone 30mg #128 to take 1 every 6 hrs, tramadol 100mg #180 to take 1 every 4 hrs, Nucynta 100mg #160 to take 1 every 4-6 hrs, and lorazepam 1mg #64 to take 1 every 12 hrs. The next appointment appears to be on 12/8/12. On this visit the chart contains two confusing prescriptions written by Dr. Wilson. One is for Nucynta with a notation that script needs to be written on a green one; another prescription for Nucynta is dated for 12/12/11 same quantity. A tramadol prescription was written but the date is 12/15/11 for 50mg #240. Dr. Wilson makes a note on the same miscellaneous form that Calloway lab test was within normal limits, the plan was to discontinue Soma, leave other meds the same and decrease oxycodone 30mg by 1 pill and increase oxycodone

15mg by 1 pill and the following month discontinue the oxycodone 15. A triage note for the same day appeared to be signed by [REDACTED]. The patient was given the following prescriptions: oxycodone 30mg #132 which was increased not decreased and directions were to take 1 every 6 hrs, lorazepam 1mg #66 which was increased with directions to take 1 pill every 12 hrs, the Nucynta 100mg #165 which was increased and no change in directions, tramadol which appeared to be phoned to the pharmacy and changed to 50mg #198 with directions to take 1 every 4 hrs and Paxil 25mg #33 which was an increase and no change in directions. **(The Kasper report does not reflect these Rx as they are reflected by the copies in the chart).** On 1/5/12 prescriptions were issued again for the patient but there is no note of any kind from Dr. Wilson. There is a triage note from an office person that was unremarkable. A urine drug screen was performed for that day opiates tested positive at more than 3000 but not confirmed. The prescriptions were given to the patient early by 2 days. Ultram 50mg #240 with directions 2 every 6 hours, Lorazepam 1mg #60 with directions 1 every 12 hrs, oxycodone 30mg #120 with directions 1 every 6hrs, Nucynta 100mg #150 with directions 1 every 5 hrs and Paxil 25mg #30 with 1 every day. 2/6/12 the patient returns and Dr. Wilson makes a note that the patient is satisfied with the current regimen and the plan is to write the same meds except decrease the oxycodone 30mg by 1. The patient was issued the following prescriptions: the oxycodone 30mg was decreased to #90, Ultram was changed to 100mg #120 to take 1 every 6 hrs, Lorazepam and Paxil remained the same. A prescription copy for oxycodone 10mg #90 with directions to take 1 pill every 8 hrs was in the chart for 2/16/12 but there is no note or documentation to explain its existence. 3/7/12 Dr. Wilson makes a notation that the patient is satisfied with her current regimen, requests 3 refills on her Paxil which he granted and he will continue to write same medications. The triage note from staff member Yavonda reports the patient to be complaining of low back, neck and sciatica pain and was having pain in her ovaries. The patient was given the same RX including another RX for the oxycodone 10mg #90. The lorazepam prescription had the date of 3/8/12 on it which was different from the other which had the 3/7/12 date. 4/2/12 The patient returned and was noted by Dr. Wilson to be satisfied with her current regimen and he was going to write for the same meds. The triage note documents that patient "may have took 1/2 Klonopin". The chart contains what appear to be copies of prescriptions issued on this visit but there is confusion. The chart does not appear to contain all copies of prescriptions issued. The KASPER lists Lorazepam #60 filled on 4/2, oxycodone 30mg #90 filled on 4/2/12 and Nucynta 100mg #150 filled on 4/2/12 and oxycodone 10mg #90 filled on 4/12/12. It is unclear what prescriptions the patient was issued in the office visit of 4/2/12. The last visit documented in the chart was on 4/30/12. Dr. Wilson notes the patient as doing well and to write the same meds. Prescriptions were issued for Lorazepam 1mg #56, oxycodone 10mg #84, oxycodone 30mg #84, Nucynta 100mg #140, Ultram 100mg #112 and Paxil 30mg #84.

DIAGNOSIS, TREATMENT & RECORDS-All three categories were below minimum standards.

The patient had a diagnosis of severe stenosis at multiple levels in her spine. The chart contained an adequate history and physical upon her initial treatment by Dr. Argotte. There was no documentation that Dr. Wilson ever examined the patient. He never attempted to clarify the possible diagnosis of carpal tunnel syndrome. There was no follow up on previously ordered studies and referrals. There were no other treatments for the patient except for medications. The attempts to monitor the patients' use of controlled substances were inadequate. Though urine drug screening was utilized at each visit the decision to cancel confirmation of presumed positive substances not prescribed was concerning. The patient admitted she was taking medications not prescribed for her but to her husband. Results of another screening indicated she had taken buprenorphine and hydrocodone; neither prescribed. The buprenorphine is found in a transdermal opioid medication called Butrans. Buprenorphine is also Suboxone. The confirmations initially requested for both of these substances were cancelled for reasons that were not clear. There was no documentation that the results were reviewed and considered by Dr. Wilson. There were other confirmations that were cancelled for reasons that are not clear. The prescribing mixture was inappropriate. Dr. Wilson exceeded the maximum recommended dose for the safe prescribing tramadol. This was particularly concerning because the patient was also prescribed SSRI medication which in combination with tramadol may cause seizures etc. The records never contained any working diagnoses. The chart had divided categories of records that were confusing and often had conflicting dates. The controlled substance prescriptions never were written to the appropriate and expected standard of also including the address of the patient. KASPER tracking numbers were at times on the triage record.

OVERALL OPINION- Below minimum standards and considered to be gross ignorance and gross incompetence.

There was never any documentation of a physical examination or diagnosis rendered by Dr. Wilson. He never followed up on any prior studies requested. He appeared to ignore obvious aberrant behaviors concerning high risk medications. He ignored repeated abnormal urine drug testing results. His prescribing of medications was grossly incompetent and without apparent concern for the safety of the patient. He prescribed multiple high risk medications with inappropriate doses and combinations.

4. [REDACTED] She appeared to have received care from Commonwealth Quality Health Care in 2010. (CQH) She was treated by numerous physicians at CQH. Physicians included Najam Azmat, MD; Mary Beth Scott-Calor, DO; Alex Argotte MD; R. Greenlaw, MD and H. Dehaven MD prior to Dr. Wilson. She presented with complaints of arm, elbow, low back and neck pain. She was involved in an accident at the age of 16 or 16 or 17 and fractured her left arm; the fracture required the placement of hardware. She was involved in motor vehicle accidents in 2001-2003 and in 2009. She began to have complaints of neck and back pain in addition to the arm pain. MRI studies taken in 2009 revealed the following: cervical spine study was normal except for straightening of the normal curve suggesting an underlying muscle spasm; thoracic spine was normal and the lumbar spine demonstrated a disc bulge at L5-S1. The patient also complained of significant anxiety and insomnia. She was diagnosed in 2010 with CPS/chronic pain syndrome, myofascial pain and "probably fibromyalgia" by the initial treating physician at CQH. (It is difficult to follow the flow of patient care due to the placement of records in the chart). There were episodes of aberrant behavior documented throughout the chart prior to Dr. Wilson's care. Examples include "borrowing" medications from friends, see note per Dr. Argotte on 3/10/11; purchasing medications "off the street", see note per illegible name written on "Miscellaneous Patient Information" sheet dated 12/14/10; note written "no pot" on 1/24/11 by what appears to be ? Dr? Some attempts at pill counts were not successful, see note written on 4/7/11 by Dr. Argotte. In addition, the patient had multiple red flags with urine drug screening. For example, the urine drug test performed on 9/30/11 did not pass validity testing and the sample contained opiates in addition to the oxycodone and benzodiazepine. The sample was not sent for confirmation of the hydrocodone (opiate). She was ordered to have a physical therapy psychiatric evaluation and other diagnostic studies but was unable to go because she reported financial limitations. On 9/30/11 she was given orders to have MRI studies of the cervical, thoracic and lumbar spine and a note indicated Percocet would be added until the results of the diagnostic studies were completed. 10/31/11 Dr. Wilson began care of the patient. There is a note under the "progress notes" tab of the chart that was not signed by anyone but lists a KASPER tracking number, vital signs and various questions. Under the "RX" tab of the chart is a note written on the same day which appears to be from Dr. Wilson and states, "pt satisfied with current med regimen, will script same meds and return in 1 month". The patient was given the following medications: oxycodone 15mg #90 to take 1 every 8 hrs, Percocet 10/650 #60 to take every 12 hrs and Xanax 2mg #60 to take 1 every 12 hrs. The urine drug screen on this date did not have benzodiazepines present as should be. 11/29/11 she returned for follow up and Dr. Wilson notes the abnormal lab, he also notes that the patient requests Fioricet for her headache because she took her mother's Fioricet and it "worked". He notes other medications are working well. He wrote he would continue all other medications. The following prescriptions were given: oxycodone 15mg #90, Percocet 10/650 #60, Xanax 1mg #30 and Fioricet #30 with directions to take 1 daily prn. The patient was called in for a pill count on 12/7/11 but stated she could come on the following Monday. She came for the pill count on 12/12/11 and it appeared to be okay. She was given an additional prescription for Xanax on that day because her prior

prescription was a partial prescription. The visit of 12/22/11 has a notation from Dr. Wilson, "Calloway 11/29 OK". She was given the same prescriptions as the 11/29/11 visit and in error was given an additional Xanax prescription. 1/19/12 patient returned for follow up. Dr. Wilson made a note that the patient goes by the name [REDACTED], she was satisfied with her current regimen and all medications were to be written the same. However, there was not a prescription noted for Fioricet. The Xanax continued to be off the regular schedule as the patient picked up a prescription for Xanax on 12/27/11. 2/16/12 A triage note by the nurse/staff could not be found for this date. There was a note written by Dr. Wilson stating "no complaints, plan: write meds same". She was given the same prescriptions for oxycodone, Percocet and Xanax. A urine drug test on this date indicated there was no Xanax in the urine. 3/15/12 Dr. Wilson makes a note that patient was without complaints; benzodiazepines were negative and plan to write the same meds. She was issued the same prescriptions for oxycodone, Percocet and Xanax. 4/12/12 Dr. Wilson addressed the negative benzodiazepine result from the previous visit. He wrote a lengthy note as compared to prior notes and addressed in this note the patients use of soft drinks and dental deterioration; he instructed her regarding proper dental hygiene. At this visit he writes his plan is to decrease the oxycodone by 1 pill and increase the Percocet by one and other medications to remain the same. He issued the prescriptions with changes as he described but did not explanation why. Prescriptions issued were: Oxycodone 15mg #60 with directions 1 every 12 hrs, Percocet 10/650 #90 1 every 8 hrs and Xanax 1mg #60 every 12 hrs. 5/10/12 the patients' urine drug test was again negative for benzodiazepines. The follow up triage note from the nurse/staff indicates "pt was told no more bad labs 2 -bzo in final lab, -bzo today". Dr. Wilson makes a note, "pt w/o complaints, plan: write meds same". On this visit Dr. Wilson increased the patients medications as follows and was given the following prescriptions: oxycodone 15mg #70 (with no change in directions) 1 every 12 hrs, Percocet 10/650 #105 (no change in directions) 1 every 8hrs and Xanax 1mg #70 (no change in directions) 1 every 12 hrs.

DIAGNOSIS & TREATMENT- Below minimum standard for both.

There never appeared to be a diagnosis given by Dr. Wilson. There was no documentation in the record that he ever examined the patient, reviewed prior studies or notes and followed up on prior diagnosis and plans. The diagnostic studies do not indicate the patient has a diagnosis that justified the use of the prescribed controlled substances for pain. She was treated with more than one high risk shorter acting opioid without the indications. The patient was given medications repeatedly while the record documented repeated aberrant behaviors. KASPER data reviewed indicates the patient was also given multiple early refills on her medications. Dr. Wilson never wrote any orders for consultations or referrals to diagnose pain complaints or treat her anxiety.

RECORDS – Below the minimum standard.

The organization of forms and documents in the chart was poor. The chart contains tab separators but the documents are placed throughout. An example of this is the placement of what appears to be a progress note and on a form titled, "Miscellaneous

Patient Information" in the RX tab and also appears at times in the "History and Physical" tab. There are numerous forms which do not contain any name, etc. There are notes written without any signature. As stated above there is no diagnosis by Dr. Wilson. The working diagnosis is never validated. None of the controlled substance prescriptions are written to standard; all without address, some without the year and none with the numerical quantity written out. There are tracking numbers periodically that indicate a KASPER report was obtained but rarely are the results of the report noted.

OVERALL OPINION- Clearly below the minimum standards. Grossly ignorant and grossly incompetent.

Dr. Wilson continued to prescribe high risk medications without documentation that he examined the patient or rendered a diagnosis. He prescribed these medications to a patient that did not have the indications to use them and increased them frequently. Further, he ignored obvious behaviors that indicated the patient was either diverting the medication or developing an addiction to the medications. A review of the KASPER data indicated that the patient was given significant early refills from February thru May of 2012. While the record contains tracking numbers to indicate a KASPER report was obtained it is apparent by Dr. Wilson's actions indicate that he never considered this information while treating the patient or simply chose to ignore it. He counseled the patient about proper dental hygiene but did not address bad urine drug testing results. The decision making regarding not only the choice of medication but quantities is flawed. He departed from the minimum standards to such an extent that his care of the patient is concluded to be grossly ignorant and grossly incompetent.

