STATE OF NEW YORK DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

Public

IN THE MATTER

OF

BARRY M. SCHULTZ, M.D.
CO-11-06-3392-A

COMMISSIONER'S SUMMARY ORDER

TO: BARRY M. SCHULTZ, M.D.
13550 Jog Road
Suite 204
Delray Beach, FL 33446

BARRY M. SCHULTZ, M.D.
REDACTED

The undersigned, Nirav R. Shah, M.D., M.P.H., Commissioner of Health, pursuant to New York Public Health Law §230, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, has determined that the duly authorized professional disciplinary agency of another jurisdiction, the State of Florida, Department of Health (hereinafter "Florida Board"), has made a finding substantially equivalent to a finding that the practice of medicine by **BARRY M. SCHULTZ, M.D.**, Respondent, New York license number 162310, in that jurisdiction, constitutes an imminent danger to the health of its people, as is more fully set forth in the Order of Emergency Suspension on License, dated April 13, 2011, attached, hereto, as Appendix "A," and made a part, hereof.

It is, therefore:

ORDERED, pursuant to New York Public Health Law §230(12)(b), that effective immediately, **BARRY M. SCHULTZ, M.D.**, shall not practice medicine in the State of New York or in any other jurisdiction where that practice is predicated on a valid New York State license to practice medicine.

ANY PRACTICE OF MEDICINE IN THE STATE OF NEW YORK IN VIOLATION OF THIS ORDER SHALL CONSTITUTE PROFESSIONAL MISCONDUCT WITHIN THE MEANING OF NEW YORK EDUCATION LAW §6530(29) AND MAY CONSTITUTE UNAUTHORIZED MEDICAL PRACTICE, A FELONY DEFINED BY NEW YORK EDUCATION LAW §6512.

This Order shall remain in effect until the final conclusion of a hearing which shall commence within thirty (30) days after the final conclusion of the disciplinary proceeding in Florida.

The hearing will be held pursuant to the provisions of New York Public Health Law §230, and New York State Administrative Procedure Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on a date and at a location to be set forth in a written Notice of Referral Proceeding to be provided to the Respondent after the final conclusion of the Florida Board proceeding. Said written Notice may be provided in person, by mail, or by other means. If Respondent wishes to be provided said written notice at an address other than that set forth above, Respondent shall so notify, in writing, both the attorney whose name is set forth in this Order, and the Director of the Office of Professional Medical Conduct, at the addresses set forth below.

RESPONDENT SHALL NOTIFY THE DIRECTOR OF THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT, NEW YORK STATE DEPARTMENT OF HEALTH, 433 RIVER STREET, SUITE 303, TROY, NY 12180-2299, VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED, OF THE FINAL CONCLUSION OF THE PROCEEDING IMMEDIATELY UPON SUCH

CONCLUSION.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATE: Albany, New York
Apr 27, 2012

REDACTED

NIRAV R. SHAH, M.D., M.P.H.
Commissioner of Health
New York State Department of Health

Inquires should be directed to:

Michael G. Bass
Assistant Counsel
Bureau of Professional Medical Conduct
Corning Tower – Room 2512
Empire State Plaza
Albany, New York 12237
(518) 473-4282

Appendix A

Final Order No. DOH-11-805-ESO-MQA
FILED DATE - 4.13.11
Department of Health
By: Sandra Soto
Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

IN RE: The Emergency Suspension of the License of
Barry M. Schultz, M.D.
License Number: ME 67047
Case Number: 2011-05081

ORDER OF EMERGENCY SUSPENSION OF LICENSE

H. Frank Farmer, Jr., M.D., Ph.D., State Surgeon General, ORDERS the emergency suspension of the license of Barry M. Schultz, M.D. to practice as a physician in the State of Florida. Dr. Schultz holds license number ME 67047. His address of record is 13550 Jog Road, Suite 204, Delray Beach, Florida 33446, and alternatively 16155 Via Monte Verde Drive, Delray Beach, Florida 33446. The following Findings of Fact and Conclusions of Law support the emergency suspension of Dr. Schultz's license to practice as a physician in the State of Florida.

FINDINGS OF FACT

1. The Department of Health (Department) is the state agency charged with regulating the practice of medicine, pursuant to Chapters 20, 456 and 458, Florida Statutes. Section 456.073(8), Florida Statutes (2010), authorizes the State Surgeon General to

summarily suspend Dr. Schultz's license to practice as a physician in the State of Florida in accordance with Section 120.60(6), Florida Statutes (2010).

2. At all times material to this Order, Dr. Schultz was practicing as a physician, in the State of Florida, pursuant to Chapter 458, Florida Statutes.

3. At all times material to this Order, Dr. Schultz was a dispensing practitioner, specializing in Internal Medicine, Geriatric Medicine and Hospice Medicine, within the State of Florida.

4. At all times material to this Order, Dr. Schultz was not board certified in pain management, within the State of Florida.

5. At all times material to this Order, Dr. Schultz treated the following ten patients who are referred to by their initials as K.H., P.G., R.L., M.D., S.G., H.G., S.B., G.N., B.F. and K.F. allegedly for chronic pain management.

6. The investigation was predicated upon a complaint to the Palm Beach County Multi-Agency Diversion Task Force from a pharmacist who advised that he was presented with a prescription issued by Dr. Schultz for 1,590 tablets of oxycodone 30mg for a

thirty-day supply. The pharmacist said that he believed the quantity was "extremely excessive."

7. On or about August 26, 2010, the Department in cooperation with the Palm Beach County Multi-Agency Diversion Task Force commenced a routine dispensing practitioner inspection from August 2010, through March 2011, at the medical office known as the Schultz Medical Group, located at 13550 Jog Road, Suite 204, Delray Beach, Florida 33446, where it appeared that excessive and inappropriate quantities of controlled substances were being prescribed to patients. Dr. Schultz's business card reflected Schultz Medical Group Internal, Geriatric and Pain Medicine.

8. The types of controlled substances in question that were prescribed by Dr. Schultz are listed as follows:

a) Hydrocodone (opioid) is commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes, hydrocodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States; abuse of hydrocodone may lead to severe psychological or physical dependence.

b) Oxycodone (opioid) is commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes, oxycodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States; abuse of oxycodone may lead to severe psychological or physical dependence.

c) Roxicodone (opioid) is the brand name for fast acting oxycodone.

d) Percocet (opioid) is the brand name for a drug that contains oxycodone.

e) Oxycontin (opioid) is a legend drug as defined by Section 465.003(8), Florida Statutes, and contains oxycodone.

f) Hydromorphone (opioid) is commonly prescribed under the brand name Dilaudid and prescribed to treat pain. According to Section 893.03(2), Florida Statutes, hydromorphone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States; abuse of hydromorphone may lead to severe psychological or physical dependence.

g) Actiq (opioid) is a lozenge or popsicle that delivers fentanyl through the tissues in the mouth and is prescribed to treat severe pain. Fentanyl is an opioid drug that can decrease mental alertness and affect judgment. According to Section 893.03(2), Florida Statutes, fentanyl is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States; and abuse of the substance may lead to severe psychological or physical dependence.

h) Methadone (opioid) is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, methadone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States; abuse of methadone may lead to severe psychological or physical dependence.

i) Morphine (opiate) is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, morphine is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in

the United States, and abuse of morphine may lead to severe psychological or physical dependence.

j) Alprazolam (benzodiazepine) is often sold under the brand name Xanax, and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, alprazolam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States; abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

k) Diazepam (benzodiazepine) is often sold under the brand name Valium, and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, diazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States; abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

l) Carisoprodol, commonly known by the brand name Soma, is a muscle relaxant prescribed to treat muscular pain. According to Section 893.03(4), Florida Statutes, carisoprodol is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States; abuse of carisoprodol may lead to limited physical or psychological dependence relative to the substances in Schedule III.