5. [REDACTED] Patient appears to initially present to the facility in 2010. However, from review of the chart it is not conclusive as to when he actually presented. A consent form located in the "History and Physical" section does not have a date on it because white out has been used to cover up the date written on it. This form is some type of consent and contains a patient signature in several places; both dates on the form have been covered up with white out. He complained of chronic pain as a result of a motor vehicle accident in 2006. In that accident he sustained multiple fractures; right leg, left ankle (which required surgery) and left wrist. He also complained of lower back pain that was radiating down the leg. In the patient's self-reported questionnaire he reported that he had an arrest for a DUI in mid 2010. On another document it notes the patient to be on probation June/July 2012. The chart contains an MRI of the lumbar spine dated 5/16/2011 which was normal and a thoracic MRI dated 5/18/11 had mild disc space narrowing as a result of a disc bulge at T10-11. The patient was treated at CQM by N. Azmat, MD; M. Scott-Calar, DO; A. Argotte, MD; R. Greenlaw, MD; H. Dehaven, MD prior to Dr. Wilson. The records contained a history and physical examination per Dr. Argotte and a psychological evaluation as requested by Dr. Argotte. It was noted by prior physicians that the patient had experienced seizures. The outcome of the psychological evaluation was noted as "guarded" and it was suggested he be referred to a substance abuse professional for evaluation and referral to a neurologist evaluation for possible prior head injury. He was also given orders to have physical therapy. It was also during the care of Dr. Argotte that the patient was given the orders for MRI studies which were done and noted as above. There did not appear to be any follow up on the recommendations. The chart also contained numerous abnormal urine drug test results to include medications not prescribed, medications prescribed that were absent and detection of marijuana use. It appeared the patient was actually dismissed from the facility for noncompliance sometime in September 2011. At the time of dismissal he was being prescribed Neurontin, Xanax, Ultram and oxycodone. Dr. Wilson began to see the patient on 11/10/11. The patient was dismissed after his September visit and given two weeks of medications at the time of dismissal. When he returned he had clonazepam, opiates, oxycodone, Xanax and THC in the urine drug test. Dr. Wilson wrote a note on the "Miscellaneous Patient Information" form that the patient stated the Neurontin and Ultram do not help and the patient was complaining of breakthrough pain and insomnia. He instructed the patient to take 25mg Benadryl at bedtime, discontinue the Neurontin and Ultram, and add oxycodone 10mg for breakthrough pain. There was no discussion of the failed urine drug test, any apparent physical examination or documentation of prior consultation notes etc. There did not appear to be a KASPER report obtained at this visit. He was issued the following prescriptions: Xanax 1mg #68 with directions of 1 pill every 12 hrs, oxycodone 15mg #130 with NO directions and oxycodone 10mg #68 with directions for 1 pill every 12 hrs. 12/12/11 the patient returned for follow-up. The urine drug test at this visit for negative for benzodiazepines which were prescribed and okay for oxycodone. Dr. Wilson made a note on this visit that the prior urine test was positive for clonazepam; he would have the patient return in 15 days for a pill count and given same prescriptions except for Xanax enough for 15 days. He was issued prescriptions Xanax 1mg #30 to take 1 every 12

hrs, oxycodone 10mg #60 to take 1 every 12 hrs and oxycodone 15mg #120 to take 1 every 6 hours. Attempts to call the patient for a pill count on 12/19/11 and 12/20/11 were unsuccessful because they could not reach the patient. A pill count was performed on 1/3/12 and the quantities were not correct, the patient stated he thought he had misplaced some of the oxycodone. 1/10/12 the patient presented for follow up and the note from Dr. Wilson reports that patient is satisfied with the current regimen but complains of insomnia, the patient is requesting Xanax for sleep and Dr. Wilson wrote; "denied". The patient reported Ambien and Benadryl not working. Plan was to write for same medications and add Elavil 25mg for sleep. A urine drug test on this date was negative again for Xanax and positive for oxycodone and opiates. The opiates are never sent for confirmation. The patient was issued the following prescriptions: Elavil 25mg #30, oxycodone 10mg #60, Xanax 1mg #30 and oxycodone 15mg #120. A pill count is noted on 1/26/12 that the pharmacy employee "Tony" counted the patients medication at the pharmacy and it is as should be. 2/7/12 he returned for follow up and Dr. Wilson notes the patient to be satisfied with the current regimen and write same meds. The patient was issued the same prescriptions as the previous month. 3/7/12 The patient is issued the same prescriptions except the Xanax is now increased back to #60 with directions every 12 hrs. Dr. Wilson makes a note that the patients anxiety has increased and he will increase the Xanax by 1 and continue other medications the same. 4/4/12 the patient returned with complaints of poor sleep. Dr. Wilson makes a note that the patient reported to him the Elavil was "too weak for sleep", Dr. Wilson's plan was to change the oxycodone 10mg to Percocet 10/650 and decrease the oxycodone 15 by 1 pill and increase elavil to 75mg and continue other medications the same. The patient was issued the following prescriptions: Elavil 75mg #30, oxycodone 15mg #90 to take 1 every 8 hours, Percocet 10/650 #90 to take 1 every 8hrs and Xanax 1mg #60 to take 1 every 12hrs. The urine drug test on this day was positive for THC, Xanax, opiates and oxycodone. Opiates were not sent for confirmation. 5/7/12 note per Dr. Wilson states the patient was without complaints, patient wants to finish GED and join the military and then to college. Plan was to continue same medications. The patient was issued the same prescriptions but with a small increase all quantities with the same prior directions without explanation. Xanax 1mg #64, Elavil 75mg #32, Percocet 10/650 #96 and oxycodone 15mg #96. The urine drug test for this date was positive for THC and negative for benzodiazepines.

DIAGNOSIS, TREATMENT & RECORDS: All three areas are clearly below the minimum standards.

There is no documentation that Dr. Wilson ever examined the patient or rendered a diagnosis. The diagnostic studies do not justify the use of the medications prescribed. There did not appear to be any follow up on the prior orders for additional studies. The patient was evaluated by psychological services and the outcome of this evaluation indicated the patient needed to be evaluated by a substance abuse specialist. The record was clear that the patient had an arrest for a DUI and was on probation. There was never any documentation that Dr. Wilson considered this information in treating the

patient. There were no other therapies used to control his pain. The patient demonstrated multiple aberrant behaviors related to use of controlled substances. There were KASPER tracking numbers in the chart but the KASPER data did not appear to be considered. The patient was given multiple early refills and he actually was given Xanax #98 in 28 days according to KASPER data. The patient had quantities of medications that were inappropriate and not justified. The combination of high dose benzodiazepines with opioid medications was inappropriate. Continued use of benzodiazepines with the knowledge the patient failed to have this medication present in the urine is not acceptable. The records did contain multiple tracking numbers for KASPER data. All controlled substance prescriptions failed to be written to standard; omitting the patients address and written numerical quantity, some did not have the year written and some lacked written directions.

OVERALL OPINION- Clearly below the minimum standards. The care of this patient was considered to be grossly incompetent, ignorant and negligent. Dr. Wilson prescribed multiple high risk opioid medications to a young patient that did not have the medical indications to be prescribed such medications. There is no explanation as to why this patient was allowed to return to the facility after he had been dismissed for aberrant behaviors. This patient was clearly demonstrating aberrant behaviors and should not have been prescribed controlled substances. This patient was most likely diverting the medications he was prescribed.

6. [REDACTED] The initial visit appears to be either September or November of 2010; the record is not clear. The patient reportedly was involved in a motor vehicle accident in 2003 and maybe in also 2007 (again the record is not clear) he continued to have pain in his lower back radiating to his leg and trouble sleeping. He also complained of neck pain radiating down both arms and his back. MRI and CT studies in the record are all essentially normal. These studies are from 6/17/2010 and 1/7/2008. There are of the lumbar and thoracic spine. The patient was treated by all the prior Commonwealth Quality Healthcare physicians and Dr. Wilson. His initial treatment included Soma, Valium and hydrocodone and these medications continued until the patient started seeing Dr. Wilson. There are no copies of prescriptions given to the patient included in the record before 9/20/11. The patient appears to have been dismissed from the facility in 4/18/12 for "bad labs/pill count". This patients record is not in any order; it appears to have been removed from a ringed binder and placed in a yellow envelop after the patient was dismissed. 10/18/11 Dr. Wilson gave the patient the following prescriptions: Lorcet 10/650 #90 with directions to take 1 pill every 8 hrs, Soma 350mg #90 to take every 8 hrs, Valium 10mg #90 to take every 8 hrs and an order for the patient to have an MRI of the lumbar and thoracic spine because of pain with radiculopathy, possible compression with numbness and tingling. There was what appeared to be a triage note completed by "Sue" who describes left knee pain and pain in the lower back that was shooting up the spine and down the legs. He reported his meds were working but he still had pain. There is no note from Dr. Wilson or notations from him on the triage form. There was no diagnosis rendered. 11/16/11 The patient presented for follow up and the urine drug test was positive for oxycodone which was not prescribed. There are notes on the urine test form that have been covered up with white out and could not be read. The patient said he had taken his mothers Percocet. Dr. Wilson makes a note on the "Miscellaneous Patient Information" form that the patient was complaining of valium not helping and he was having breakthrough pain, his plan was to replace the valium with Xanax 1mg bid and replace the Lorcet with oxycodone 10mg 4 times per day and keep the Soma the same. He issued the following prescriptions: oxycodone 10mg #120 to take 1 pill every 6 hrs, Soma 350 #90 to take 1 every 8 hrs and Xanax 1mg #60 to take 1 every 12hrs. 12/14/11 The patient returns, reports a friend gave him an oxycodone 15mg and it worked better, ran out of medications and had to "borrow from friends and family" because his medications were stolen, "had entire safe stolen". He requested his oxycodone be raised to the 15mg. Dr. Wilson notes the patients previous urine test results and that the patient took his mothers Percocet. He noted patients complaint of the "oxy's barely" decrease pain; complaints of anxiety and plans to replace the oxycodone 10's with the 15 at #150, increase the Xanax by 1 per day and continue the soma. He issued the following prescriptions: oxycodone 15mg #150 to take 1 pill every 4-6 hrs, soma 350 #90 to take 1 every 8 hrs and Xanax 1mg #90 with directions to take 1 pill every 8 hrs. 1/12/12 he returned for follow up stating meds were working well per staff member "Follow up Triage" note per "Sue"; Dr. Wilson writes a note that the patient was complaining of breakthrough pain and anxiety and he planned to decrease soma by 1 pill, increase Xanax by 1 pill and add Percocet for breakthrough pain. He issued the following

prescriptions: Oxycodone 15mg #150 q5h, Percocet 10/650 #60 1 every 12 hrs, Soma 350mg #60 1 every 12 hrs and Xanax 1mg #120 to take 1 every 6 hrs. On 1/26/12 the pharmacy employee "Tony" called in a "pill count" which indicated all correct except he had 1 more Xanax than prescribed. 2/9/12 the patient presented and the follow up triage note by the nurse states "Pt says he will bring paperwork showing PI was dismissed". There is no documentation of explanation regarding this statement. It suggests the patient had been charged perhaps with a public intoxication offense. But it is unclear, not addressed or explained. Dr. Wilson does not mention this in his note. Dr. Wilson makes a note that states the patient is satisfied with the current regimen, and he plans to decrease the oxycodone by 1 and increase the Percocet by 1 and decrease the Soma by 1. He writes (lab e) but there is no explanation as to what he was stating. He also writes other meds same and "pt is maxed out". He issued the following prescriptions: oxycodone 15mg #120 1 every 6 hrs, Percocet 10/650 #90 1 every 8hrs, Soma 350mg #30 1 every day and Xanax 1mg #120 to take 1 every 6 hrs. 3/8/12 he returned and said his medications were helping as noted per the triage note from "Sue". Dr. Wilson makes a note that the patient was complaining of increased pain, he planned to add 1 Percocet, other meds same, he will let the patient continue Soma because he has been cut back from #120 pills. He gives the patient the following diagnoses: acrophobia, agoraphobia and claustrophobia. He issued the following prescriptions: oxycodone 15mg #120, Percocet 10/650 #120, Xanax 1mg #120 and Soma 350 #30. 4/4/12 the triage note states meds are helping, Dr. Wilson makes a note that the patient requested an increase in the oxycodone which was denied and all medications to stay the same. He issued the same prescriptions as the preceding month.

DIAGNOSIS, TREATMENT & RECORDS: All three are below the minimum standards.

There is no justifiable diagnosis in which to use scheduled 2 controlled substances. There is no history and physical in the record. There was no record of any follow up on diagnostic studies that were ordered. There were no other treatments or evaluations for this patient. There was no apparent follow up on the notation of public intoxication and illegal behavior related to controlled substances. The record included what appeared to be a printout from a local newspaper that listed the patient as being arrested for public intoxication with Dr. Wilson made the diagnoses of phobias as described above without any documentation as how he came to those conclusions. Treatment for the psychiatric diagnoses was not appropriate. Dr. Wilson prescribed high dose medications in its most abusable form to an individual that presented without the diagnoses to warrant such prescribing. Further, he continually increased the benzodiazepine, continued another sedating drug (soma) and in combination with high dose opioids. While there were frequent abnormal urine drug test results, the patient was continued on the same dangerous medications without justification. KASPER tracking numbers appeared consistently throughout the record but Dr. Wilson never made note of the information. The patient was given early refills on medications frequently; 2-4 days early. The patient demonstrated aberrant behaviors. The pill count phoned in from the pharmacy employee was highly suspect. It is also noted by this reviewer that the patient

Chester Dorton has the same pill count phoned in. The records were disorganized and incomplete. None of the controlled substances prescriptions had the patients address on them.

OVERALL OPINION – Clearly below minimum standards. Gross Ignorance, negligence and incompetence.

Dr. Wilson prescribed high risk medications for many months on this patient while ignoring aberrant behaviors. He prescribed medications to this patient who did not have a diagnosis.

7. [REDACTED] This patient appeared to present on 7/28/11. He was dismissed in April 2012 for having cocaine in a urine drug test. (The records have been removed from a chart binder and placed into a yellow envelope. The contents are disorganized and it difficult to determine flow of care as the complete date is often not on the documents). He complained of lower back pain that radiated to his left leg. He reported to have had two prior back surgeries and the problem was precipitated by a motor vehicle accident in 2001. He also reported he had 2 prior knee surgeries. He had been a patient of another pain management center, "Care More" but stated he left because he was not happy with the physician. He reported the Percocet's and Lorcet were no longer helping him. Included in the record were several MRI reports. An MRI of the lumbar spine dated 12/9/2002 notes postoperative changes at L5-S1 consistent with a laminectomy on the left and fibrosis, disc degeneration and spondylosis at L4-5, minimal retrolisthesis of L5-S1; he reported some type of trauma in 7/11 and had MRI studies of the cervical spine dated 7/17/11 was normal, MRI of the thoracic spine dated 7/17/11 demonstrated a mild curvature of the upper spine but was otherwise normal; an MRI of the lumbar spine dated 7/17/11 demonstrated degenerative disc disease with acquired central canal and neural foraminal narrowing. Following a motor vehicle accident in 1/2012 he had an MRI of the lumbar spine dated 1/03/12 which demonstrated a minimal central disc bulge at L4-5, central and left paracentral disc bulge at L5-S1 on the left creating left neural foraminal stenosis and slightly displacing the S1 left nerve root sleeve and an MRI of the cervical spine on the same date (1/03/12) showed small diameter of the spinal canal probably due to congenitally short pedicles otherwise the study was normal.. The patient had considered additional surgery and/or placement of a "nerve stimulator pump". The patient also reported he had a back brace. Prior to Dr. Wilson he was prescribed Neurontin for approximately 1 month, Xanax 1mg twice per day, oxycodone in various strengths including Percocet's and approximately one month of nortriptyline. 10/18/11 Dr. Wilson began seeing the patient. A note for the same date written on the "Miscellaneous Patient Information" form documents that patient not having any new complaints or injuries and his treatment plan will continue; the initials "Ya" appear on this note. Beneath that note Dr. Wilson wrote, Percocet 10/650 q8h #90, oxycodone 30mg q6h #120 and Xanax 1mg bid. He issued those prescriptions to the patient. 11/16/11 the patient returned for follow up and the follow up triage note reported the patient to have left knee pain, weather was intensifying his pain and a rock had fallen on him while working underground. He also complained of the Percocet's upsetting his stomach and not offering much relief. This note was not signed. Dr. Wilson makes a note that the patient complained of increased pain, Percocet's were upsetting his stomach, relief and he would replace the Percocet with oxy 15 and continue other medications the same. He issued the following prescriptions: oxycodone 15mg #93 with directions to take 1 pill every 8 hrs, oxycodone 30mg #124 to take 1 pill every 6 hrs and Xanax 1mg #62 to take 1 pill every 12 hrs. 12/15/11 The patient returned and complained of new pain in his neck and mid back as a result of a motor vehicle accident December 5th. The patient went to the ER for care following the accident. There is no signature or initials on the follow up triage note. Dr. Wilson makes a note on the "Miscellaneous Patient Information" form that the Calloway lab from 11/16/11 was okay;

a urine drug test was performed on this date and abnormal with amphetamines, THC and opiates in the screen in addition to the Xanax and oxycodone. The Xanax and oxycodone were expected to be in the urine. For unknown reasoning the amphetamines and opiates were not confirmed. There was no documentation by Dr. Wilson that he reviewed these results on the day the patient was present. The patient complained of more pain because he had been in a prior motor vehicle accident with the vehicle flipping over 3 times. Dr. Wilson planned to increase the oxy 15 by one and continue other meds the same, he made a note that the patient had "plateaued w/ox". He issued the following prescriptions: oxycodone 15mg #132 with directions to take 1 every 6hrs, oxycodone 30mg #132 to take 1 every 6 hrs and Xanax 1mg #66 to take 1 every 12 hrs. There appeared to be a pill count performed on 12/21/11 which for the most part was acceptable. 1/16/12 it appeared the patient was asked about the results from the previous month's urine drug test. The patient reported he had been a patient at a weight loss clinic for several months and received "Adipex". He also reported he took Fioricet from his wife for a headache and had been around friends who were smoking THC. The follow up triage note states the patient understands he can be dismissed. This note is signed by L Kidd, RN. Dr. Wilson makes a note that the patient was satisfied with the current regimen and his plan was to continue the same meds. He issued the patient the following prescriptions: oxycodone 15mg #120, oxycodone 30mg #120 and Xanax 1mg #60. 2/13/12 the patient did not have any new complaints, the triage note circles yes to the question if the patient had visited another medical facility since the last visit and a notation is made, "neurologist-pt says he did not take anything". A urine drug test was again abnormal and contained THC. Dr. Wilson makes a note that the patient is satisfied with the current treatment regimen and he will decrease the oxycodone 30 by 1. He issued the following prescriptions: oxycodone 30mg #90, oxycodone 15mg #120 and Xanax 1mg #60. 3/12/12 The triage follow up notes patient to describe increased pain since the Dec motor vehicle accident, left knee and mid back pain. Dr. Wilson makes a note that the patient is without complaints and he plans to decrease the oxycodone 30mg by 1 and other medications to stay the same. He issues the following prescriptions: oxycodone 15mg #120, oxycodone 30mg #60 and Xanax 1mg #60. The urine drug test on this day was again abnormal; positive on screen for opiates and THC. 4/9/12 the patient returned and cocaine was in his urine. He was given a dismissal letter and prescriptions for 2 weeks of his medications. He was issued the following prescriptions: oxycodone 15mg #60, oxycodone 30mg #30 and Xanax 1mg #30. The patient dismissal letter included a note that if the final labs "come back - (negative) cocaine will call you and will be a pt again".

DIAGNOSIS & TREATMENT -Below the minimum standards for both.

The patient appeared to have proper diagnostic studies for his back complaints. It would appear the patient had a lumbar spine condition that did cause pain. There was discrepancy in the diagnostic studies; one diagnostic study did not indicate the prior back surgery and one did. If the patient had back surgery he would have been very young and this age would be approximately 15-17 years old. There were also no records from the prior pain management care. There were no physical examination

notes to indicate the patient had lumbar scarring. The patient never appeared to have any diagnostic studies of his left knee indicating the cause of his pain complaints. There never appeared to be any physical examination of the patient by anyone. There no notes to indicate that Dr. Wilson ever examined the patient or rendered a diagnosis other than for pain and anxiety. The patient was treated with 2 short acting opioid medications with multiple doses in combination with high dose benzodiazepines. There were no other adjunctive therapies utilized or referrals. If the patient had anxiety problems that required benzodiazepines he should have been referred to a psychiatrist for evaluation of this problem and proper treatment. The patient was ultimately dismissed when he used cocaine. However, he was treated for approximately 8 months by Dr. Wilson while he obviously ignored the indicators of aberrant behavior.

RECORDS – Below the minimum standards.

There was no history and physical, follow up evaluations lack appropriate content, the controlled substance prescriptions were never written to standard. The records contain multiple urine drug testing results but appeared to be ignored. The record contained triage follow up notes that did not correlate to notations made by Dr. Wilson. The triage notes often did not have any signatures. The records contained multiple tracking numbers for the KASPER data but this too appeared to be ignored. In review of KASPER data for this patient, he was given multiple early refills of controlled substances without explanation.

OVERALL OPINION – below the minimum standards and gross ignorance, negligence and incompetence.

Dr. Wilson demonstrated incompetence and lack of knowledge in treating pain and prescribing medications to treat pain. He failed to adequately prevent probable fraud and abuse of high risk controlled substances. Dr. Wilson failed to practice the most fundamental and basic component of medicine; conducting a physical examination and formulating a diagnosis. There was no indication that he did either one.

8. [REDACTED] 12/22/11 the patient initiated care with Commonwealth Quality Health Care/Dr. Wilson. He had been under the care of another pain specialist/Kentucky Pain Physicians in Pikeville, Kentucky; Robert Windsor, MD. He reported leaving that facility because "the medication wasn't helping and the Dr. wouldn't listen." He said he had back pain for approximately 3 years. He reported that he had used a heating pad and a back brace. He also reported that he was disabled due to "bad" nerves. He stated he was previously under the care of a psychiatrist for depression and anxiety. Dr. Wilson makes a note on the "Miscellaneous Patient Information" form that the patient presented to be "evaluated with complaint of chronic pain lower back". The plan was "ox 10's #120, Klonopin 1mg #60. The patient reported he was on hydrocodone 7.5, clonazepam 1mg and fizanadine 4mg. A urine drug test was performed on this initial visit and abnormal for multiple benzodiazepines, oxycodone and opiates. Records were obtained from the prior pain management physician and these included office visit notes and diagnostic studies. An MRI of the lumbar spine was essentially normal except for mild disc bulging at L4-5 and L5-S1. A nerve conduction and EMG study was performed on 8/9/11 and the result was normal. Dr. Wilson issued the patient the following prescriptions: oxycodone 10mg #120 to take 1 every 6 hrs and Klonopin 1mg #60 to take 1 pill every 12 hrs. 1/23/12 the patient returned for follow up and stated he was involved in a motor vehicle accident on January 3rd. He reported was seen in the ER and said everything was fine but he was having increased pain. This information is written on the "Miscellaneous Patient Information" form by L. Kidd, RN. The follow up triage note for the same day also completed by Kidd, RN notes the patient reporting the Klonopin is not strong enough, there were no new complaints, he may have taken a Xanax at his uncle's funeral. Dr. Wilson makes a note that the patient is complaining that the oxy's are too weak, Klonopin does not work and plans to replace the oxy 10's with 15's and replace the Klonopin with Xanax. He issues the following prescriptions: oxycodone 15mg #120 to take 1 every 6hrs and Xanax 1mg #60 to take 1 every 12 hrs. The urine drug test on this date is positive for barbiturates, no benzodiazepines, opiates and oxycodone; the confirmation testing was negative for benzos and oxycodone but is not conclusive. 2/20/12 the follow up triage note reports pts meds are working good, he reported he was seen in the ER for a cold. Dr. Wilson writes the patient is without complaints and to write the same meds. The urine drug test on this date was positive for multiple benzodiazepines, opiates and oxycodone. The patient was issued the same prescriptions as the preceding month. 3/19/12 the follow up triage note says the pain had increased in his lower back and he was asking for break thru pain medication, he was warned about previous lab results, the note was signed by L. Kidd, RN. The urine drug test was negative for benzodiazepines. Dr. Wilson makes a note that the patient was asking for breakthrough, "benz labs are a concern. Plan to increase oxy 15 by 1 and other meds same, trend labs closely". Dr. Wilson continued the Xanax 1mg #60 to take every 12 hrs and was given an increase in his oxycodone 15mg to every 5 hr #150. 4/16/12 he returned for follow up and did not have any new complaints was warned about inconsistent labs and asked for an increase in Xanax due to difficulty sleeping and "stays aggravated". This note again per L. Kidd, RN. A urine drug test for this date was again negative for Xanax, tramadol, opiates and

oxycodone. There was no documentation or notes from Dr. Wilson but he issued the following prescriptions: Xanax 1mg #60, oxycodone 15mg #120 and Percocet 10/650 #60. Percocet was added to the mixture on this visit with no explanation. 5/14/12 the patient was dismissed from the facility and given 15 day prescriptions. There is no note or documentation from Dr. Wilson. He issued the following prescriptions: Xanax 1mg #30, oxycodone 15mg #60 and Percocet 10/650 #60.

There were 3 attempts at pill counts; 2 the patient was unable to either be reached or he could not come in and one pill count appeared to be okay basically ok.

DIAGNOSIS & TREATMENT- Below minimum standards for both.

This patient did not have a diagnosis that warranted the use of the opioid medications prescribed. Dr. Wilson never obtained a history and physical. There was no documentation that he examined this patient. Dr. Wilson frequently increased the medications without any written explanation for his actions.

RECORDS- (The record contains a document that the Kirk Law Firm is representing the patient for an injury claim from the motor vehicle accident of 1/3/2012 and related release of information forms). There was no physical examination. There were no follow up notes.

OVERALL OPINION- Below minimum standards. Gross negligence, ignorance and incompetent.

Dr. Wilson prescribed high risk opioid medications to a patient without a diagnosis and with indication that the medication would most probably be diverted.

9. [REDACTED] Initially presented on 3/28/11 with complaints of pain that began after multiple car accidents at the age of 18; approximately 2005. She was treated at a prior pain management clinic and was under the care of "Dr. Albert" who prescribed Soma, Xanax, Percocet, Lorcet and stomach medications. She complained of upper back and neck pain shooting down her spine into her lower back and making her right leg numb. She indicated she was presenting for pain medications and informed that prior treatment included physical therapy and the use of a heating pad. MRI studies were in the chart and on 6/24/2010 the cervical spine results indicated mild disc bulging from C4-5 thru C7-T1 with congenital narrowing of the spinal canal due to short pedicles and a muscle spasm at the time of the study; lumbar and thoracic study on the same date demonstrated multilevel disc bulging with a right paracentral posterior disc herniation an associated radial tear at T11-12, there was also bilateral facet hypertrophy at the L5-S1 level with moderate impingement upon the bilateral lateral recesses. A. Argotte, MD did the initial evaluation which included a physical examination and history. He referred the patient to a spine surgeon, physical therapy, orders for lab work and a psychological evaluation. He issued the following prescriptions: Percocet 7.5/500mg #60 with directions to take 1 q12hr prn, Soma 350mg #30 to take q24hrs prn, Lorcet #120 to take 1 every 6hrs prn and Xanax 1mg #30 to take 1 every 24hrs prn. The patient was unable to keep her follow up appointment because of family surgery. She returned on 5/18/11 she had the requested lab work performed. Her urine drug screen was questionable. She reported her medications were working well. It was not explained why the patients medications lasted beyond 30 days. She reported symptoms of depression and stated she was in the process of going through a divorce. The psychiatric/psychological evaluation was scheduled. The patient was issued prescriptions for soma #30, Lorcet #120, Paxil 10mg #30, ibuprofen 600mh #90, Neurontin 100mg #60, Percocet 7.5/500 #60 and Xanax 1mg #30. 6/15/11 Pt reported the medications were helping. She thought Paxil was causing itching. She was issued the following prescriptions: Soma #30, Paxil was increased to 20mg #30, Neurontin was changed to 200mg bid #60, Lorcet #120 and ibuprofen 600mg #90. He made note that he eliminated the Xanax because it was not in the urine. Percocet also appeared to be eliminated. 7/7/11 the facility doctor was now Dr. Greenlaw who issues the following prescriptions: Neurontin 300mg #60, ibuprofen 600mg #90, Soma 350 #30, Lorcet #60, Percocet 7.5/500 #90 and Xanax .5mg #30. Paxil and ibuprofen were not longer prescribed for the patient. She reported on this visit she had to double up on her Lorcet because she was not prescribed the Percocet on the prior visit. Visits from 8/4/11 thru 9/28/11 were conducted by Dr. Dehaven. The patient reported overall her medications were working. The September urine drug screen was not as it should have been. Prior to her first visit with Dr. Wilson she had increases in Xanax, Percocet and Neurontin. 10/26/11 Dr. Wilson begins to see the patient. The triage note per "Yavonda" notes patients medications are working. Dr. Wilson writes a note that "pt Calloway shows essentially no narcs in system other meds ok" and plan is to order 15 days of narc and have pill count. The lab results are not as Dr. Wilson thought. Oxycodone and Xanax were in the urine. He issues the following prescriptions: Xanax 1mg #60, Neurontin 300mg #90, Percocet 10/650 #45 and Lorcet 10/650 #30. A pill count attempt on

11/4/11 could not be done because the patient could not be reached. On 11/9/11 the patient was issued 15 days of the Lorcet and Percocet. It is not clear if she had the pill count or not. 11/23/11 she returned and reported her meds were working good per follow up triage note; this note is not signed by any staff member nor Dr. Wilson. Dr. Wilson makes a note that "Calloway okay", the patient requested one more "perc" and he planned to replace the Percocet with oxy 10's #120 and other meds to remain the same. He issued the following prescriptions: oxycodone 10mg #130 with directions to take 1 every 6 hrs, Xanax 1mg #68 with directions to take 1 every 12hrs, Lorcet 10/650 #68 to take 1 every 12hrs and Neurontin 300mg #102 to take every 8 hrs. There appeared to be a pill count request that was unsuccessful on 12/23/11 because the patient could not be contacted. 12/27/11 the patient returned stating her meds were helping but the oxycodone made her feel funny. The triage note was not signed. Dr. Wilson makes a note stating the oxy made patient feel dizzy, she was taking them on an empty stomach he instructed her to take them with meals and otherwise she is satisfied with her regimen and he planned to continue the same medications. He issued prescriptions for the same medications except he changed the quantity to 30 day supply. 1/24/12 she reported she was not sleeping well, the oxycodone made her feel dizzy and high and had new right leg numbness. She also reported she didn't need as many Neurontin. This triage note is signed by L. Kidd, RN. Dr. Wilson writes a note that the oxycodone doesn't work as well as the Percocet, he plans to replace the oxycodone with Percocet and increase the Lorcet by 1 pill and continue all other meds. He issued the following prescriptions: Percocet 10/650 #90, Lorcet 10/325 #90, Xanax 1mg #60 and Neurontin 300mg. 2/21/12 there were no new complaints noted on the follow up triage note, the entire physical assessment note including a nursing diagnosis with suggestion to send the patient for a psych evaluation, was completed by L. Kidd, RN. Dr. Wilson makes a note that the patient was without complaints and plan is to write the same meds. He issues the same prescriptions as per previous month. 3/20/12 follow up triage note reports no new complaints but states "Norco" gives her a headache and she had sleep deprivation. Pt also reported on this visit that she had a visit with another provider for a breast exam. Dr. Wilson makes a note that the patient is without complaints and he plans to write the same medications. He issues the same medications as the preceding month. 4/17/12 triage note indicates the patient is having right arm and right leg numbness and is being evaluated for masses in her breast and stomach, this form is completed by Butcher, (SMA). Dr. Wilson makes a note that the patient is without complaints, a left breast mass and right lower quadrant mass requiring surgery for diagnosis, plan is to write for same meds and a general surgery referral. He issues the same prescriptions as the preceding month. 5/14/12 the triage note indicates the meds are helping, the report on her breast and stomach are "good". Dr. Wilson notes the patient is without complaints and plans to write for the same meds. He issues the same prescriptions but increases the quantities on all slightly without any explanation.