9. The Department's investigator and Agent Murray of the Palm Beach County Multi-Agency Diversion Task Force reviewed the drug dispensing logs with Dr. Schultz. The logs revealed that Dr. Schultz prescribed and/or dispensed 5,040 oxycodone tablets to one patient within a nineteen day period, and prescribed and/or dispensed 4,599 oxycodone tablets to another patient within a forty-five day period. From March 25, 2010 through May 11 2010, within forty-seven days, Dr. Schultz prescribed and/or dispensed a minimum of 80,350 tablets of oxycodone 30mg.

10. On or about October 15, 2010, the first search warrant was served at Dr. Schultz's office by Agent Murray, and other law

enforcement personnel. Agent Murray reviewed drug dispensing records from January 1, 2010 through September 2, 2010, patient information sheets, patient contacts, and patient comfort sheets with Dr. Schultz.

11. The records identified Patient K.H. as the patient for whom Dr. Schultz prescribed and/or dispensed 5,040 tablets of oxycodone within a single nineteen day period. Agent Murray conducted a consensual interview with Dr. Schultz regarding the excessive prescribing of oxycodone to Patient K.H.

12. Dr. Schultz acknowledged that he was prescribing and/or dispensing to Patient K.H. the equivalent of sixty-six tablets of oxycodone 30mg a day. When asked if a patient could suffer liver damage or death by ingesting sixty-six tablets of oxycodone 30mg on a daily basis, Dr. Schultz replied, "I believe so."

13. Dr. Schultz stated that he recently discharged Patient K.H. based upon his belief that he/she was selling the oxycodone. When asked why he did not discharge him/her sooner, Dr. Schultz stated that he did not have a good reason to do so, and added that "he was making a lot of money off of him/her."

14. The records identified Patient P.G. as the patient for whom Dr. Schultz prescribed and/or dispensed 4,599 tablets of oxycodone within a single forty-five day period. Agent Murray continued the consensual interview with Dr. Schultz regarding the excessive prescribing of oxycodone to Patient P.G.

15. Agent Murray asked Dr. Schultz if he believed that prescribing and/or dispensing 540 tablets of oxycodone 30mg and 400 tablets of Methadone 10mg to Patient P.G., a small female, within a thirty-day period was excessive. Dr. Schultz conceded that although the doses were excessive, Patient P.G. was in the one-percentile of the population that exhibited a high tolerance to opioids. Agent Murray replied that it appeared Dr. Schultz repeatedly prescribed and/or dispensed excessive amounts of opioids to many of his patients. Dr. Schultz did not comment.

16. Agent Murray reviewed the dispensing logs for the ten representative patients from January 1, 2010 through September 2, 2010. Although many of the representative patients were prescribed and/or dispensed excessive quantities of controlled substances by Dr.

Schultz in excess of eight years, the dispensing logs obtained by the agent encompassed only the preceding seven months.

17. The dispensing logs clearly showed that in addition to Patients K.H. and P.G., within the past seven months Dr. Schultz prescribed and/or dispensed the following drugs to Patient R.L., 22,136 tablets of Oxycodone 30mg; Patient M.D., 3,980 tablets of Oxycodone 30mg; Patient S.G., 3,600 tablets of Oxycodone 30mg; Patient H.G., 2,880 tablets of Oxycodone 30mg and 1,700 tablets of Methadone 10mg; Patient S.B., 4,192 tablets of Oxycodone 30mg; Patient G.N., 7,020 tablets of Oxycodone 30mg; Patient B.F., 7,752 tablets of Oxycodone 30mg; and, Patient K.F., 2,460 tablets of Oxycodone 30mg and 2,400 tablets of Methadone 10mg (within one month).

18. Dr. Schultz said that he was the only person who ordered the controlled substances for his dispensary, and that he sold each tablet of oxycodone 30mg for $1.60 and 100 tablets of Methadone 10mg for $30.00.

19. On or about December 1, 2010, a second search warrant and a court order were served at Dr. Schultz's office by the Palm

Beach County Multi-Agency Diversion Task Force. The medical records and dispensing logs for patients K.H., P.G., R.L., M.D., S.G., H.G., S.B., G.N., B.F. and K.F. were obtained. The patient files were reviewed by an independent pain management expert who is a Florida physician certified by the American Board of Physical Medicine and Rehabilitation. The expert rendered a written opinion at the request of law enforcement.

20. On or about March 24, 2011, based upon the evidence collected by the Department, the Palm Beach County Multi-Agency Diversion Task Force, and the written opinion from the independent pain management expert, Dr. Schultz was arrested and charged with six felony counts of trafficking in 28gm or more of oxycodone. As charged, each one of the six counts subjects Dr. Shultz to a *minimum mandatory* sentence of 25 years in prison and a $500,000 fine. Additionally, Dr. Schultz was also charged with six additional felony counts of unlawfully prescribing trafficking amounts of controlled substances without medical justification. The Circuit Court set bond in the amount of $950,000.

21. In the practice of medicine, a proper medical assessment includes the patient's prior medical history, prior pain management treatment history, factors that make the pain worse or alleviate the pain, the pain's intensity and location, verification of prior controlled substance prescriptions including the date and quantity of the last prescription received, name of the previous treating physician, name and address of pharmacy where the last controlled substance prescriptions were filled together will all relevant contact information and verification of all the foregoing by the physician personally contacting the previous pharmacy and treating physician, together with the reason for the referral, verification for the reasons of referral with the prior treating physician, thorough physical examinations, psychological evaluations, and gradually adjusting (titrating) the dose of a medication until the desired effect is achieved.

FACTS SPECIFIC TO PATIENT K.H.

22. From on or about July 1, 2010, until on or about August July 20, 2010, Dr. Schultz prescribed and/or dispensed 5,040 tablets of oxycodone within a nineteen day period to Patient K.H.

23. On or about December 23, 2010, as a result of the investigation an independent medical expert in pain management reviewed Dr. Schultz's medical records for Patient K.H.

24. The expert reportedly expressed the opinion that Dr. Schultz violated the standard of care in treating Patient K.H. and found that Dr. Schultz inappropriately prescribed excessive quantities and inappropriate combinations of controlled substances without medical records justifying these prescriptions.

25. The expert also found that during the many years of prescribing controlled substances to Patient K.H., Dr. Schultz did not maintain any documentation warranting this type of medical treatment.

26. According to the narrative, the expert opined:

> The prescriptions provided and dispensed from Dr. Schultz's office were markedly excessive, certainly dangerous, and potentially toxic. The doses of medications used in combination would not be considered standard of care and the doses started were extremely excessive. It is highly unlikely that the patient was utilizing this amount of medications himself. There was no documented drug screens, no other treatment alternatives were even offered to the patient and there was no attempt to review diagnostic studies.

27. During an interview with Agent Murray, Patient K.H. stated that he/she presented himself/herself to Dr. Schultz in 2004, seeking treatment for back pain. Patient K.H. said that he/she had previously been treated for his/her back pain by another physician who prescribed 180 tablets of oxycodone 30mg, 80 tablets of Lorcet and 120 tablets of Xanax.

28. Patient K.H. said that during his/her first visit to Dr. Schultz, he/she was prescribed 400 tablets of oxycodone 30mg, 270 tablets of Oxycontin 80mg, 300 tablets of Methadone 40mg, and 90 tablets of Xanax. After a few months, Patient K.H. reported that he/she became very ill and began to hallucinate. Yet, Dr. Schultz slowly increased his/her prescriptions to 900 tablets of Oxycodone 30mg, 500 tablets/wafers of Methadone 40 mg, 300 tablets of Percocet 10mg and 90 tablets of Xanax.

29. Patient K.H. said that once Dr. Schultz opened his "in-house" pharmacy, the patients were required to purchase their prescriptions at the office. Alternatively, Dr. Schultz would write prescriptions to be dispensed at other pharmacies, then separate the original prescription into two or three prescriptions to give the illusion

to outside pharmacies that lesser quantities were being prescribed by Dr. Schultz.

30. Patient K.H. said that he/she became a "junkie" and addicted to the medications that Dr. Schultz prescribed. On several occasions Patient K.H. would make multiple visits within a 30-day period to obtain additional oxycodone. In exchange for the early visits, Patient K.H. was required to pay Dr. Schultz "a few hundred dollars extra." If Patient K.H. did not have money, Dr. Schultz would "credit" him/her the medications and allow the patient to pay after "splitting" or reducing the quantity of tablets on the prescriptions. Dr. Schultz increased the prescription for oxycodone from 400 tablets, to 1,300, to 1,600, to over 2,000 a month, and Patient K.H. would pay Dr. Schultz several hundred dollars cash.

31. Patient K.H. said that Dr. Schultz encouraged him/her to recruit new patients. Patient K.H. reported encountering a "very" pregnant patient who would receive 1,000 tablets of oxycodone 30mg from Dr. Schultz. The pregnant patient would then illegally sell the tablets for $8.00 to $10.00 each. Patient K.H. advised Dr. Schultz

that his patients were selling the medications, and Dr. Schultz replied that he did not care what the patients did with the pills.

32. Patient K.H. told the agent that Dr. Schultz never examined him/her, never performed a range of motion test and merely filled out paperwork. Patient K.H. is currently being treated by another physician for his/her pain, and is prescribed 170 tablets of oxycodone 30mg and 60 tablets of Lorcet every thirty days.

33. Dr. Schultz's medical records indicate that he prescribed multiple and simultaneous prescriptions for large quantities of oxycodone 30mg and Percocet 10/325mg for Patient K.H. on the dates and in the quantities described in the following table. The medical records did not contain medical justification for the high frequency and simultaneous prescription of such large quantities of controlled substances.

Oxycodone 30mg Tablets	Percocet 10/325mg Tablets
1/4/10 400	
1/5/10 200	
1/12/10 300	

Oxycodone 30mg Tablets	Percocet 10/325mg Tablets
1/13/10 200	
1/20/10 400	
1/25/10 300 200 (500 Total)	
1/26/10 200 200 (400 Total)	
	2/4/10 100
2/9/10 400	2/9/10 100
2/23/10 200	
3/1/10 500	3/1/10 300
3/9/10 200	
	3/15/10 300
3/25/10 500	
3/29/10 300	

Oxycodone 30mg Tablets	Percocet 10/325mg Tablets
4/8/10 270 270 270 180 180 (1,170 Total)	4/8/10 400
4/26/10 1,620	4/26/10 400
5/17/10 990 180 270 180 (1,620 Total)	5/17/10 400
5/24/10 270 450 (720 Total)	
6/10/10 1,980	
	6/15/10 100 200 (300 Total)
6/30/10 1,980	
7/14/10 2,160	
8/4/10 450	
TOTAL TABLETS 16,200	TOTAL TABLETS 2,300

34. The above chart reflects that according to Dr. Schultz's medical records, he simultaneously prescribed excessive quantities and doses of short acting and immediate release opioids to Patient K.H. during the course of 212 days.

35. Respondent's medical records reflect that Respondent prescribed 18,500 tablets of short acting opioids to Patient K.H. solely on the uncorroborated and unverified verbal medical and drug history conveyed by the patient to the Respondent.

36. Respondent's medical records reflect that Respondent prescribed Patient K.H. inappropriate amounts of short acting opiates purportedly for pain management that was not based on accepted scientific knowledge, was without a legitimate medical purpose, and was without any medical justification or titrating to the desired effect.

37. A reasonably prudent physician would not have concurrently and excessively prescribed and/or dispensed two or more immediate release opioids without performing a thorough and complete medical history, without performing a thorough and complete substance abuse history, without performing a thorough and complete medical examination, without performing a thorough

and complete psychological evaluation, without an accurate diagnosis of the patient's condition, without regularly ordering urine drug screens tests, without a legitimate medical purpose, without titrating to the desired effect, and without considering other interventional treatments, therapies or consultations.

FACTS SPECIFIC TO PATIENT P.G.

38. From on or about June 30, 2010, until on or about August 4, 2010, Dr. Schultz prescribed and/or dispensed 4,599 tablets of oxycodone 30mg within a forty-five day period to Patient P.G.

39. On or about December 23, 2010, as a result of the investigation an independent medical expert in pain management reviewed Dr. Schultz's medical records for Patient P.G.

40. The expert expressed the opinion that Dr. Schultz violated the standard of care in treating Patient P.G. and found that Dr. Schultz inappropriately prescribed excessive quantities of controlled substances without medical justification.

41. The expert found that Dr. Schultz prescribed controlled substances to Patient P.G. without performing a neurological

examination to substantiate any of the patient's alleged complaints and there was no diagnostic study documented.

42. According to the narrative, the expert opined:

> There was only one drug screen noted and [it] was positive of Methadone but [failed to disclose] oxycodone. Dr. Schultz indicated in his records that it was a violation yet he continued to prescribe the medications at [sic] large quantities. There are also questions raised regarding misdiagnoses and no evidence of any imaging study or other objective measures for [sic] that would have correlated with her complaints . . . the prescriptions written for patient PG are excessive and not substantiated or supported by the documentation.

43. During an interview with Agent Murray, Patient P.G. stated that she first presented herself to Dr. Schultz in 2003, to treat her pain. Patient P.G. said that she did provide some medical history and an out-dated MRI from 1998 (it is absent from the patient's file) to Dr. Schultz.

44. Patient P.G. said that during the first office visit, Dr. Schultz's prescribed 100 tablets of Roxicodone/oxycodone 30mg, 60 tablets of Methadone 40mg, and 60 tablets of Xanax. She stated that Dr. Schultz slowly increased her prescriptions to 540 tablets of Oxycodone 30mg, 400 tablets of Methadone 10mg, and 90 tablets of

diazepam 10mg. She also said that Dr. Schultz did not provide any directions concerning the appropriate dose that Patient P.G. should ingest or any information regarding possible interactions between the drugs.