DIAGNOSIS- &TREATMENT- Below minimum standards

This patient had a diagnosis that did warrant the use of opioids to treat pain. However, there did not appear to be any physical examination by Dr. Wilson. There was an adequate history and physical examination on the chart as obtained by Dr. Argotte. There was no documentation to suggest that Dr. Wilson reviewed the prior diagnostic studies. Dr. Wilson never rendered a diagnosis. The patient had various complaints as noted on the follow up triage note by staff members; but Dr. Wilson's notes often were contradictory; "no complaints" etc. There were no other treatments utilized. The previously requested studies and evaluations were never followed up on. There were regular urine drug tests and tracking numbers to indicate KASPER data was obtained. The controlled substance prescriptions were consistently written without the patients address. There was no indication for the prescribing of Xanax. The notes by Dr. Wilson do not reflect the data written in the triage notes.

RECORDS – Borderline

OVERALL OPINION – Below minimum standards.

The prescribing was inappropriate; the physician demonstrated gross ignorance and gross negligence.

10. [REDACTED] Initial visit to the Commonwealth Quality Health Care was on 7/13/11. She complained of pain in her feet, lower back, legs and knees. She reported to have been in a 4-wheeler accident and this caused pain. She also reported after giving birth to twins she had more pain. She had been to a pain management physician and reported the medications he gave her worked but he retired. She also reported that use of a heating pad helped and putting a board under her mattress helped. She reported her last pain medications to be in 2/11. The urine drug test on the initial visit was negative for any medications but positive for THC. It was noted that a test for the integrity of the urine sample was out of range. An MRI study of the lumbar spine from 10/5/2010 was on the chart and results were normal. She reported that she had been taking Lorcet 10/650 #120, Percocet 10/650 #30, Soma 350 #60, Xanax 2mg #30 and Fioricet #30. Dr. Greenlaw was physician in the facility at that time and issued the following prescriptions: Xanax 1mg #60 with directions to take 1 pill every 12 hrs, Baclofen 20mg #90 1 every 8hrs, Lorcet 7.5/500 #120 1 every 6hrs and Fioricet #30 1 every 24 hrs prn. She returned on 8/10/11 and reported her medications were working but asked to have the Lorcet 10 and said the Baclofen made her sick; "soured stomach". There was no signature of the person who actually wrote this note but H. Dehaven did sign at the bottom and date it 8/10/11. There appears to be an additional note intended for 8/10/11 but it has the date 8/11/11 on this note but is also signed by H. Dehaven and dated 8/10/11. The urine drug test was again positive for THC. Dr. Dehaven now appeared to be the practicing physician and issued the following prescriptions: Xanax 1mg #60, Lorcet 10/325 #120 and Fioricet #30. 9/9/11 the patient is complaining of pain in both feet and Dr. Dehaven plans to refer her to a podiatrist. The urine drug test is again positive for THC. There is an additional note for this same day under the "RX" tab of the chart and states the patient requested to have Lorcet 10/650 instead of 10/325. The same prescriptions were issued but the Lorcet was changed to 10/650 #120. 10/10/11 Dr. Wilson begins care of the patient. The triage note states the patient was having tingling in her neck and sharp pain in her left and right shoulder, left and right shooting, sharp leg pain and left knee pain and sharp back pain. Meds were working. The urine drug test was positive for THC now x4. Someone wrote of note on the "Miscellaneous Patient Information" form that appeared to be the handwriting of "Yavonda" but it was signed by Dr. Wilson. This note reports the patient to have toothaches from exposed nerve endings, increase pain symptoms at times and having muscle spasms. The patient asked for Soma. She was issued the same prescriptions as the preceding month except the Lorcet was changed back to 10/325mg. There was no documentation of examination or other diagnostic studies. 11/7/11 repeat urine drug testing indicated THC was in the urine now for the 5th time in a row. The patient reported meds were helping but sometimes she needed an extra Xanax. Dr. Wilson makes a note that the patient reports her pain to return early after each dose and other meds were okay. His plan is to increase the Lorcet back to the 10/650 and continue other meds the same. He issued the following prescriptions: Xanax 1mg #64 to take 1 pill every 12hrs, Lorcet 10/650 #160 to take 1 every 4-6 hrs and Fioricet #32 to take 1 daily. 12/7/11 the urine drug test for this visit was again positive for THC-6th time; the specimen did not pass integrity testing by having the oxidant screen out of range. The patient reported her meds were

working well but on some days she may have some extra pain. Dr. Wilson writes a note that the patient was complaining of breakthrough pain and he planned to add oxycodone 10 #60 and continue all other medications. She was issued the following prescriptions: Xanax 1mg #60, Fioricet #30, Lorcet 10/650 now #150 and oxycodone 10mg #60 to take 1 every 12 hrs. 1/5/12 follow up triage note reports pain has gotten better with meds and the oxycodone 10 "really worked". Dr. Wilson makes a note that the patient is satisfied with current regimen and plans to write the same meds. He issued the same prescriptions as the preceding month. 2/2/12 the triage note indicates the meds are working and patient is having left knee pain. Dr. Wilson notes the patient is requesting an increase in the oxy quantity or strength and he writes denied, otherwise no complaints. He informs the patient the Lorcet will be "leveled off" at #90 and plans to decrease this by 1 pill and continue all other medications. He issues the same prescriptions except the Lorcet 10/650 is #120 now. 3/1 or 3/2/12 one note lists follow up as 3/2. The urine drug test on this date is now negative for THC but fails the integrity test. She reports her medications to be working. There is no note from Dr. Wilson on this date and he issues the same prescriptions as the preceding month. She returns on 3/29/12 the triage note indicates meds are working well, Dr. Wilson makes a note that she is without complaints, and his plan is to decrease her Lorcet by 1 pill and increase her oxycodone by 1 pill and leave the other medications the same. A urine drug test on this date is again positive for THC. He issues the prescriptions as planned. 4/26/12 the patients' urine drug test is conflicting, she denies use of THC, she states her medications are working, Dr. Wilson makes a note that the patient is requesting an increase in Xanax which he plans to deny and otherwise patient is satisfied with her medications; he issues all medications the same as the previous month. 5/23/12 documentation on the triage follow up note per staff Beitcher notes the patient reports her pain has increased because of gardening, her urine drug test was positive for THC, she reports occasional smoking of THC to help with pain and she was counseled regarding possible dismissal for THC use. The note from Dr. Wilson notes the patients request for increase in pain medications because of gardening; he plans to increase the oxycodone 10mg to 15mg and leave other medications the same. He increases all medications and issues the following prescriptions: oxycodone 15mg #105 with directions to take 1 every 8 hrs, Lorcet 10/650 #140 to take 1 every 6 hrs, Fioricet #35 to take 1 daily, and Xanax 1mg #70 to take 1 pill every 12 hrs.

DIAGNOSIS, TREATMENT & RECORD- Below the minimum standards for all three.

There was no diagnosis established that indicated the patient should be treated with high risk opioid medications. There was no documentation that Dr. Wilson ever examined the patient. There was no follow up for further investigation of her pain complaints. There was no working diagnosis. The repeated aberrant behaviors regarding illegal drug use and repeated questionable adulterated urine test results were ignored. The patient was continued on high risk medications.

OVERALL OPINION – Below minimum standards.

The care provided by Dr. Wilson indicated not only gross ignorance but also negligence and incompetence. This patient should not have been prescribed this combination of medications. This patient did not have any pathology that warranted opioid medications. There was no history and physical examination.

11. [REDACTED] (This patient was also an employee of Commonwealth Quality Medical Care). It appeared the patient presented in March 2011. The initial consents and forms have conflicting dates; some data filled out in pencil and some with signatures in pencil. Dr. Argotte initially evaluated the patient on 3/10/11. She complained of chronic right hip pain as a result of a 2004 stress fracture while in military service. She also reported being in multiple motor vehicle accidents in 2003, 2004 and 2005. She denied any hospital care following the motor vehicle accidents. She described ongoing and chronic pain in her lower back and right hip. She also reported a history of a tibia and foot fracture that occurred in approximately 2004. She complained of headaches. She reported she had spinal steroid injections in 2006/2007 and physical therapy in 2007. She also reported begin treated in 2010 for anxiety and depression. MRI studies of the lumbar spine dated 9/13/08 note the patient to have L5-S1 disc desiccation with an annular tear and a small left paracentral disc protrusion. Cervical x-rays dated 10/09/08 are normal. An MRI/MRA of the brain was normal on 5/15/2008. X-rays of the pelvis were normal except for the presence of surgical clips in the left pelvis. X-rays of the SI joints were normal on 10/0/08. Bone density study of the left hip and lumbar spine on 8/25/08 was normal. (Prior records from 12/9/08 describe concerns regarding the patients use of large amount of controlled substances while in the military, screening questionnaires at that time were suggestive of substance abuse but not diagnostic, and presentation on physical exam at that time suggested opioid withdrawal. The conclusion of the physician who provided pain management at that time, at another facility, stated, "All of this information together suggests some degree of substance abuse or concerns thereof"). Dr. Argotte diagnosed the patient with lumbar disc bulging and requested a new MRI. He resumed prescribing of medications and gave orders for MRI studies, physical therapy evaluation, psychiatric evaluation and lab work. He issued prescriptions for Percocet 10/325 #120, Lorcet 10/325 #30, Ambien 10mg #30 and Xanax 1mg #60. The prescriptions written by Dr. Argotte from March 2011 until June of 2011 were concerning. There were prescriptions without the name of the patient but signed in the chart from Dr. Argotte. From March until June, the patient requested more medications, denied use of cocaine, failed a urine drug test once by not having Percocet in the urine when prescribed and failed another urine drug test for not having Xanax present in the urine when it was prescribed, used more Xanax than prescribed and did not have any of the testing or referrals done as ordered. In July, August and September of 2011 Dr. Greenlaw and then Dr. Dehaven saw the patient. There are concerning prescription copies that appear without a name but signed by the physician. The patient was now receiving Tylox, Oxycodone 15mg, Klonopin 1mg and Ambien 10mg. In September she failed another urine drug test by having medication not prescribed for her in the urine; hydrocodone and the Klonopin was not in the urine but prescribed. On this same visit she requested additional doses of medication for anxiety. 10/10/11 Dr. Wilson issued prescriptions for the patient for the first time. There was no note from Dr. Wilson. A note written on the "Miscellaneous Patient Information" form for that date appears to be written by a staff member. Dr. Wilson issued the following prescriptions to the patient: Tylox 5mg #120, Oxycodone 15mg #120, Ambien 10mg #30 and Klonopin .5mg to take ½ tab #15. 10/31/11 the patient returned and a note written by Dr. Wilson

reported her to be complaining of a sore throat, she was satisfied with her current med regimen; he would write for a Z-pack and continue other meds. The urine drug test was negative for the prescribed Klonopin. He issued oxycodone 15mg #120, Tylox 5/500 #120, Ambien 10mg #30 and Klonopin 1mg #60. He issued these prescriptions within 21 days from the previous prescriptions without explanation. 11/28/11 The patient presented for follow up; Dr. Wilson made a note that the patient was satisfied with her current regimen and continue to write for the same medications. 12/12/11 The patient presented again early for an appointment but at this appointment stated on 11/30/11 her medications were stolen. A statement written by the patient on the form titled, "Miscellaneous Patient Information" and dated 12/12 stated she had arrived home from work on 11/30/11 and was met by social services and the police. She was told they received a complaint that she was selling her pain medications. They requested to see her medications and she learned at that time that all of her oxycodone 15mg was gone (filled #120 on 11/28/11) and #68 of her Tylox was remaining from the #120 she filled on 11/28/11. She wrote that this appeared to be an "obvious set up" from the neighbors who were in a property dispute with her. She also reported that she went to the hospital the next day and took a drug test to prove she had been taking her medications. Dr. Wilson's plan was to have a pill count and issued prescriptions for the same medications. There was no documentation that the patient went for the urine drug test as she claimed. 1/3/12 At this follow up visit Dr. Wilson notes the patient to be complaining of increased pain due to cold weather and he plans to increase her oxycodone 15mg by one. He issued the prescriptions for: Oxycodone 15mg #150, Tylox #120, Klonopin 1mg #60 and Ambien 10mg #30. The next two follow up visits appear to have the dates altered. There are prescriptions written for 2/20/12 but a 2 is written over a 1. These prescriptions appear to be written on 1/26/12 but were clearly altered to be 2/20/12. The record contains a note written by Dr. Wilson on 2/20/12 that states the patient was satisfied with her current regimen and he issued the same prescriptions. These are the prescriptions that have the 2 written over the 1 on the date. There is an unsigned "Follow up Triage" note that indicates the current medical regimen will continue. There is a prescription issued by Dr. Wilson for blood pressure medication with what appears to be written 1/20/12 or 1/26/12; this date has been altered and there are no notes corresponding to either date. There is no documentation for a March visit but there are prescription copies in the record for 3/8/12. The 8 on the prescriptions appears to have been written over the top of another number. The prescriptions were: Lisinopril 5mg # 30, oxycodone 15mg #150, Ambien 10mg #30 and Percocet 10/325 #120. 4/5/12 Dr. Wilson makes a note that the patient is without complaint and he will decrease the oxycodone by one. The prescriptions were issued for Ambien 10mg #30, Klonopin 1mg #60, Oxycodone 15mg #120 and Percocet 10/325 #120. 5/15/12 a follow up triage form is used but not signed by anyone; this form indicates the current medical regimen will continue. There is a note by Dr. Wilson that reports the patient was without complaint and he will write for the same medications. He issued the same prescriptions as the preceding month.

DIAGNOSIS-Below minimum standards.

The patient did have a diagnosis that may cause pain but did not warrant the medications prescribed. Dr. Wilson never appeared to render a diagnosis. There was no use of the acceptable methods of establishing a patient diagnosis such as a physical examination, use of additional laboratory and radiographic studies. Dr. Wilson never requested any other testing or studies. Incidentally, Dr. Wilson also prescribed blood pressure medications to this patient without the proper standards being taken.

TREATMENT- Below minimum standards.

The patient had records that described prior concerns about the patient displaying substance abuse behaviors; there was no documentation that these records were reviewed by Dr. Wilson. It never appeared that Dr. Wilson examined the patient. There was no follow up on referrals or diagnostic studies requested by other physicians at the same facility prior to Dr. Wilson's arrival. The patient continued to be prescribed high risk medications regardless of her urine drug test results. The use of controlled substances did not appear to be monitored. There was no KASPER data, no follow up on abnormal urine drug screens. There was no explanation for the increase in medications from Tylox 5mg to Percocet 10/325. There were no other therapies used to treat this patient.

RECORDS- Below minimum standards.

The chart contained numerous forms that were filled out in pencil, forms had conflicting date/years on them, the controlled substance prescriptions were not written to standard and many did not have the name of the patient written on the prescription itself. None of the controlled substance prescriptions had the address of the patient written on the prescription. There were prescriptions that were signed but the left blank. There are prescriptions that appear to have the dates altered. There is no mention of KASPER data being obtained except when under the care of Dr. Argotte.

OVERALL OPINION- Below minimum standards. Grossly incompetent, grossly ignorant and grossly incompet.