45. Patient P.G. informed the agent that during the course of treatment, Dr. Schultz never performed a physical examination, any evaluations, any testing, any radiology, or discuss alternative treatments with her. The agent showed Patient P.G. her medical records wherein Dr. Shultz documented purportedly performing physical examinations during the course of Patient P.G.'s treatment, to which the patient exclaimed "that's a lie and he never touched me." Patient P.G. stated that the only examination she ever received from Dr. Schultz's office was having her vitals taken by the medical assistant.

46. According to the agent, a review of Patient P.G.'s medical records evidenced a pattern of templates that were copied and pasted from visit to visit for several years, with no change in the patient's health status. The only change was the patient's vitals, as noted by a medical assistant.

47. Patient P.G. reported that while in the examination room waiting for Dr. Schultz to write the prescription, the patient observed her friend tender additional money to Dr. Schultz for additional drugs. When this same friend asked Dr. Schultz for drugs, his response was "what is in it for me?"

48. Patient P.G. said that once Dr. Schultz opened his "in-house" dispensing pharmacy "it got worse for me." Dr. Schultz would only sell whole bottles to his patients, and not necessarily what they were being prescribed or needed. She stated that she became very addicted to the medications that Dr. Schultz prescribed and sold to her, and "that was when it was bad."

49. Patient P.G. stated that she did provide urine samples for testing, however the samples would be mixed with other patients' samples. The samples were not marked or identifiable in any manner.

50. Patient P.G. is currently being treated by another physician for pain who weaned (titrated) her from the 540 tablets of oxycodone 30mg that Dr. Schultz had been prescribing, down to 180 tablets of oxycodone 30mg for a thirty day supply.

51. Dr. Schultz's medical records indicate that he prescribed multiple prescriptions for large quantities of oxycodone 30mg for Patient P.G. on the dates and in the quantities described in the following table. The medical records did not contain medical justification for the large quantities of controlled substances.

Oxycodone 30mg Tablets
1/7/10 100 100 (200 Total)
2/3/10 400
3/29/10 500
4/22/10 540
5/24/10 540
6/15/10 540
7/13/10 540)
TOTAL TABLETS 3,760

52. The above chart reflects that according to Dr. Schultz's own medical records, he prescribed excessive quantities and doses of

short acting and immediate release opioids to Patient P.G. during the course of 187 days.

53. Respondent's medical records reflect that Respondent prescribed Patient P.G. inappropriate amounts of short acting opiates purportedly for pain management that was not based on accepted scientific knowledge, was without a legitimate medical purpose, and was without any medical justification or titrating to the desired effect.

54. A reasonably prudent physician would not have excessively prescribed and/or dispensed immediate release opioids without performing a thorough and complete medical history, without performing a thorough and complete substance abuse history, without performing a thorough and complete medical examination, without performing a thorough and complete psychological evaluation, without an accurate diagnosis of the patient's condition, without regularly ordering urine drug screens tests, without a legitimate medical purpose, without titrating to the desired effect, and without considering other interventional treatments, therapies or consultations.

FACTS SPECIFIC TO PATIENT R.L.

55. From on or about January 6, 2010, until on or about August 23, 2010, Dr. Schultz prescribed and/or dispensed 23,716 tablets of oxycodone 30mg within a 229-day period to Patient R.L.

56. On or about December 23, 2010, as a result of the investigation an independent medical expert in pain management reviewed Dr. Schultz's medical records for Patient R.L.

57. The expert expressed the opinion that Dr. Schultz violated the standard of care in treating Patient R.L. during the alleged pain management treatment, and confirmed that Dr. Schultz inappropriately prescribed excessive quantities of controlled substances without medical records justifying these prescriptions.

58. The expert found that Dr. Schultz excessively prescribed opioids, specifically Roxicodone, without a fundamental basis for same.

59. According to the narrative, the expert opined:

> There were deficits in the standard of care, as there was no basis to prescribe the dose and frequency on the medications. The frequency was not only excessive, but reckless. The only possibilities that would remain for the dose and frequency that was being supplied would be either severe addiction or more likely drug diversion. There was never any physical examination suggesting a neurologic deficit or other reliable objective. While it appears that a thorough history and physical is performed at each visit, it is quite obvious that this is a template of the records. Dr. Schultz carries forth the same review of systems and physical examinations save for change in the vital signs from 2004 through 2010.

60. During an interview with Agent Murray, Patient R.L. stated that he/she presented himself to Dr. Schultz in 2003, seeking treatment for neck and thoracic injuries that were sustained in 1994. Patient R.L. said that he/she did provide medical and diagnostic records, although the only MRI report in the medical record was from 2008.

61. Dr. Schultz's medical records indicate that he prescribed multiple prescriptions for large quantities of oxycodone 30mg for Patient R.L. on the dates and in the quantities described in the following table. The medical records did not contain medical justification for the high frequency of such large quantities of controlled substances.

Oxycodone 30mg Tablets
1/6/10 500
2/2/10 1,000
3/4/10 1,000
3/31/10 1,000
4/1/10 1,000
4/21/10 540
4/27/10 1,080
5/5/10 500
5/11/10 1080
5/20/10 270
5/25/10 1,350
6/8/10 1,530
6/20/10 1,700
7/1/10 1,530
7/8/10 1,530
7/20/10 1,980
8/5/10 810

Oxycodone 30mg Tablets
8/9/10 672
8/11/10 2,016
8/16/10 2,016
8/23/10 112
TOTAL TABLETS 23,716

62. The above chart reflects that according to Dr. Schultz's own medical records, he prescribed excessive quantities and doses of short acting and immediate release opioids to Patient R.L. during the course of 229 days.

63. Respondent's medical records reflect that Respondent prescribed Patient R.L. inappropriate amounts of short acting opiates purportedly for pain management that was not based on accepted scientific knowledge, was without a legitimate medical purpose, and was without any medical justification or titrating to the desired effect.

64. A reasonably prudent physician would not have excessively prescribed and/or dispensed immediate release opioids

without performing a thorough and complete medical history, without performing a thorough and complete substance abuse history, without performing a thorough and complete medical examination, without performing a thorough and complete psychological evaluation, without an accurate diagnosis of the patient's condition, without regularly ordering urine drug screens tests, without a legitimate medical purpose, without titrating to the desired effect, and without considering other interventional treatments, therapies or consultations.

FACTS SPECIFIC TO PATIENT M.D.

65. From on or about November 18, 2009, until on or about July 12, 2010, Dr. Schultz prescribed and/or dispensed 7,470 tablets of oxycodone 30mg within a 236-day period to Patient M.D.

66. On or about December 23, 2010, as a result of the investigation an independent medical expert in pain management reviewed Dr. Schultz's medical records for Patient M.D.

67. The expert expressed the opinion that Dr. Schultz violated the standard of care in treating Patient M.D. and found that Dr. Schultz inappropriately prescribed excessive quantities and

inappropriate combinations of controlled substances without medical records justifying these prescriptions.

68. The expert found that Dr. Schultz excessively prescribed controlled substances to Patient M.D. to the point of being "egregious."

69. According to the narrative, the expert opined:

> [T]hat the standard of care had not been met by the records and the prescriptions. At no point from 2002 to 2010 did Dr. Schultz note any neurologic abnormality consistent with any significant radicular problem in the back. There was no diagnostic study such as an x-ray or MRI ever showing a problem. There is no documented evidence of any structural abnormality or correlations with any pain generator that would warrant chronic uses of high doses of opioid medications. At no point is any other alternative such as exercise, non-opioid analgesics, physical therapy, and consultations with a pain specialist or back specialist, referral to an addiction medicine specialist ever considered or documented. The only treatment ever recommended was medications. The combination of Actiq, Soma, Roxicodone, and Oxycontin represents four highly addictive substances. In addition, Actiq has only one FDA approved indication, specifically for breakthrough cancer pain. The only two possibilities for these prescriptions would be drug addiction verses drug diversion or a combination of the same. There are deficits in the record keeping as the records appear to be copied templates from visit to visits.

70. During an interview with Agent Murray, Patient M.D. stated that he/she presented himself to Dr. Schultz in 2002, seeking treatment for back pain. Patient M.D. was never treated for cancer.

71. Patient M.D. said that during his/her first visit to Dr. Schultz, he/she was prescribed Oxycontin 80mg, Actiq 800mcg, Soma 350mg, and "it kept going up from there." Dr. Schultz later prescribed 360 tablets of Roxicodone 30mg in addition to the other prescriptions, which eventually increased to 1,280 tablets, per month.

72. Patient M.D. said that Dr. Schultz wanted cash for the dispensed medications or he would charge his patients an additional 10% if they paid with a credit card. Patient M.D. said that if he/she took the prescription to a pharmacy, many times the pharmacist would refuse to fill it due to the large quantity.

73. Patient M.D. said that he/she believes Dr. Shultz would give him/her prescriptions for any quantity of oxycodone that he/she requested, and Patient M.D. said that he/she has become addicted. Patient M.D. said "I'm hoping by the summer I can be off of everything."

74. Patient M.D. disputes the veracity of Dr. Schultz's medical records. The entries in Patient M.D.'s medical records are never changed from month to month, and year to year. Only the vitals changed, as recorded by the medical assistants. After visiting Dr. Schultz for a period of eight years, only one assessment sheet was found in the file.

75. Dr. Schultz documented that he examined Patient M.D. during every office visit, including range of motion, heart, lungs and an evaluation for asthma. Dr. Schultz wrote that the patient's respiratory system is negative for cough, dysnea, and hemopysis and his/her lungs were clear to auscultation and percussion. Patient M.D. said that Dr. Schultz never examined him/her, never evaluated him/her for asthma, never listened to his/her heart, never listened to his/her lungs, and never performed any range of motion tests.

76. Dr. Schultz's medical records disclose that he prescribed multiple prescriptions for large quantities of oxycodone 30mg for Patient M.D. on the dates and in the quantities described in the following table. The medical records did not contain medical

justification for the high frequency of such large quantities of controlled substances.

Oxycodone 30mg Tablets
11/18/09 1,000
12/23/09 1,100
1/21/10 1,000
2/16/10 1,000
3/15/10 900
4/29/10 810
6/16/10 990
7/1/10 270
7/12/10 200
2/23/10 200
TOTAL TABLETS 7,470

77. The above chart reflects that according to Dr. Schultz's medical records, he prescribed excessive quantities and doses of

short acting and immediate release opioids to Patient M.D. during the course of 236 days.

78. Respondent's medical records reflect that Respondent prescribed Patient M.D. inappropriate amounts of short acting opiates purportedly for pain management that was not based on accepted scientific knowledge, was without a legitimate medical purpose, and was without any medical justification or titrating to the desired effect.

79. A reasonably prudent physician would not have concurrently and excessively prescribed and/or dispensed two or more immediate release opioids without performing a thorough and complete medical history, without performing a thorough and complete substance abuse history, without performing a thorough and complete medical examination, without performing a thorough and complete psychological evaluation, without an accurate diagnosis of the patient's condition, without regularly ordering urine drug screens tests, without a legitimate medical purpose, without titrating to the desired effect, and without considering other interventional treatments, therapies or consultations.

FACTS SPECIFIC TO PATIENT S.G.

80. From on or about December 21, 2009, until on or about July 30, 2010, Dr. Schultz prescribed and/or dispensed 4,150 tablets of oxycodone 30mg within a 221-day period to Patient S.G.

81. On or about December 23, 2010, as a result of the investigation an independent medical expert in pain management reviewed Dr. Schultz's medical records for Patient S.G.

82. The expert expressed the opinion that Dr. Schultz violated the standard of care in treating Patient S.G. and found that Dr. Schultz inappropriately prescribed excessive quantities and inappropriate combinations of controlled substances without medical records justifying these prescriptions.

83. The expert found that Dr. Schultz prescribed to Patient S.G. "extremely high doses of opiate analgesics with high doses of benzodiazepines" without a legitimate medical reason.

84. According to the narrative, the expert opined:

> [There was] no abnormally [sic] on physical examination, diagnostic study, or objective assessment that would have warranted these dedications (prescriptions). A complaint of chronic pain and the need to use 450 to 600 mg of oxycodone daily is not suggested, confirmed, or

even suspected by the history or physical examination. There was no objective abnormality recorded that would have warranted there types of prescriptions. This represents aberrant drug behavior and the differential would include either drug diversion or opiate addiction. Dr. Schultz prescribed high doses of controlled substances at a very frequent and alarming rate.

85. During an interview with Agent Murray, Patient S.G. stated that he/she presented himself to Dr. Schultz in 2009, seeking treatment for back pain. Patient S.G. said that he/she had previously been treated for his/her back pain by another physician who prescribed physical therapy, chiropractic care, and a thirty-day supply of 270 tablets of oxycodone 30mg.

86. Patient S.G. said that during his/her first visit, Dr. Schultz did not perform a complete and thorough medical examination, any diagnostic testing, and there was no documentation of an MRI. Dr. Schultz prescribed 400 tablets of oxycodone 30mg to Patient S.G.

87. Patient S.G. paid Dr. Schultz with cash, even though he/she does have health insurance coverage. A review of the documentation contained in Patient S.G.'s medical records show that there was never any change from month to month, except for the vitals as recorded by the medical assistants.

88. Dr. Schultz soon increased the prescriptions from 400 tablets of oxycodone 30mg to 630 tablets of oxycodone 30mg. Patient S.G. believes the quantities increased once Dr. Schultz began dispensing from the office and the quantities appeared to coincide with the quantities contained in the unopened bottles. Patient S.G. stated that a new bottle contained 90 tablets of oxycodone 30mg, and for that reason, Dr. Schultz would prescribe 540 tablets of oxycodone 30mg resulting in the sale of six new bottles to a patient.

89. Patient S.G. said that if he/she wanted to have the prescriptions dispensed by an outside pharmacy Dr. Schultz would write separate prescriptions so that a pharmacist would not become wary or question the large quantity of oxycodone 30mg being prescribed. This method helped avoid suspicion and gave the illusion to outside pharmacies that lesser quantities were being prescribed by Dr. Schultz.

90. Patient S.G is concerned and embarrassed that he/she may have unknowingly become addicted as a direct consequence of Dr. Schultz's prescribing practices. Patient S.G. claims that he/she told Dr. Schultz that he/she was afraid of becoming addicted. Patient

S.G. stated that Dr. Schultz did not seem concerned, nor did he offer any addiction therapy or referrals.