Did Dr. Wilson sign prescriptions in advance? The prescriptions written in January and February appeared to be in his handwriting but they were obviously altered. Did the patient who was also an employee alter the existing record? The KASPER data obtained for the dates of the patient prescriptions with Dr. Wilson for the consultant to review clearly indicate conflicting prescriptions when compared to the chart. Had a KASPER report been obtained and reviewed by Dr. Wilson he could have stopped the behavior. It appears he did not monitor the patient in any way regarding these high risk medications. The one time he planned for a pill count it never was mentioned thereafter. Another concern is that he prescribed controlled substance to his fellow employee. Prescribing to an employee or fellow employee constitutes unethical behavior. Dr. Wilson prescribed high risk medications that most probably were being diverted and he was completely negligent in taking the proper precautions to prevent such behaviors. In summary, this patient was prescribed medications that were excessive and Dr. Wilson's behavior was unethical and grossly negligent.

KASPER data for this patient does not correspond to the prescription copies that were in the record. Prescriptions were filled on 10/10/11, 10/31/11, 11/02/11, 11/22/11, 11/28/11, 12/12/11, 1/3/12, 1/26/12, 2/20/12, 3/12/12, 4/13/12. This patient was using 3 different pharmacies and her husband was also a patient of Dr. Wilson's receiving similar medications.

12 [REDACTED] (Husband of employee [REDACTED]) Presented to facility 4/20/11 referred by his spouse who was an employee and a patient of the facility. He complained of lower back pain that originated after a motor vehicle accident in either 2003 or 2004. He provided an MRI report from Florida dated 2/12/09 which reported bulging of the annulus fibrosus at L4-5 and L5-S1 and partial dehydration of the L4-5 disc. He reported having physical therapy in 2004 which did not help. He did not have any other therapies or consultations.

Pt acknowledged he "borrowed" his mother's Percocet. His pharmacy printout indicated he had been prescribed hydrocodone and filled this on 3/29/11. His initial urine drug test was confirmed positive for morphine sulfate, hydrocodone and oxycodone/oxymorphone. Dr. Argotte prescribed Lorcet 10/650 #120 and ibuprofen 800 mg #90. He was also given orders to be evaluated by physical therapy and psychiatry. He presents again on 5/1/11 and reports the Lorcet is not helping but he did not want more pain medication but needed something for sleep, he was unemployed but was able to cut grass and performs weight lifting exercises. An MRI of the spine was ordered on this visit. He was issued Ambien 10mg #30, Lorcet 10mg #135 which was 11 days from the last RX, and ibuprofen. The chart follow up notes are confusing as to dates. There is a Calloway lab record with the date of a urine specimen collected on 5/11/11; there is no other record found in the chart that the patient was seen on that date. The next visit of 6/1/11 noted pt did not have the MRI studies done as ordered, the Lorcet was decreased to #120 and other medications continued. 7/20/11 is the next visit, he complained the pain was not controlled by the medication and he requests breakthrough medications and something to treat his anxiety. Dr. Greenlaw is now taking care of him and again MRI studies are ordered, he is issued Ultram 50mg #120, Lorcet 1/65 #120 and ibuprofen. On 8/17/11 he is now seen by Dr. Dehaven and the patient reports meds are not working at all. He is issued Percocet 7.5/325 #60, oxycodone 15mg #60, Percocet 10/325 #120 and Ambien 10mg #30. There is no note from the physician. The same prescriptions were issued for 9/26/11 by Dr. Dehaven. 10/24/11 Dr. Wilson sees the patient for the first time. A note made by a staff member indicates meds are working great for the patient but he has had "several spells with groin and side pain...treated by urologist previously, no conclusive findings". Dr. Wilson makes a note that the patient requests the Percocet be discontinued because of expense and is asking for an increase in the oxy 15 to #155. Dr. Wilson writes his plan is to discontinue the Percocet and increase the oxycodone 15 to #155, continue Ambien he makes a note that the patient requests weaning off opioids after? (Cannot read the word). Dr. Wilson did not do as he planned; he issued the following prescriptions for the patient: Percocet 10/325 #120, oxycodone 15mg #60 and Ambien 10mg #30. He also wrote an order for the patient to have an MRI without contrast of the c-spine. A urine drug test was performed on this visit and was noted to be positive for hydrocodone and oxycodone. A note on the lab form stated patient took hydrocodone from an old script. There are no visit notes for 11/14/11 however a urine drug test was positive for alcohol in addition to opiates and oxycodone. 12/5/11 he returned and Dr. Wilson makes a note that the patient was satisfied with the current regimen and plans to continue same. On this visit he is issued the following prescriptions: oxycodone 15mg #150 and Ambien 10mg #30. There is no discussion

of the changes made. 1/16/12 Dr. Wilson makes a note that the patient is satisfied with his current regimen, had a head and chest cold and pt requested an antibiotic. He wrote that he would continue the same meds and give a Z-pack. The prescriptions issued were not the same as the previous month and he was issued the following prescriptions: Percocet 10/325 #60, oxycodone 15mg #150, Ambien 10mg #30 and a Z-pack. 2/13/12 Dr. Wilson makes a note that the patients was without complaints and continue same meds. A note written by a staff member on a form titled, "Follow-Up Triage" notes the patient went to the urologist who prescribed him Opana but the notation stated the patient did not fill the Opana. Dr. Wilson issued the same prescriptions as the preceding month. 3/26/12 Dr. Wilson makes a note that the patient was without complaints and write for the same meds. However, he issued the same medications but increased the Percocet 10/325 to #90, oxycodone 15mg remained #150 and the Ambien was #30. There was no explanation for the change. 5/21/12 is the last record for the patient. A follow up triage note is not completed and not signed. Dr. Wilson makes a note that the patient is satisfied with the current regimen and continue same meds. Again, he issues the prescription of Percocet with an increase now to #120 and the oxycodone 15mg remains #120.

DIAGNOSIS & TREATMENT- Both are below minimum standards.

Dr. Wilson never renders a diagnosis. The diagnosis indicated by the MRI study from 2009 does not justify the medications prescribed for this patient. The MRI findings are essentially normal and do not suggest severe, chronic back pain. There is no indication that Dr. Wilson ever examined the patient; no initial or follow up examinations. When he makes a note that the patient would like to wean off opioids he does not demonstrate any action toward that goal. In fact, he increases the high risk opioid medication for the patient. There was never any follow up on the abnormal urine drug tests, requests for imaging studies or other referrals. There were no other treatments or adjuncts used. There were no precautions regarding the use of the high risk medications prescribed. There were no KASPER reports noted. The visit history was not clear. It appeared the patient presented for an appointment and failed a urine drug test but there was no documentation or follow up for these results.

RECORDS- Below minimum standards.

Many of the forms were not signed by the patient or a staff member. Many of the forms had conflicting dates. The controlled substance prescriptions were not written to standard. There was no working diagnosis. The follow up notes were inadequate. The only examination was the history and physical performed by Dr. Argotte.

OVERALL OPINION- Below minimum standards. Gross ignorance, negligence and incompetence.

Dr. Wilson prescribed excessive amounts and high risk medications to a patient without a diagnosis that justified the use of these medications. He continued to prescribe to this patient who demonstrated aberrant behaviors. He ignored the patients request to stop opioid medications. He did not appear to have any plan other than to continue the same

medications yet he increased them repeatedly. There was no monitoring of this patient and his controlled substance prescriptions. A KASPER report may have alerted Dr. Wilson to possible prescription fraud.

KASPER data does not match the prescription history in the chart. There are copies of prescriptions in the chart for 10/24/11, 12/5/11, 1/16/12, 2/13/12, 3/5/12 and 5/21/12. The KASPER data indicates that prescriptions were also filled for 11/14/11, 12/27/11, 3/5/12 and 4/16/12 in addition but there are no records in the patients' chart that correspond to these prescriptions.

(The patients spouse, an employee and patient of the facility, also had suspicious prescriptions in her chart as well as concerning KASPER data.)

13. [REDACTED] This patient was treated at Commonwealth Quality Healthcare by 4 physicians prior to Dr. Wilson. There was no history and physical under the designated "History /Physical" tab in the chart. The section of the chart labeled, "Progress Notes" appears to contain the only history and physical examination of the patient and this was conducted by Dr. Argotte on 3/7/11. The patient had a long history of chronic pain with initial traumatic injuries as a child; shoulder and clavicle fractures. IN 1991 he sustained injuries to his lower back and neck. He reported that he had right carpal tunnel disorder but refused surgery. Additionally he complained of severe bilateral knee pain and was going to have a total knee replacement. He reportedly had prior arthroscopic knee surgeries. He had psychiatric issues of anxiety and depression and had previously been under a psychiatrist care in 2010. Diagnostic studies included in the chart included: Whole body bone scan of 10/15/09 which was positive for prior rib fractures, and knee disease; MRI of the lumbar spine 2/1/2010 positive for mild to moderate L4-5 spinal stenosis as a result of disc bulging, osteophytes and congenitally short pedicles and bulging of the disc at L5-S1; MRI of the cervical spine on 2/1/2010 C5-6 and C6-7 disc bulging with bilateral and neural foraminal encroachment and hypertrophic facet joint change; radiographs of the knees 6/9/11 demonstrated moderately advanced degenerative disease of the right knee and mild on the left; MRI of the right knee demonstrated a bone contusion of the medial tibial plateau and an incomplete tear of the anterior cruciate ligament; the left knee had moderate degenerative changes and an MRI of the left ankle on 12/01/2010 demonstrated severe degenerative changes. His plan of care at that time included continuation of current medications which were oxycodone 30mg bid and oxycodone 15mg bid for breakthrough pain, soma 350 for muscle spasms, elavil 10mg at bedtime, referral to physical therapy and attempts to obtain prior psychiatric records. The patient had a urine drug test on this visit and was positive for marijuana and he indicated he would stop. He was diagnosed with chronic low back pain with spinal stenosis, cervical disc bulging with foraminal stenosis and facet hypertrophy and severe osteoarthritis of the knees needing a right total knee replacement. Dr. Argotte planned to wean the patient off oxycodone and change to Percocet, add an arthritis medication and address depression and anxiety. The patient had Valium in the urine at the June visit which was not prescribed. At the July, August and September visits his care was provided by Dr. Greenlaw and Dr. Dehaven. His medications now included Celexa 20mg, Xanax 1mg #90, Ultram # 90, Neurontin 800mg #90, Norflex 100mg #30 and oxycodone 30mg #120. 10/10/11 Dr. Wilson initiates care of the patient. A note written on the "Miscellaneous Patient Information" sheet by a staff member lists the medications he is taking and that he will have a total knee replacement. He is issued the same prescriptions of celexa 20mg, oxycodone 30mg #120, Xanax 1mg #90, Neurontin 800mg #90, Norflex 100mg #30, and Ultram 50mg #90. 11/7/11 Pt returned for follow up, Dr. Wilson makes a note that the patient was scheduled for knee replacement surgery in 8 days and he would increase pain medications by increasing the oxycodone 30mg to #150 and adding oxycodone 15mg #60. He gave the patient the increased medications as planned and continued all other medications. 12/5/11 he returned for follow up after having his knee surgery. The patient was having increased pain. Dr. Wilson issued all the same medications as the

previous visit except he increased the oxycodone 15 mg to #90. 1/3/12 the patient was issued the same prescriptions as the preceding month but the oxycodone 15mg was reduced to #60. There was no note or documentation that correlates to this date. 2/9/12 There are prescriptions issued to the patient for this date of oxycodone 15mg #30, Ultram 50mg #45, oxycodone 30mg #75, Neurontin 800mg #45, xanax 1mg #45 and celexa 20mg #15. 2/28/12 Dr. Wilson makes a note that the patient was doing well and he would decrease the oxycodone 30mg by one and increase the oxycodone by one and continue all other medications. 3/27/12 Dr. Wilson makes a note that the patient was doing well, warned about bad lab results and issued all medications the same except for a decrease in Xanax by 1 pill. While he makes a note of the changes planned, he did not decrease the Xanax and the oxycodone 15mg and oxycodone 30mg were issued with quantity of #90 and #120. 4/23/12 The patient returned for follow up and a note written by "Whitney" on the "Miscellaneous Patient Information" sheet states the patient would need to find another clinic because he could not function on the amount of medication he was getting. He could not handle the decrease in oxycodone. The note further states, "Pt will not ever be taken back as a patient due to his constant drug seeking behavior". At the bottom of this same paper it appears Dr. Wilson made a note, "oxy 30/60, 15/120, will be no more than this". However, the patient was issued prescriptions that do not correspond to his plan. He was issued the following prescriptions: oxycodone 15mg #90, oxycodone 30mg #120, Xanax 1mg #90, celexa 20mg #30, Ultram 50g #90, Neurontin 800mg #90 and Norflex 100mg #30. 5/21/12 a follow up triage note states the patient was adjusting to his medications. Dr. Wilson makes a note that the patient is complaining of persistent pain and he will decrease the oxy 30 by 1 and make other adjustments next month by decreasing the oxycodone 30 mg and increasing the oxycodone 15mg. The patient was issued the following prescriptions: oxycodone 30mg #90, oxycodone 15mg #90, celexa 20mg #32, Neurontin 800mg #90, Xanax 1mg #90, Norflex 100mg #32 and Ultram 50mg #90.

DIAGNOSIS- Within minimum standards.

This patient had a diagnosis that justified the use of controlled substances to treat his pain. There were never any documentations that Dr. Wilson examined the patient or rendered a diagnosis.

TREATMENT- Within minimum standards.

The patient had regular follow up visits to evaluate his need for controlled substances. He had urine drug testing. There were KASPER tracking numbers occasionally noted in the chart. Combining Xanax with the opioids in the doses prescribed was concerning.

RECORDS- Below minimum standards.

There is one physical examination in the record. There was no documentation that Dr. Wilson ever examined the patient. The follow up notes were not acceptable. The controlled substance prescriptions were not written to standard. There were no records of the hospitalization describing the total knee replacement; no physical therapy notes.

OVERALL OPINION-Below minimum standards.

The combination of high dose opioid medication with large quantities of benzodiazepines is dangerous; Dr. Wilson prescribes this combination as though there are no consequences. There were no other treatment options offered for this patient. There were no referrals to psychiatry or other specialists. The fact that no documentation was found to show that Dr. Wilson examined the patient is concerning.

14. [REDACTED] (Former owner of Commonwealth Quality Healthcare). Pt complained of chronic pain that began after having a motor cycle accident in 2002 and ATV accident in 2004. The chart lists several dates for these accidents and it is unclear when they actually occurred. She reported that she sustained a pelvic and clavicle fracture. She complained of chronic lower back, neck pain and headaches. The only physical examination documented in the chart is per Dr. Argotte on 3/1/11. diagnostic studies on the chart included an MRI of the lumbar spine dated 8/19/2011 from Missouri which was positive for a posterior broad based disc bulge and a left paracentral protrusion causing stenosis at L4-5 and facet hypertrophy at L5-S1; an MRI of the cervical spine dated 8/3/2009 positive for foraminal narrowing at C3-4 and C4-5. (This patient had radiograph reports from Tampa Florida, Missouri and Kentucky in her chart). She reported she was taking oxycodone 15mg #120, soma 350mg qd prn, Xanax 1 mg, valium 5mg qd and Fioricet. She denied having physical therapy. Dr. Argotte wrote orders for her to be evaluated by psychiatry for anxiety, depression and chronic pain and physical therapy for muscle strengthening and increasing range of motion. He issued the following prescriptions: oxycodone 15mg #120, Xanax 1mg #30, Imitrex and flonase. Over the next several months Dr. Argotte attempted adjunctive therapies such as ibuprofen and continued the same medications. There were no patient visits for the next several months because the patient had taken a job in Oklahoma. 11/10/11 Dr. Wilson issued prescriptions for the patient. A note written for this date states there are no copies of these prescriptions in the chart because they accidentally got shredded. The prescriptions were written for the patient because she was in Oklahoma working. 11/22/11 Dr. Wilson made a note in the chart that the patient complained of chronic pelvic pain due to a 4-wheeler accident, continue oxycodone 15mg #120. A notation on the same form states patient is out of town working and she stopped by to get script, will not fill until due. He issued the following prescriptions to the patient: oxycodone 15mg #120 and Xanax 1mg #15. There is a follow up triage note that is confusing with date 12/08/11 stating no side effects from medications, continue same plan and no changes; this note is signed by Andrea Kennedy. There are no prescriptions with the 12/9/11 date on them. 12/14/11 Dr. Wilson issues prescriptions for oxycodone 15mg #120 and Xanax 1mg #30. It appears the patient was not seen but had prescriptions sent by mail. 1/12/12 note written on the "Miscellaneous Patient Information" form states, [REDACTED] is still in Oka working! Meds working well!" There is no signature on this form and does not appear to be in Dr. Wilson's handwriting. 2/8/12 Prescriptions were issued for oxycodone 15mg #120 and Xanax 1mg #30. It does not appear that the patient was seen by Dr. Wilson on this day. 3/5/12 Dr. Wilson makes a note that the patient is satisfied with her current regimen and the plan is to continue the same medications. He issues the same prescriptions as the preceding month. 4/5/12 Dr. Wilson writes the same note as the preceding month that the patient was satisfied with her regimen; he would continue the same prescriptions and issues the same prescriptions. However, on 4/5/12 the patient was not seen and there were notes initialed by "JC", that the "patient could not get a flight but will be here in the morning". So it appears the patient was not seen on 4/5/12 by Dr. Wilson but he wrote a note indicating he had seen her as noted above. 5/3/12 Dr. Wilson makes a note, "pt without

complaints, continue same meds". However, he issued both prescriptions with increased quantities and no explanation. Prescriptions were for oxycodone 15mg #140 and Xanax 1mg #35.

DIAGNOSIS – Below minimum standards.

There appeared to be justification for controlled substances per the imaging studies. However, there were no physical examination notes per Dr. Wilson, no additional testing obtained.

TREATMENT - Below minimum standards.

There were no other treatment options or modalities for this patient. There was no follow up on the referrals to psychiatry or physical therapy. There were indications that the patient was continued on high risk medication without being evaluated. There was no explanation for the increase in the benzodiazepine. This patient was not being monitored for her controlled substance use. She was not evaluated regularly.

RECORDS - Below minimum standards.

There were no physical examination notes or adequate progress notes by Dr. Wilson. The record appears to indicate he wrote notes when the patient was not present. A KASPER report appeared to have been requested twice. The controlled substance prescriptions were not written to the required standard.

OVERALL OPINION - Below minimum standards. Gross negligence.

It is grossly negligent to prescribe controlled substances for a patient that you have not met or examined. The combination of high dose opioid and benzodiazepine is unsafe.

15. [REDACTED] (This patient is an employee of Commonwealth Quality Healthcare). She complained of chronic lower back pain that radiated down her legs for approximately 2 yrs. The pain began after caring for her husband by lifting etc. She had prior treatment by Dr. Azmat and Mary Beth Calor, DO. Dr. Calor also treated the patient's hypertension and thyroid disorder. There were few records in the chart and of the records they are in a disheveled fashion with many pages being blank. A copy of an MRI of the lumbar spine report appears in the record dated 10/27/2008. It is positive for a mild posterior disk bulge at L3-4, probable L3-4 radial tear, bilateral facet hypertrophy and right neural foraminal stenosis, a midline disk herniation at L4-5 with bilateral facet hypertrophy and moderate to severe impingement upon the right lateral recess and mild disk bulging at L5-S1. The only documented physical examination was per Dr. Argotte on 4/6/11. On 4/4/11 the chart contains a document that appears to be completed by the patient. This form is one that is utilized by the medical provider to ascertain information about the pain complaint along with vital signs. Dr. Argotte ordered the patient to have MRI studies of her cervical, thoracic and lumbar spine, physical therapy evaluation for muscle strengthening and improve range of motion; and a psychiatric evaluation for anxiety, depression and chronic pain. He issued prescriptions for Percocet 10/650 #120, Neurontin 200mg #60 and ibuprofen 800mg #90. A urine drug test performed on 4/6/11 was negative for any substances. A notation dated 6/6/11 per Dr. Argotte states he will no longer see the patient for pain management. There is no explanation. A urine drug test dated 6/27/11 is noted in the record and positive only for hydrocodone; at this time the patient was being treated with Percocet. 11/23/11 Dr. Wilson makes his first note on the patient. This note appears to be with some corrections or white out marks, it is unclear what happened to the note. In his note he writes the patient complains of neck and lower back pain, the present MRI's were verified but were greater than 5 years old and his plan was to get new MRI studies of the spine. He also writes that his plan will be for Tylox 5/500 bid, Percocet 10/325 qid and ox 10 one daily. The date on this note appears to be altered. The KASPER data obtained by the consultant indicates for this date the patient filled oxycodone 5/500#60, phentermine 37.5mg #60, and Endocet 10/325 #150. The chart contains copies of prescriptions that do not match the notation date. Also included in the chart are copies of prescriptions dated 10/18/11 for Percocet 10/325 #150, Adipex 37.4mg #60, Neurontin 100mg #120 and Norvasc 10mg #30. There was one prescription copy dated 11/18/11 for Tylox 5/500 #60 and has #3 of 4 at the top; the other copies are not found in the record. There were no other prescription copies for this date. The next note appears to be written on 12/23/11 but this date also looks to be altered somewhat. Dr. Wilson notes something about Calloway lab, it is unclear whether the lab was okay or not, the patient was requesting Percocet in place of Lorcet and his plan was to add Percocet 10/325 #120. (He had not prescribed Lorcet for the patient according to the chart). A follow up triage note dated 12/22/11 is in the chart but does not have the patients name or any other signature. There are no copies of prescriptions for either of these dates in the chart. 1/11/12 again there is a follow up triage note that does not have the patients name or other signatures; it appears in the same handwriting and appears to be the patients' handwriting. Dr. Wilson has a note for this date but this date too has been

altered by writing over it. He writes the patient is satisfied with her current regimen. The remainder of his note is not legible. It appeared to state something about a weight loss drug and he planned to write for the same medications. There are no copies of prescriptions in the chart from this date. On 2/9/12 a follow up triage form is in the chart but does not have any name or identification. There are no notes from Dr. Wilson.

DIAGNOSIS- Below minimum standards.

MRI studies indicate the patient had a condition which could cause pain. However, Dr. Wilson never rendered a diagnosis. There was no documentation that he ever examined the patient. There did not appear to be any attempt to obtain previously ordered MRI studies.

TREATMENT- Below minimum standards.

The use of multiple controlled substances to treat this patient's pain was inappropriate. There was no follow up on previously ordered diagnostic studies by other physicians nor Dr. Wilson. There was only one KASPER data notation. The urine drug testing was not as it should have been and these results were never addressed. There were no other treatments or therapies ordered. A treatment plan was not followed.

RECORDS- Below minimum standards.

There were no physical examinations, no working diagnoses. The notes were grossly inadequate. The chart contained forms/documents that were either blank, not marked appropriately with identifiers or not signed by anyone. It was obvious often the patient who was also an employee filled out some of her follow up forms. There were obvious discrepancies in dates on both follow up forms and prescriptions. It appeared Dr. Wilson tried to make his notes match his prescribing upon 2 occasions after the fact.

OVERALL OPINION- Below minimum standards. Grossly negligent.

It is unethical to prescribe controlled substances for an employee/fellow employee. The treatment was inappropriate. There was no examination or medical diagnosis rendered.

16. [REDACTED] This patient had lower back and left lower extremity pain that began approximately 17yrs prior, following a crushing injury by a heavy piece of equipment called a dozer. He also complained of pain in his neck and shoulders for approximately 10yrs following a motor vehicle accident. He had been to a physician for pain management but that physician was "shut down" according to the patient. He presented to Commonwealth Quality Healthcare in 3/11. The mainstay of his pain management treatment had been with hydrocodone, soma, Xanax and tramadol. Dr. Argotte initially evaluated the patient conducting a history and physical and found him to be reliable. He discontinued the soma; continued Xanax at 1mg every 12 hrs as needed, increased his tramadol and resumed hydrocodone, (Lorcet 10/650 #120). He ordered physical therapy, a left shoulder x-ray, MRI of the cervical and lumbar spine and psychological evaluation. He was also to return to his internist/family physician for blood pressure and diabetes management. An existing MRI report of the lumbar spine was obtained dated 9/12/05 and results indicated severe L4-5 facet degenerative disease causing bilateral foraminal narrowing and an anterolisthesis of L4 on L5 and a large left L5-S1 paracentral disc extrusion affecting the left S1 nerve root with degenerative disc disease also at that level. An MRI of the left lower extremity for the same date indicated degenerative changes involving the third and fourth MTP joints consistent with osteochondrosis. He returned the following month doing well with medications; Dr. Argotte began Elavil 25mg at bedtime and Neurontin 600mg every 24hrs and continued the other medications for pain. It was also noted on this visit Dr. Argotte prescribed blood pressure medications. The patient went for the psychological evaluation on 4/26/11 and the resulting report sent to Dr. Argotte concluded the patient was determined not to pose any risk to self or others, was currently doing okay managing pain and stress and the patient was not interested in receiving any services at that time. The patient also went for the physical therapy evaluation on 3/30/11 and a treatment plan was developed to improve range of motion and reduce pain. The patient had the MRI of the lumbar spine performed on 8/30/11 and was noted for moderate degenerative disc disease, neural foraminal narrowing, grade 1 spondylolisthesis at L4-5 and a large left and central disc herniation at L5-S1. Dr. Greenlaw began care of the patient in July 2011, medications continued except he added oxycodone 15mg instead of the Lorcet. Neurontin had been discontinued because it gave him a rash but was prescribed again at a lower dose. 10/26/11 Dr. Wilson begins care of the patient. He made the following notes; patient was having breakthrough pain and tramadol wasn't helping, Calloway lab was ok, Kasper was ok, increase the oxy to 30mg tid and tramadol tid. He issued the following prescriptions to the patient: Ultram 50mg #90, oxycodone 30mg #90 (the patient had been on oxycodone 15mg #100 the previous month from the previous physician), Xanax 1mg #60 and Elavil 25mg #30. 11/23/11 note per Dr. Wilson states the patient was satisfied with his current regimen and his plan was to continue the same medications. He issued the same prescriptions as the preceding month. There was a form that indicated attempts were made to phone the patient for a pill count but the phone was never answered. 12/22/11 Dr. Wilson makes a note that the patient was satisfied with the current regimen, plan was to continue same medications and Calloway "Ok'd by nurses". He issued the same prescriptions as the preceding month. 1/19/12

Follow up triage note by staff describes patient to be doing well on meds but needs new sleeping med. Urine drug testing demonstrated high levels of opiates but was never sent for confirmation after the patient was no longer being prescribed hydrocodone. Dr. Wilson makes a note that the patient was satisfied with his current regimen but Elavil was not helping with sleep and he would replace Elavil with Ambien. He was issued the same prescriptions except no Elavil which was replaced by the Ambien as planned; 10mg #30. 2/16/12 the follow up triage note reported the patient to be complaining of more shoulder pain in the previous weeks; a form titled, "FOLLOW-UP PATIENT" was completed by Kidd, RN. This appeared to be a physical examination form. Dr. Wilson makes a note that the patient was without complaints, he planned to decrease the oxy 30 and add oxy 15, the remainder of his note is not clear as to the meaning, "Plan: Leave last 30". He issued the following prescriptions to the patient: oxycodone 15mg #30, oxycodone 30mg #60, Ultram 50mg #90, Xanax 1mg #60 and Ambien 10mg #30. 3/15/12 patient returned for follow up and was reporting numbness in his right arm, Dr. Wilson makes a note that the patient was warned about a pill count, that he was complaining of shooting pain and tingling, plan was to continue the oxy 30 and increase the oxy 15 and add Neurontin 600mg #60 and continue all other medications. He issued the following prescriptions: oxycodone 15mg #90, oxycodone 30mg #30, Neurontin 600mg #60, tramadol 50mg #90, Xanax 1mg #60 and Ambien 10mg #30. 4/12/12 the patient returned and reported doing well. Dr. Wilson makes a note the patient was without complaints, plan was to replace the oxy 30 with Percocet 10 #90, continue all other medications and the following month to discontinue the tramadol. He issued the following prescriptions: oxycodone 15mg #90, Percocet 10/650 #90, tramadol 50mg #90, Xanax 1mg #60, Ambien 10mg #30 and Neurontin 600mg #60. 5/10/12 The follow up triage note per staff reports that patient without any new complains, Dr. Wilson makes a note that the patient was without complaints and plans to write the same medications. However, he issued prescriptions without the changes he planned from the previous month and with no change in directions but also increased the quantities of each. He issued the following prescriptions to the patient: oxycodone 15mg #105, Percocet 10/650 #105, tramadol 50mg #105, Xanax 1mg #70, Ambien 10mg #35 and Neurontin 600mg #70.

DIAGNOSIS- Below minimum.

There was no documentation that Dr. Wilson examined the patient as a means to make an evaluation and render a diagnosis. The patient clearly had lumbar pathology that could result in the pain he described. There was never any diagnosis of his shoulder and neck pain. There was never any diagnosis rendered regarding his left foot pain and study results. Dr. Wilson never documented a diagnosis of any kind.

TREATMENT- Below minimum.

The use of controlled substances as part of this patients overall treatment plan was appropriate. It is also concerning that the patient had a previous problem tolerating Neurontin at low doses yet it was prescribed again at a higher dose. Neurontin was

prescribing again in response to the patients shoulder complaints. When the patient complained of shoulder pain, numbness and tingling there did not appear to be any physical examination by Dr. Wilson. Dr. Argotte originally ordered a shoulder x-ray and a cervical MRI; there was neither documentation of follow up on those previously ordered studies or documentation of ordering any studies to evaluate the patients' complaints. The patient was evaluated by physical therapy when he saw Dr. Argotte. There were never any additional records or discussions regarding physical therapy following that initial evaluation. There were no other adjunctive therapies suggested such as interventional injections therapies. There were no other referrals made such as to the orthopedist or spine specialist. The only other prior adjunct used for the patient per documentation was a back brace. The patient did have urine drug testing and occasional KASPER data notations. When the patient had high levels of opiates in his urine drug screening it was never sent for confirmation.

RECORDS-Below minimum.

The records contained acceptable urine drug testing documentation. The controlled substance prescriptions were not written to standard. The record contained 2 radiograph reports on another patient. There were no physical examinations by Dr. Wilson documented. There was no working diagnosis. Most of the consents have the appropriate date and signing.

OVERALL OPINION- Below minimum standards. Gross ignorance and incompetence.