91. Dr. Schultz's medical records indicate that he prescribed multiple prescriptions for large quantities of oxycodone 30mg on the dates and in the quantities described in the following table. The medical records did not contain medical justification for the high frequency of such large quantities of controlled substances.

Oxycodone 30mg Tablets
12/21/09 400
1/14/10 500
2/11/10 500
3/11/10 500
5/6/10 540
6/3/10 540
7/1/10 630
7/30/10 540
TOTAL TABLETS 4,150

92. The above chart reflects that according to Dr. Schultz's medical records, he prescribed excessive quantities and doses of short acting and immediate release opioids to Patient S.G. during the course of 221 days.

93. Respondent's medical records reflect that Respondent prescribed Patient S.G. inappropriate amounts of short acting opiates purportedly for pain management that was not based on accepted scientific knowledge, was without a legitimate medical purpose, and was without any medical justification or titrating to the desired effect.

94. A reasonably prudent physician would not have concurrently and excessively prescribed and/or dispensed two or more immediate release opioids without performing a thorough and complete medical history, without performing a thorough and complete substance abuse history, without performing a thorough and complete medical examination, without performing a thorough and complete psychological evaluation, without an accurate diagnosis of the patient's condition, without regularly ordering urine drug screens tests, without a legitimate medical purpose, without titrating

to the desired effect, and without considering other interventional treatments, therapies or consultations.

FACTS SPECIFIC TO PATIENT H.G.

95. From on or about January 19, 2010, until on or about August 2, 2010, Dr. Schultz prescribed and/or dispensed 4,220 tablets of oxycodone 30mg and 2,100 tablets of Methadone 10mg within a 195-day period to Patient H.G, a then 78 year-old individual.

96. On or about December 23, 2010, as a result of the investigation an independent medical expert in pain management reviewed Dr. Schultz's medical records for Patient H.G.

97. The expert expressed the opinion that Dr. Schultz violated the standard of care in treating Patient H.G. and found that Dr. Schultz inappropriately prescribed excessive quantities and inappropriate combinations of controlled substances without medical records justifying these prescriptions.

98. According to the narrative, the expert found that "the prescribing of Dr. Schultz for patient H.G. is inappropriate, excessive and frankly dangerous."

99. According to the narrative, the expert opined:

A 78 year old individual with a history of stroke would not be an appropriate candidate for methadone, especially at a dose of 80mg every 8 hours. It would be inappropriate to use two short-acting opioids such as methadone and Roxicodone as the high doses concurrently. There is evidence of a stroke and hip fracture, yet there was never documented any evidence of abnormality on physical examinations, in addition no neurologic exam is ever documented despite the patient complaints. The prescriptions were not justified by the records. Dr. Schultz does not clearly document the manner he uses to diagnose the condition and carried forth the same diagnosis from visit to visit from 2005. There was no treatment alternatives ever discussed. There was no documentation as to the tolerance of medication or any documentation to ensure that the patient was not diverting the medication.

100. During an interview with Agent Murray, Patient H.G. stated that he/she presented to himself/herself to Dr. Schultz in 2005, for treatment of a bad back and as well as seeking a new primary care physician. Patient H.G. said that he/she had previously been treated for his/her back pain by another physician at the Veteran's Affairs hospital that consisted of injections in the back and Motrin. Patient H.G. said that during his/her first visit to Dr. Schultz, he/she was prescribed 400 tablets of oxycodone 30mg. After a few months, Dr. Schultz increased his/her prescriptions to 540 tablets of oxycodone 30mg and 600 tablets of Methadone 10mg.

101. Agent Murray reviewed the record with Patient H.G., and reported that "it was obvious that the quantities of Oxycodone almost doubled when Dr. Schultz started dispensing from his office and when he/she stopped dispensing the quantities drastically decreased."

102. Patient H.G. said that he/she paid Dr. Schultz with cash for the drugs, even though he/she had full medical insurance coverage. A review of the documentation contained in Patient H.G.'s medical records show that there were never any significant changes from month to month.

103. Patient H.G. told the agent that several years ago he/she suffered a stroke, and in 2009, he/she fell and fractured his/her hip. As a result of these ailments, Patient H.G. has great difficulty in using a "walker," so he/she is generally confined to a wheel chair. Nevertheless, Dr. Schultz documented that Patient H.G. walks with a "normal gait." Additionally, Patient H.G. said that Dr. Schultz has never evaluated his/her level of pain.

104. Dr. Schultz's medical records indicate that he prescribed multiple and simultaneous prescriptions for large quantities of

oxycodone 30mg and Methadone 10mg for Patient H.G. on the dates and in the quantities described in the following table. The medical records did not contain medical justification for the high frequency and simultaneous prescription of such large quantities of controlled substances.

Oxycodone 30mg Tablets	Methadone 10mg Tablets
1/19/10 400	
2/11/10 400	
3/11/10 400	3/11/10 500
4/8/10 540	4/8/10 500
5/12/10 500	5/12/10 500
6/3/10 540	
6/29/10 540	
7/7/10 360	
7/30/10 360	
8/2/10 180	
TOTAL TABLETS 4,220	TOTAL TABLETS 2,100

105. The above chart reflects that according to Dr. Schultz's medical records, he simultaneously prescribed excessive quantities and doses of short acting and immediate release opioids to Patient H.G. during the course of 195 days.

106. Respondent's medical records reflect that Respondent prescribed 6,320 tablets of short acting opioids to Patient H.G. solely on the uncorroborated and unverified verbal medical and drug history conveyed by the patient to the Respondent.

107. Respondent's medical records reflect that Respondent prescribed Patient H.G. inappropriate amounts of similar short acting opiates purportedly for pain management that was not based on accepted scientific knowledge, was without a legitimate medical purpose, and was without any medical justification or titrating to the desired effect.

108. A reasonably prudent physician would not have concurrently and excessively prescribed and/or dispensed two or more immediate release opioids without performing a thorough and complete medical history, without performing a thorough and complete substance abuse history, without performing a thorough

and complete medical examination, without performing a thorough and complete psychological evaluation, without an accurate diagnosis of the patient's condition, without regularly ordering urine drug screens tests, without a legitimate medical purpose, without titrating to the desired effect, and without considering other interventional treatments, therapies or consultations.

FACTS SPECIFIC TO PATIENT S.B.

109. From on or about January 1, 2010, until on or about September 2, 2010, Dr. Schultz prescribed and/or dispensed 4,192 tablets of oxycodone 30mg.

110. On or about December 23, 2010, as a result of the investigation an independent medical expert in pain management reviewed Dr. Schultz's medical records for Patient S.B.

111. The expert expressed the opinion that Dr. Schultz violated the standard of care in treating Patient S.B. and found that Dr. Schultz inappropriately prescribed excessive quantities and inappropriate combinations of controlled substances without medical records justifying these prescriptions.

112. The expert found "that patient S.B. received large quantities of methadone and Roxicodone from Dr. Schultz."

113. According to the narrative, the expert opined:

> There was no physical examination abnormality or other objective abnormality which would have related to or corresponded with the complaints as delineated. The risk of toxicity of [sic] high doses of methadone and Roxicodone make it likely implausible that the patient was using these two agents as prescribed.