Dr. Wilson never examined the patient. Appropriate testing was not obtained. Dr. Wilson demonstrates a general "disconnect" in medical decision making. He planned to decrease medication and eliminate some medication but he did the opposite; he increased and added medications. The record indicates Dr. Wilson does not appear to use rational medical decision making based upon knowledge and understanding of how to utilize these medications.

17. [REDACTED] Initial visit appears to be on 8/2/11. The patient reported he had pain in his lower back as the result of two motor vehicle accidents. He complained of constant pain that radiated down both legs. By his report this was his first visit to a pain treatment facility. He denied medications but did report he took pills from his wife and the staff notes reads, "both were white". He reported that he was disabled and unemployed and could not read or write. There was no physician history and physical; the physician providing care at this time was Dr. Dehaven. A copy of an MRI of the thoracic spine dated 9/30/2009 was in the chart. The results indicated degenerative changes in the thoracic spine with mild bilateral recess narrowing at T11-12 and minimal levoscoliosis of approximately 6 degrees. The patient was given a diagnosis (in what appears to be the handwriting of employee Yavonda Lazar) of "deg changes Tspine, scoliosis at mid Thoracic Area '09". The patient was issued the following prescriptions: Valium 5mg #30, Lorcet 10/650 #90 and Neurontin 400mg #90. The patient returned on 8/30/11. There is a note written by "Ya" on the "Miscellaneous Patient Information" form that states the patient was "informed he will be on strict probation. States he can't read or write and his wife filled out his paperwork and he wasn't clear on rules, promises he will follow the rules and comply". He further reported "got meds mixed up on accident" with his wife's meds. This note is signed by Dr. Dehaven. The record contained a urine drug test result which was positive for oxycodone; but this test result belonged to his father, [REDACTED] date of birth [REDACTED]. He was issued prescriptions for Valium 5mg #30, Hydrocodone 10/325 #90 and Neurontin 400mg #90. He returned on 9/28/11 and a note written on the "Miscellaneous Patient Information" form was in the handwriting of employee Yavonda Lazar, states patient had been under more stress and was taking an extra pain pill at night, Lorcet 10/650 was issued and increased to #120, the valium and Neurontin remained the same. A urine drug test for this date had Klonopin present per confirmation but this was not prescribed. The chart contains a note that the urine test results were ok. 10/27/11 Dr. Wilson initiates care, makes a note that the patient requests increase in Valium, pain levels ok and he will write prescriptions. There is also a triage note written by employees for the same date. A urine drug test on this date was noted not to pass one component of the validity screen; result of out of range. Dr. Wilson issued the following prescriptions and each had an increase in quantity with no change in directions: Lorcet 10/650 #128, Valium 5mg #64, and Neurontin 400mg #96. 11/28/11 The patient returned for follow up; said medications were working; Dr. Wilson makes a note that the patient was satisfied with the current regimen and he planned to write the same medication. A urine drug screen for this date was positive for oxymorphone verified per confirmation which indicated either use of oxycodone that had completely metabolized to oxymorphone or oxymorphone use. He issued the following prescriptions and again with quantities that were not explained: Lorcet 10/650 #124, Valium 5mg #62 and Neurontin 400mg #93. In mid November, a pill count had been attempted but was unsuccessful due to inability to contact the patient. 12/27/11 A urine drug test again resulted positive for oxymorphone. A follow-up triage note by Kidd, RN reports patient as not having any idea why his test was positive for "oxy". Dr. Wilson makes a note that the Calloway lab was positive for oxymorphone, the patient was satisfied with his current regimen and he planned a pill count in 15 days for the Lorcet and other meds the same. He issued the same prescriptions as the previous month except the quantity of the Lorcet was

not #60. There was documentation in the chart for a pill count performed on 1/9/12 which appeared to be okay and on this date he was issued another prescription for #60 Lorcet. 1/23/12 He returned and stated his wife was prescribed oxycodone and she may have gotten it mixed up with his valium. Dr. Wilson makes a note that the patient was warned about "ox" in lab; patient was satisfied with current regimen and continues same meds. He issued the following prescriptions: Lorcet 10/650 #120, Valium 5mg #60 and Neurontin 400mg #90. 2/20/12 The patient was without complaint and the same medications were issued. 3/19/12 he returned for follow up and was complaining of more pain at when lying down at night, Dr. Wilson makes a note that the patient requested one more Lorcet, he would increase the Lorcet and continue other meds the same. He issued the same prescriptions with the exception of Lorcet 10/650 which now he increased the quantity to #150. 4/17/12 the patient reported his pain had decreased Dr. Wilson makes a note that patient was without complaints and write for same meds. The same prescriptions were issued. 5/14/12 the triage follow up note states the patient was asking for an increase in Valium for sleep at night. Dr. Wilson makes a note that the patient was complaining of insomnia, otherwise without complaints and plan is to write the meds the same. However, he issued all prescriptions with increases and adds a sleeping pill: Lorcet 10/650 #160, Valium 5mg #64, Ambien 10mg #32 and Neurontin 400mg #96.

DIAGNOSIS- Below minimum standard.

This patient did not have a diagnosis that warranted the pain medication prescribed. Dr. Wilson never rendered a diagnosis. There was no apparent physical examination from Dr. Wilson or anyone. There were no additional tests obtained in which to make a diagnosis.

TREATMENT- Below minimum standard.

This patient was treated with excessive amounts of acetaminophen in combination with his opiate medication. The amount of amount medication prescribed was excessive and not indicated. When he complained of any symptom he generally had all medications increased. When he complained of sleeping difficulty he was given not only a sleeping pill in addition to the benzodiazepine he was taking but increases in the benzodiazepine, opiate and Neurontin. There were no documented attempts to use adjunctive therapies or make any referrals. There were no psychological or psychiatric referrals. There were multiple problems with urine drug studies. Utilization of urine drug testing was problematic.

RECORDS- Below minimum standard.

There was NO history and physical. The follow up notes by the physician were inadequate. The chart contained lab results that belonged to his father. The controlled substance prescriptions were never written to the expected standard. There were frequent notations that KASPER data had been obtained. Urine drug testing was performed albeit with difficulty in utilizing the results. A pill count was performed.

OVERALL OPINION- Below minimum standard. Grossly negligent, incompetent and ignorant.

Dr. Wilson did not appear to assess the patient. He noted what the patient was requesting, i.e., another pain pill, and complied regardless of the risk or indication. The addition of multiple benzodiazepines in addition to the high dose opiate was very concerning.

18. [REDACTED] The initial visit appears to be 6/8/11 and was conducted by Dr. Argotte. The patient had chronic pain for many years with the onset beginning in 1991 with a reaching type of injury. He complained of pain in his neck radiating to his left shoulder, lower back pain radiating to both legs and muscle spasms. He reported being under the care of a Dr. Karel for pain management for approximately 7 years until "Health Dept closed him". Dr. Karel referred him to Southern Ohio Pain Management, he obtained care there for approximately 3 months and then that facility was closed down. The Southern Ohio Pain Management facility reopened but the patient reportedly became frustrated with continued appointment changes so he presented to Commonwealth Quality Healthcare for treatment. He reported prior treatment with epidural injections, physical therapy, and medications. His recent history was positive for peptic ulcer disease with recent stomach bleeding stomach. His history was positive for alcoholism; he obtained rehabilitation treatment and was sober at least for 20 years. He also reported prior problems with depression requiring treatment twice. He also reported being discharged from military duty for being unfit medically; the chart contained copies of these records. At the time of his evaluation with Dr. Argotte, his driver's license was suspended due to not having insurance. Physical examination was positive for abnormalities including muscle weakness in his right lower extremity. Diagnostic studies were ordered; physical therapy and psychological evaluations were ordered. Prior imaging studies were obtained dating from 1995 until 2008/9. The updated studies performed on 6/29/11 indicated the patient had lumbar degenerative disc disease with a posterior annular tear and a right paracentral disc herniation contacting the right S1 nerve root at L5-S1, thoracic facet hypertrophy at T8-11 with small central disc protrusions at T8-9 and T9-10, and cervical spondylosis, advanced at C4-5 and 5-6, with cord compression at C5-6 and stenosis. Dr. Argotte issued the following prescriptions: Percocet 10/325 #150, Ambien 10mg #30, Wellbutrin 75mg #60, Norflex 100mg #30 and Neurontin 100mg #60. When the patient returned for follow up, Dr. Argotte was no longer practicing at the facility. Reassessment forms for this follow up date of 7/7/11 were for the most part not completed. The office visit forms/notes were confusing for the next several months and it is not clear who actually made the treatment plans. The prescriptions were per Dr. Greenlaw and Dr. Dehaven. The 7/7/11 prescriptions were for oxycodone 15mg #120, Norflex 100mg #30, Neurontin 400mg #90 and a referral to an orthopedic surgeon was also written on the same date. Prescriptions the following month were for Percocet 10/650 #60, oxycodone 30mg #120, Xanax 2mg #60 and Neurontin 400mg #90. In September the same prescriptions were issued but now included Soma 350mg #30 and Nexium 40mg #30. In September the patient was called for a pill count and he stated he was in Ohio and would be in as soon as possible. Another phone note for September documents the patient phoning to report he went to the ER for unbearable pain. The 9/29/11 prescriptions were for all the previous medications except the Soma 350 was increased to #60 and the Percocet 10/650 was increased to #90. 10/26/11 Dr. Wilson begins to see the patient and makes a note that the Calloway lab was ok and he writes the letters MRI E; it is unclear but appears to be referring to the MRI reports; he notes the patient was without complaints but writes he will increase the Nexium by 5. The directions were to take 1 Nexium 40mg every 18 hrs. The triage follow up also notes the patient to being doing well and without complaints. Dr. Wilson issues the same prescriptions as the

preceding physician but increases the quantity of the Nexium to #45. 11/23/11 he returns for follow up, the follow up triage note indicates the patient is doing well, the right knee gives out and the patient thinks he may need to change the Percocet to oxy 10 or 15mg if possible. Dr. Wilson makes a note that the patient was satisfied with the current regimen, he planned to decrease the ox 30's to #90, replace the Percocet with ox 10's, add nortriptyline and continue other medications. He issued the following prescriptions: oxycodone 10mg #90, oxycodone 30mg #90, soma 350mg #60, Xanax 1mg #120, Nexium 40mg #45 and nortriptyline 25mg #90. There is documentation that a pill count was requested on 12/1/11; the patient was left a message to call back. On 12/19/11 the patient presented for a pill count; he was short several days of oxycodone 30mg and oxycodone 10mg. 12/22/11 he presented requesting medications to be adjusted and complained of his left knee giving out. Dr. Wilson makes notes that the Calloway lab was ok, the nortriptyline was no help, muscle spasms were diminishing, the ox's were weak and his plan was to discontinue the soma and nortriptyline and replace the oxycodone 10 with oxycodone 15mg and leave other meds the same. He also makes a note that the patient is "maxed on ox's". He issues the following prescriptions: oxycodone 15mg #90, oxycodone 30mg #90, Xanax 1mg #60 and Nexium 40mg #45. 1/23/12 he returns and describes increasing pain and increasing marital stress and divorce; Dr. Wilson makes notes that the patient requested more Xanax and he would grant this and requested more oxycodone 15mg but would deny this; he would leave other medications the same except also decrease the Nexium to #30. He issued the following prescriptions; oxycodone 15mg #90, Xanax 1mg #90, oxycodone 30mg #90 and Nexium 40mg #30. 2/20/12 he reports having increased pain because of decreased medications, Dr. Wilson notes the patient is satisfied with his current regimen, complains of an upper respiratory infection and requests a Z-pack, plan is to decrease the oxy 30 by 1 and increase the oxy 15 by 1 and add a Z-pack. The following prescriptions were issued: oxycodone 15mg #120, oxycodone 30mg #609, Xanax 1mg #90, Nexium 40mg #30 and a Z-pack. 3/19/12 Dr. Wilson makes notes the complained of being dizzy, cold and clammy and bad nausea approximately 2-3weeks prior to the appointment and writes, "suggestive of MI patient. Pt also complains of ED". Plan was to advise the patient to be "evaluated for probable MI and plateau meds". Dr. Wilson issued the same prescriptions as the preceding month. The urine drug test for this date was positive for morphine. This was addressed on the follow up visit when the patient was questioned and reported taking one of his father's meds by "accident", he said he would bring proof that his father took that medication. On the follow up visit of 4/16/12 Dr. Wilson notes the patient took his father's morphine by mistake and writes, "I give second chances". His plan was to replace the oxy 30 with Percocet 10/650 #120 and leave the other medications the same. He issued the prescriptions as follows: oxycodone 15mg #120, Percocet 10/650 #120, Xanax 1mg #90 and Nexium 40mg #30. The urine test on this day was positive for amphetamines; per confirmation it appeared to be adderall. There was a note on the front of the chart that stated "+methamphetamine", "no Calloway goes to Sue for dismissal".

DIAGNOSIS- Minimum standards.

There was a complete history and physical per Dr. Argotte and more than adequate diagnostic studies that justified the use of controlled substances. Again, concerning is the lack of documentation that Dr. Wilson examined or diagnosed the patient. He never gave any diagnoses.

TREATMENT- Below minimum standards.

The patient was never examined by Dr. Wilson. When the patient repeatedly complained about his knees Dr. Wilson never examined him. The record was clear that this patient was at higher risk for the use of controlled substances given his history of alcoholism and depression. This patient may have been most suited for long acting opioid medications; not multiple short acting medications. Further, the patient described being treated by what most probably was a pill mill in Ohio and when called for a pill count he was unable to come for the pill count because he was in Ohio. Records should have been obtained or at minimum a phone inquiry to learn if the patient was continuing to obtain pain medication from Ohio. The patient repeatedly complained of psychosocial stressors and was given increased doses of Xanax. He was never referred for supportive services such as a psychologist or psychiatrist after Dr. Argotte left. The previously requested referrals were never followed up on.

RECORDS- Within minimum.

There was an appropriate history and physical examination performed by Dr. Argotte. There diagnostic studies and multiple urine drug tests. Frequently there were tracking numbers for KASPER data. There were regular visits. Physician examinations were nonexistent after Dr. Argotte left. None of the controlled substance prescriptions were written to the required standard.

OVERALL OPINION- Below minimum standards. Gross ignorance, neglect and incompetence.

It is completely unacceptable to never examine the patient. The obvious indicators that the patient may have been treated prior at a pill mill was ignored. Dr. Wilson demonstrated a persistent "disconnect" in prescribing for this patient, his notes often did not correlate to the patient complaints. When the patient complained of persistent knee pain, there was no examination, no attempt to diagnose the problem.