114. Respondent's medical records reflect that Respondent prescribed Patient S.B. inappropriate amounts of similar short acting opiates purportedly for pain management that was not based on accepted scientific knowledge, was without a legitimate medical purpose, and was without any medical justification or titrating to the desired effect.

115. A reasonably prudent physician would not have concurrently and excessively prescribed and/or dispensed two or more immediate release opioids without performing a thorough and complete medical history, without performing a thorough and complete substance abuse history, without performing a thorough and complete medical examination, without performing a thorough

and complete psychological evaluation, without an accurate diagnosis of the patient's condition, without regularly ordering urine drug screens tests, without a legitimate medical purpose, without titrating to the desired effect, and without considering other interventional treatments, therapies or consultations.

FACTS SPECIFIC TO PATIENT G.N.

116. From on or about January 1, 2010, until on or about September 2, 2010, Dr. Schultz prescribed and/or dispensed 7,020 tablets of oxycodone 30mg.

117. On or about December 23, 2010, as a result of the investigation an independent medical expert in pain management reviewed Dr. Schultz's medical records for Patient G.N.

118. According to the narrative, the expert opined:

> These medical records do not meet with the medical standard of care. No plan was ever listed in the template of the electronic medical record which does not change from visit to visit other than the vital signs. No treatment alternatives are ever reviewed other than the listing of the medications. The medications that are provided were done to excess.

119. Respondent's medical records reflect that Respondent prescribed inappropriate amounts of similar short acting opiates

purportedly for pain management that was not based on accepted scientific knowledge, without a legitimate medical purpose, without any medical justification or titrating to the desired effect.

120. A reasonably prudent physician would not have concurrently and excessively prescribed and/or dispensed immediate release opioids without performing a thorough and complete medical history, without performing a thorough and complete substance abuse history, without performing a thorough and complete medical examination, without performing a thorough and complete psychological evaluation, without an accurate diagnosis of the patient's condition, without regularly ordering urine drug screens tests, without a legitimate medical purpose, without titrating to the desired effect, and without considering other interventional treatments, therapies or consultations.

FACTS SPECIFIC TO PATIENT B.F.

121. From on or about January 1, 2010, until on or about September 2, 2010, Dr. Schultz prescribed and/or dispensed 7,752 tablets of oxycodone 30mg.

122. On or about December 23, 2009, as a result of the investigation an independent medical expert in pain management reviewed Dr. Schultz's medical records for Patient B.F.

123. According to the narrative, the expert opined:

> [T]he prescriptions written to B.F. by Dr. Schultz reflect an alarmingly large amount of highly potentially [sic] addictive medication prescriptions. The only abnormality noted in the entire history dated back to 2002. Nowhere in the physical exams for eight years was it noted that B.F. had any neurologic deficit. The amounts of prescriptions prescribed are excessive and obviously dangerous.

124. Respondent's medical records reflect that Respondent prescribed Patient B.F. inappropriate amounts of similar short acting opiates purportedly for pain management that was not based on accepted scientific knowledge, was without a legitimate medical purpose, and was without any medical justification or titrating to the desired effect.

125. A reasonably prudent physician would not have concurrently and excessively prescribed and/or dispensed immediate release opioids without performing a thorough and complete medical history, without performing a thorough and complete substance

abuse history, without performing a thorough and complete medical examination, without performing a thorough and complete psychological evaluation, without an accurate diagnosis of the patient's condition, without regularly ordering urine drug screens tests, without a legitimate medical purpose, without titrating to the desired effect, and without considering other interventional treatments, therapies or consultations.

FACTS SPECIFIC TO PATIENT K.F.

126. From on or about January 1, 2010, until on or about September 2, 2010, Dr. Schultz prescribed and/or dispensed 2,460 tablets of oxycodone 30mg and 2,400 tablets of Methadone 10mg (within one month).

127. On or about December 23, 2010, as a result of the investigation an independent medical expert in pain management reviewed Dr. Schultz's medical records for Patient K.F.

128. According to the narrative, the expert opined:

> [T]he records do not substantiate the medications provided and [sic] was given multiple medications with known addictive potential. There was no objective basis for the patient's back pain. There was no imaging of the back performed. There was no alternative given. The

> medications provided were clearly excessive. It is also beneath [sic] the standard of care that Dr. Schultz did not wean K.F. from her medications during pregnancy.

129. Respondent's medical records reflect that Respondent prescribed Patient K.F. inappropriate amounts of similar short acting opiates purportedly for pain management that was not based on accepted scientific knowledge, was without a legitimate medical purpose, and was without any medical justification or titrating to the desired effect.

130. A reasonably prudent physician would not have concurrently and excessively prescribed and/or dispensed immediate release opioids without performing a thorough and complete medical history, without performing a thorough and complete substance abuse history, without performing a thorough and complete medical examination, without weaning Patient K.F. of her medications during pregnancy, without performing a thorough and complete psychological evaluation, without an accurate diagnosis of the patient's condition, without regularly ordering urine drug screens tests, without a legitimate medical purpose, without titrating to the

desired effect, and without considering other interventional treatments, therapies or consultations.

LEGAL ANALYSIS

131. The independent medical expert found that the scheduled controlled substances prescribed and/or dispensed by Dr. Schultz were markedly excessive, reckless, dangerous, highly toxic, and potentially lethal. Dr. Schultz did not provide a fundamental basis for prescribing clearly excessive doses that were to be ingested with great frequency.

132. Dr. Schultz egregiously and recklessly prescribed and/or dispensed toxic quantities of opioids to patients who did not exhibit any objective abnormalities. Dr. Schultz prescribed and/or dispensed extremely high doses of opiate analgesics with high doses of benzodiazepines, without any evidence of an existing abnormally or objective assessment that would have warranted these medications for his patients.

133. Dr. Schultz fell below the standard of care in regards to all 10 patients identified above and he/she failed to appropriately document any medical justification for excessively dispensing

immediate release opiolds without performing thorough and complete medical histories, substance abuse histories, medical examinations, psychological evaluations, radiology images, diagnostic tests, drug screen tests, and without titrating to the desired effect and without considering other treatment modalities.

134. Section 458.331(1)(t), Florida Statutes (2005-2009), provides that committing medical malpractice constitutes grounds for disciplinary action by the Board of Medicine. Medical Malpractice is defined in Section 456.50, Florida Statutes (2005-2009), as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. For purposes of Section 458.331(1)(t), Florida Statutes (2005-2009), the Board shall give great weight to the provisions of Section 766.102, Florida Statutes (2005-2009), which provide that the prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

135. Dr. Schultz failed to practice medicine with that level of care, skill and treatment in violation of Section 458.331(1)(t), Florida Statutes (2005-2009), which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in the treatment of patients K.H., P.G., R.L., M.D., S.G., H.G., S.B., G.N., B.F. and/or K.F. in one or more of the following ways: By failing to medically justify prescribing benzodiazepines in excessive doses; by prescribing excessive and/or inappropriate quantities of opioids and benzodiazepines; by failing to diagnose an anxiety disorder to justify prescribing benzodiazepines, by failing to order urine drug screening in view of the high dosages of opioids and benzodiazepines being prescribed; by failing to show in the medical record the justification for prescribing opioids in the dosages prescribed; by failing to show in the medical record the justification for prescribing a combination of two or more immediate release opioids; by failing to wean pregnant patients off the medication, by prescribing concurrent prescriptions of immediate release opioids in combination, and at the dosages prescribed; and by violating the standards for the use of controlled substances for

pain management provided by the Board of Medicine in Rule 64B8-9.013(3), Florida Administrative Code.