19. [REDACTED] Presented to the facility on 7/27/11. He had been in a motor vehicle accident on 7/6/11. He was extradited from the vehicle initially evaluated at one hospital and transferred to another hospital. After 2 days he was discharged home with the diagnosis of a C2 avulsion fracture and a C5 fracture. The chart contains records from the hospital admission and included radiographs. The CT of the head and neck demonstrated scalp lacerations and an avulsion fracture of the C2 vertebral body and nondisplaced fractures of the left C5 pedicle and lamina with extension into the left C5 inferior articular facet and subluxation of the left C5-6 facet joint. An MRI of the cervical spine on 7/7/11 showed a C5-6 posterior central disc protrusion with annular tear and mild narrowing of the canal. Thoracic and lumbar studies were normal as were radiographs of the extremities. He complained of neck, arm lower back and leg pain. He was taking hydrocodone for pain. Documentation was on the chart that the patient was prescribed hydrocodone 5/500 #40 for 7 days, when he was discharged from the hospital and a second prescription for hydrocodone 7.5/500 #40 on 7/18/11. A urine drug test on this date was positive for hydrocodone. Dr. Dehaven was the physician at the facility, made of notation of the fracture, advised the patient to wear his cervical collar at all times, no driving in any car and follow up with surgical services. There is no physical examination except as noted by staff member, "Ya". "Ya" also completed the physicians' diagnosis and orders sections which Dr. Dehaven signed. The patient was issued the following prescriptions: oxycodone 15mg #120, tramadol 50mg #90, valium 10mg #30 and baclofen 20mg #90. On the next visit, employee "Ya" again wrote what appeared to be a physician note that Dr. Dehaven signed and noted the patient was to be referred for a neurosurgical consult, he had numbness and pain in his neck, shoulders. The same prescriptions were issued but the oxycodone 15mg was increased to #150 and the Ultram was increased to #120. The oxycodone was not in the urine drug test for this date as it should have been. The next visit of 9/20/11 the patient had THC in his urine test and there was no oxycodone in his system; he was given a warning. Baclofen was discontinued and Neurontin was added, the oxycodone, Ultram and valium remained the same. There was notation that the patient had a follow appointment with another physician and a new MRI was possibly going to be done. 10/18/11 Dr. Wilson begins care of the patient. Notes were made by "Ya" on the "Miscellaneous Patient Information" form that were confusing; the Ultram did not help, Dr. Wilson signed his last name by this statement, Percocet would be added and valium would be increased. There is no explanation for the decision to use Valium. The note also states, "Pt strongly urged to consult with surgeon". There were no physical examination notes. Dr. Wilson issues the following prescriptions: oxycodone 15mg #150, Percocet 10/650 #60, Valium 10mg #60 and Neurontin 300mg #90. The urine drug test for this date was positive again for THC, absence of the valium and ultram was present. 11/15/11 Dr. Wilson makes a note that the patient was complaining of breakthrough pain and he would replace the oxy 15 with 30's, replace the valium with Klonopin, leave the Percocet the same and adjust the Neurontin. He issued the following prescriptions: oxycodone 30mg #90, Percocet 10/650 #60, Klonopin 1mg #30 and Neurontin 600mg #90. The urine drug test on this day was confirmed positive for Valium and Klonopin yet it had not been prescribed yet to the patient. 12/15/11 The patient complained of not

sleeping and spasms but the meds were helping. Dr. Wilson makes a note that Calloway lab ok for 11/15, the patient was complaining of shooting left neck pain and insomnia; plan was to increase the Neurontin and Klonopin and leave other medications the same. He issued the following prescriptions all with increases: oxycodone 30mg #99, Percocet 10/650 #66, Klonopin 1mg #66 and Neurontin 900mg #99. 1/16/12 Patient now complained of headaches and ear numbness and running out of Klonopin. Dr. Wilson makes notes that the patient was warned noncompliance could lead to dismissal and planned to write the same meds. He issued the following prescriptions: oxycodone 30mg #90, Percocet 10/650 #60, Klonopin 1mg #60 and Neurontin 800mg #90. 2/13/12 the patient was satisfied with his current regimen and he plans to adjust Klonopin, oxycodone and Percocet. He issued the following prescriptions to the patient: oxycodone 30mg #60, Percocet 10/650 #90, Klonopin 1mg #30 and Neurontin 800mg #90. 3/12/12 the patient had THC in his urine drug test, stated medications were helping, Dr. Wilson makes a note that the patient was complaining of increased pain and he planned to increase the Percocet, convert the oxy 30 to 15mg and decrease the Klonopin. He issued the following prescriptions: oxycodone 15mg #120, Percocet 10/650 #120, Klonopin .5mg #30 and Neurontin 800mg #90. 4/9/12 There is no note or documentation from Dr. Wilson but there is a dismissal letter for "bad labs". Dr. Wilson issued the following prescriptions: oxycodone 15mg #60, Percocet 10/650 #60, Klonopin .5mg #15 and Neurontin 800mg #45.

DIAGNOSIS- Below minimum standards.

This patient clearly had a diagnosis that justified the use of controlled substance to treat pain. However, his pain was from an acute injury and was anticipated to improve. There was no physical examination by anyone in the record except for the physician at the hospital who treated the patient for his initial injuries.

TREATMENT- Below minimum standards.

The rapid transition from a mild dose of a scheduled 3 narcotic to the use of more than one high dose, scheduled 2 narcotics was inappropriate. Dr. Wilson continued the same prescribing without any documented examination or attempt to obtain consultation or repeat imaging studies. The patient was treated with inappropriate doses of medications. He was given early refills and quantities that did not make sense.

RECORDS- Below minimum standards.

There was no initial history and physical documentation by the physicians at, Commonwealth Quality HealthCare. There were no follow up examination records. Follow up notes were inadequate. The controlled substance prescriptions were never written to the required standard. Urine drug testing was done and there were tracking numbers indicating KASPER data had been obtained.

OVERALL OPINION- Below minimum standards. Grossly negligent, incompetent and ignorant.

There was no documentation that Dr. Wilson ever examined this patient. He did nothing to evaluate the patient's need for continued controlled substances. The hospital discharge physicians determined the patient to need a very low dose of hydrocodone for a short period of time. Dr. Wilson escalated this patient's use of controlled substances; he took the patient from a total of 20mg of hydrocodone to 110 mg of oxycodone without any justification; without any documentation of why the patient was not improving as expected.

20. [REDACTED] He initially presented on 8/22/11 complaining of chronic neck and lower back pain that began in 2008. He reported getting hurt when working in the coal mines and also having 2 motor vehicle accidents. He reported prior treatment by a pain management facility. He listed his medications to be oxycodone 15 #120, Vicodin, Xanax #30 and Lyrica; but he reported the vicodin and Lyrica did not help with his pain. Prior treatment for pain listed per the patient included physical therapy, steroid shots in his neck and back and the use of a neck brace. Diagnostic studies in the record included an MRI report of the cervical spine dated 11/27/2008. This report noted a right deep cervical lymph node at the level of carotid bifurcation, moderate degenerative changes and a C6-7 disc herniation with moderate central canal and moderate bilateral foraminal narrowing; and MRI of the lumbar spine dated 9/19/2009 was noted for L4-5 bilateral neural foraminal narrowing due to significant facet hypertrophy and a synovial cyst; other levels had mild bulging. A staff member makes notations on a triage form and this is signed by Dr. Dehaven. There is no history and physical in the chart. There is no documentation that Dr. Dehaven examined this patient. The patient reported poor sleep, sharp pain when turning his head, constant lower back pain with radiating right leg pain. There were no copies of prescriptions noted from Dr. Dehaven. There is a patient phone in note from the patient for 9/1/11; the patient called to report he could not take the Neurontin. 10/18/11 Dr. Wilson begins care of the patient. The triage note per "Sue" notes the patient to be complaining of neck, upper back to low back, numbness in right hand and arm and bilateral leg pain, meds not helping much. A note was written on the "Miscellaneous Patient Information" form by staff member "Ya" that says that patient could not take nortriptyline because it made him feel drunk and disoriented, that he was prescribed oxycodone for break thru pain and Xanax for anxiety. Dr. Wilson signed this note. He issued the patient the following prescriptions: Xanax 1mg #64, Ambien CR 10mg #32, oxycodone 30mg #90, and oxycodone 15mg #64. 11/17/11 the patient the Ambien was not helping, Dr. Wilson makes a note that the patient is satisfied with his current regimen; write same scripts except no Ambien. He issued the following prescriptions: Xanax 1mg #68, oxycodone 15mg #68 and oxycodone 30mg #102. 12/19/11 the patient reported medications were working well, Dr. Wilson notes the lab was okay, the patient was satisfied with the current regimen, complained of bronchitis for 4 days, continued same medications and gave a prescription for a Zpack. He issued the same prescriptions as the preceding month of Xanax 1mg #60, oxycodone 15mg #60 and oxycodone 30mg #90. 1/17/12 follow up triage note reports the patient doing well, Dr. Wilson makes a note that the patient is satisfied with the current regimen, continue same meds and "follow ox labs". The same prescriptions as the preceding month were issued to the patient. 1/31/12 the patient had a pill count and had extra medication for each by 3-5 pills. 2/14/12 the patient reported medications were working well but he was having headaches and took a Fioricet he had. The urine drug test was positive for barbiturates. Dr. Wilson notes the patient to be without complaints and he plans to decrease the oxycodone 30mg by 1 and increase the oxycodone 15mg by 1. He issued the same prescriptions as the preceding month with changes. 3/14/12 follow up triage note states the patient did not have any new complaints but was having increased pain due to decreased medications. Dr. Wilson writes a note that the patient complained of

persistent pain and anxiety and he would increase the Xanax and adjust the other medications. He issued the following prescriptions: Xanax 1mg #90, oxycodone 30mg #30 and oxycodone 15mg #120. 4/17/12 no new complaints, medication was not as effective because of the reduction, the urine drug test was negative for benzodiazepine, the patient had an appointment for 4/13/12 but had to reschedule to this date, Dr. Wilson makes a note that the patient was without complaints and he was going to replace the oxy 30 with Lorcet. He issued the following prescriptions to the patient: Xanax 1mg #90, oxycodone 15mg #120 and Lorcet 10/650 #90. 5/14/12 follow up triage note indicates the patient has increased pain with the changes in medications, Lorcet was not helping at all, Dr. Wilson makes a note that Lorcet was no help and the Percocet help very little, he will replace the Lorcet with oxy 10 and decrease the Xanax by 1. He issued the following prescriptions: Xanax 1mg #64, oxycodone 30mg #32 and oxycodone 15mg #128.

DIAGNOSIS – Below minimum standards.

The cervical and lumbar pathology indicated on the MRI report from 2009 could cause pain and the use of controlled substances could be justified. Both studies had pathology that indicated further investigation but this was never addressed. There was no physical examination in the record from anyone. A diagnosis was never rendered.

TREATMENT- Below minimum standards.

There were no adjunctive therapies of any kind for this patient. The patient reported he had prior physical therapy and steroid injections, but records were never obtained from the previously treating facility/provider.

RECORDS- Below minimum standards.

There was no history and physical in the record. None of the controlled substance prescriptions were written to the expected standard. There were tracking numbers indicating KASPER data had been obtained. Urine drug testing results were in the chart.

OVERALL OPINION- Below minimum standards. Gross ignorance, incompetence and neglect.

Dr. Wilson prescribed high risk medications to a patient that a history and physical was never obtained by him or anyone else. His prescribing routine is questionable; using multiple high risk opioids in combination with benzodiazepines is concerning. There was no apparent attempt to evaluate the patient with additional studies or refer. He did not practice medicine in taking care of this patient.

21. [REDACTED] She presented as a new patient to Dr. Wilson, 2/28/12. She reported she had been treated for 3 years by another pain management facility but it was now too far for her to drive to because she had moved. She reported the onset of her pain to begin after several car wrecks and a fall at a store. She complained of neck pain that caused migraine headaches, lower back pain and right knee pain. She reported prior treatment included hydrocodone, Percocet and oxycodone, Lidoderm patches and physical therapies. She also reported that she had been in a suboxone treatment program 12/6/11. An MRI of the cervical spine dated 10/6/09 noted mild disc bulging at C5-6, C6-7 and T1-2 with mild right foraminal stenosis at C6-7; an MRI of the sacrum dated 10/6/09 was normal; MRI of the right knee on 7/7/09 was normal and an MRI of the lumbar spine dated 7/7/09 was normal. The patient completed new patient questionnaires, a "detailed pain assessment and physical assessment" form was completed by Kidd, RN. The nurse gave a nursing diagnosis of, "chronic pain (lb) r/t destruction of nerve tissue". There was no history, no physical examination or diagnosis rendered by Dr. Wilson. He made a note, "New pt with justified pathology, triage note and form reviewed, pt interviewed and examined. There was no documentation of his physical examination or description by Dr. Wilson of the abnormal pathology or a diagnosis. He wrote his plan was to prescribe medications and he issued the following prescriptions to the patient: Percocet 10/650 #120, oxycodone 10mg #60, Xanax mg #90, Neurontin 100mg #30 and Imitrex 100mg #30. 3/27/12 the patient returned for follow up complaining of burning leg and foot pain. She was also complaining of knee pain. A urine drug test was positive for medication not prescribed but she reported having remaining hydrocodone was a prior prescription. Dr. Wilson makes a note that the patient complained her analgesics were too weak, requests stronger Neurontin; he planned to decrease the Percocet and replace the oxy 10 with 15mg and increase the Neurontin. He issued the following prescriptions: Percocet 10/650 #90, oxycodone 15mg #90, Xanax 1mg #90, Neurontin 300mg #60 and Imitrex 100mg #30. 4/24/12 Triage note indicates migraines were worsening, she was noted to have had Valium in the previous urine drug test and would be see her primary care doctor for elevated blood pressure, Dr. Wilson makes notes that Imitrex and Fioricet are not help with headaches he plans to replace Imitrex with stadol decrease the oxy 15 and increase the Percocet. He issued the following prescriptions: Percocet 10/325 #120, oxycodone 15mg #60, Xanax 1mg #90, Butorphanol nasal spray #1 bottle and Neurontin 300mg #60. 5/21/12 patient reports migraines are improving but she is not sleeping well, the urine drug test from 4/24/12 was negative for benzodiazepines and oxycodone but positive for hydrocodone, Dr. Wilson makes notes that the patient was without complaints and he plans to write for the same medications. He issued the following prescriptions to the patient: Percocet 10/325 #128, oxycodone 15mg #64, Xanax 1mg #92, Butorphanol nasal spray #1 bottle and Neurontin 300mg #64.

DIAGNOSIS- Below minimum standards.

The only diagnosis rendered for this patient was an inappropriate nursing diagnosis. While Dr. Wilson did note he reviewed the triage sheet and examined the patient there was no documentation of a history and physical examination by him. The diagnostic

studies were for the most part normal and did not justify the use of high dose controlled substances.

TREATMENT- Below minimum standards.

This patient had been in a prior pain management program for treatment. There were no records of prior treatment. The patient also reported recent treatment in a Suboxone treatment program. The use of the controlled substances to treat her pain complaints was not justified. There were no referrals to diagnostic testing ordered to further evaluate her pain complaints. Prior studies were essentially normal. The patient also had repeated urine drug test problems.

RECORDS- Below minimum standards.

The lack of physician history, physical and diagnoses was unacceptable. The controlled substance prescriptions were not written to the expected standard. Tracking numbers were documented that indicated KASPER data was obtained. Follow up physician notes were inadequate.

OVERALL OPINION- Below minimum standards. Grossly negligent, ignorant and incompetent.

Dr. Wilson failed to obtain a diagnosis or diagnoses that justified the use of the controlled substances. He not only prescribed, inappropriately, high dose, high risk opioid medications but added benzodiazepines. Further, he added Stadol which is an opioid agonist/antagonist. The prescribing of Stadol in combination with the opioids is dangerous and can precipitate opioid withdrawal. He ignored the patients' prior history of drug dependency. He treated this patient while ignoring the obvious indicators she was most probably diverting her medications.