136. Section 458.331(1)(q), Florida Statutes (2005-2009), subjects a licensee to discipline, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.

137. Dr. Schultz prescribed, dispensed, and/or administered inappropriately and/or prescribed controlled substances other than in the course of his professional practice by prescribing controlled substances in excessive or inappropriate quantities to patients K.H., P.G., R.L., M.D., S.G., H.G., S.B., G.N., B.F. and/or K.F. on or about

the dates and in the quantities and combinations more particularly described above that were not in the patient's best interests.

138. Section 458.331(1)(nn), Florida Statutes (2005-2009), provides that violating any provision of chapters 456 or 458, Florida Statutes (2005-2009), or any rules adopted pursuant thereto, is grounds for discipline by the Board of Medicine.

139. Rule 64B8-9.013(3), Florida Administrative Code, provides as follows:

> The Board has adopted the following standards for the use of controlled substances for pain control:
>
> (a) Evaluation of the Patient. A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.
>
> (b) Treatment Plan. The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient.

Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

140. On or about the dates set forth above, Dr. Schultz violated Rule 64B8-9.013(3), by prescribing one or more of the following controlled substances: Hydrocodone, oxycodone, Roxicodone, Hydromorphone, Actiq, Methadone, Morphine, Oxycontin, Percocet, alprazolam, and/or carisoprodol to patients K.H., P.G., R.L., M.D., S.G., H.G., S.B., G.N., B.F. and/or K.F., either collectively or as individuals, in the quantities and combinations particularly described herein, without conducting or documenting complete medical histories or physical examinations of the patients.

141. Dr. Schultz also violated the Rule by prescribing to the patients without documenting one or more of the following: The nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, history of substance abuse, the presence of one or more recognized medical indications for the use of a controlled substance, and without documenting

written treatment plans that state objectives that will be used to determine treatment success or indicate if any further diagnostic evaluations or other treatments are planned.

142. Section 458.331(1)(m), Florida Statutes (2005-2009), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

143. On or about the dates set forth above, Dr. Schultz violated Section 458.331(1)(m), Florida Statutes (2005-2009), by failing to keep medical records that justified the course of treatment of one or more of the following patients: K.H., P.G., R.L., M.D., S.G., H.G., S.B., G.N., B.F. and/or K.F.

144. Section 120.60(6), Florida Statutes (2010), authorizes the Department to summarily suspend a physician's license if the Department finds that the physician presents an immediate serious danger to the public health, safety, or welfare.

145. A physician licensed in the state of Florida is one of a small number of licensed professionals allowed to prescribe, administer, and dispense controlled substances in the state. The Legislature has vested a trust and confidence in these licensed professionals by permitting them to prescribe drugs with a high potential for abuse and harm. Inappropriate prescribing of highly addictive controlled substances to patients presents a danger to the public health, safety, or welfare, and does not correspond to that level of professional conduct expected of one licensed to practice medicine in this state.

146. Dr. Schultz has demonstrated, through his violation of 458.331(1)(t), (q), (nn), and (m), Florida Statutes, (2005-2009), and Rule 64B8-9.013(3), (FAC), a flagrant disregard for the duties and responsibilities imposed upon a physician practicing in the State of Florida and for the health and welfare of his patients and for the

citizens of this state. Dr. Schultz's egregious and inappropriate prescribing of potentially addictive and dangerous drugs constitutes a breach of the trust and confidence that the Legislature placed in him by issuing him a license to practice medicine and to dispense medication, including controlled substances.

147. The arrest of Dr. Schultz does not sufficiently protect the public from harm since he was granted an affordable bond amount. Once released from custody, Dr. Schultz may continue to inappropriately prescribe and/or dispense highly addicted and dangerous controlled substances to members of the public.

148. Dr. Schultz's acts manifest such a pattern and propensity to prescribe excessively and inappropriately dangerous and addictive controlled substances and to practice below the appropriate standard of care that a continuation of this practice is likely to recur. An emergency order of restriction is not sufficient to protect the public because the level of excessive and inappropriate prescribing Dr. Schultz has engaged in demonstrates an inability to make decisions that are in the best interest of his patients. Nothing short of the

suspension of Dr. Schultz's license will protect the public from this danger.

CONCLUSIONS OF LAW

149. Based on the foregoing Findings of Fact, the State Surgeon General concludes as follows:

150. The State Surgeon General has jurisdiction pursuant to Sections 20.43 and 456.073(8), Florida Statutes, and Chapter 458, Florida Statutes.

151. Dr. Schultz violated Section 458.331(1)(t), Florida Statutes (2005-2009), by committing medical malpractice in treating one or more of the following patients: K.H., P.G., R.L., M.D., S.G., H.G., S.B., G.N., B.F. and/or K.F.

152. Dr. Schultz violated Section 458.331(1)(q), Florida Statutes (2005-2009), by inappropriately prescribing excessive and inappropriate quantities of controlled substances to one or more of the following patients: K.H., P.G., R.L., M.D., S.G., H.G., S.B., G.N., B.F. and/or K.F., either collectively or individually.

153. Dr. Schultz violated Section 458.331(1)(nn), Florida Statutes (2005-2009), by violating a rule adopted pursuant to

Chapter 458 because he failed to document or adhere to the Florida Board of Medicine standards for the use of controlled substances for pain control contained within Rule 64B8-9.013(3), Florida Administrative Code, in his treatment of one or more of the following patients: K.H., P.G., R.L., M.D., S.G., H.G., S.B., G.N., B.F. and/or K.F.

154. Dr. Schultz violated Section 458.331(1)(m), Florida Statutes (2005-2009), by failing to keep medical records that justify the course of treatment of patients K.H., P.G., R.L., M.D., S.G., H.G., S.B., G.N., B.F. and/or K.F.

155. Dr. Schultz's continued practice as a physician constitutes an immediate serious danger to the health, safety, or welfare of the public and this summary procedure is fair under the circumstances to adequately protect the public.

WHEREFORE, In accordance with Section 120.60(6), Florida Statutes, it is ORDERED THAT:

1. The license of Barry M. Schultz, M.D., license number ME 67047 is immediately suspended.

2. A proceeding seeking formal discipline of the license of Barry M. Schultz, M.D., to practice as a physician will be promptly instituted and acted upon in compliance with Sections 120.569 and 120.60(6), Florida Statutes.

DONE and ORDERED this 13 day of April, 2011.

REDACTED

H. Frank Farmer, Jr., M.D., Ph.D.,
State Surgeon General
Department of Health

Prepared by:
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NOTICE OF RIGHT TO JUDICIAL REVIEW

Pursuant to Sections 120.60(6), and 120.68, Florida Statutes, this Order is judicially reviewable. Review proceedings are governed by the Florida Rules of Appellate Procedure. Proceedings are commenced by filing a Petition for Review, in accordance with Florida Rule of Appellate Procedure 9.100, with the District Court of Appeal, accompanied by a filing fee prescribed by law, and a copy of the petition with the Agency Clerk of the Department within 30 days of the date this Order is filed.