

COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss.

Division of Administrative Law Appeals
One Congress Street, 11th Floor
Boston, MA -2114
www.mass.gov/dala

Board of Registration in Medicine,
Petitioner

v.

Docket No. **RM-09-665**
Dated: February 24, 2017

Bentley A. Ogoke, M.D.,
Respondent

Appearance for Petitioner:

John Costello, Esq.
Gloria Brooks, Esq.
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Appearance for Respondent:

Paul Cirel, Esq.
Ingrid Martin, Esq.
Collora, LLP
100 High Street, 20th floor
Boston, MA 02110

Administrative Magistrate:

Sarah H. Luick, Esq.

SUMMARY OF RECOMMENDED DECISION

The Board of Registration in Medicine failed to prove most of the charges against Dr. Ogoke for his treatments of the patients addressed in the Statement of Allegations - patients A, B, C, E, F, G, H, I, J, K, L, M, N and O. The charges included Dr. Ogoke: yelling at patients and staff; maintaining a messy office; not giving physical examinations before prescribing opioid medications; and, not enforcing the narcotics agreement his patients signed to use prescriptions properly and not to use illicit drugs. The Statement of Allegations also included charges specific to his treatment of each of these patients that involved: failing to timely provide requested medical records; over-prescribing opioid medication and prescribing opioids for too long; performing unnecessarily risky interventional procedures; not maintaining adequate medical records on these patients by not including all the details of each prescription written at a patient's

visit within a visit report; not adequately discussing within the visit reports why high dose opioid medications were prescribed and maintained for the patient; and, not adequately discussing within the visit reports a patient's red flag conduct such as drug-seeking behavior, use of illicit drugs, and failing to take prescribed medications properly.

There was no proof that Dr. Ogoke intentionally ignored the pertinent standards of care, or was acting fraudulently in administering patient care, but there were times when he failed to adequately satisfy a standard of care for particular patients based on expert opinion.

- There was sufficient proof that Dr. Ogoke violated the standard of care by his failure to uncover the many UDS results that Pt. G had that were positive for Marijuana while he was prescribing her high opioid dose medications.
- There was sufficient proof to show that Dr. Ogoke failed to timely send Pt. H his medical records after Pt. H stopped his care with Dr. Ogoke.
- There was sufficient proof that Dr. Ogoke failed to adequately monitor Pt. J, who had tested positive on more than one urine drug screen test for Cocaine and Marijuana, and who continued to be prescribed high dose opioids even after Dr. Ogoke learned of these test results.
- There was sufficient proof that Dr. Ogoke failed to adequately explain in his visit reports Pt. M's conduct during large gaps in time when Pt. M did not meet his scheduled appointments and treatments, and why Dr. Ogoke reached the decisions he did on prescribing medications and determining other treatments when Pt. M returned to his care.

RECOMMENDED DECISION

On October 7, 2009, the Board of Registration in Medicine (BORM) filed a Statement of Allegations against the Respondent, Dr. Bentley A. Ogoke, along with an Order of Reference to the Division of Administrative Law Appeals (DALA) to hold a hearing on the Statement of Allegations. Also filed with DALA was an Order to Use Pseudonyms for the names of patients addressed by the Statement of Allegations, and the Voluntary Agreement Not to Practice Medicine entered into by Dr. Ogoke with the BORM. The Statement of Allegations ordered Dr. Ogoke to show cause why he should not be disciplined for his conduct in regard to the individual care he gave each of the patients addressed in the Statement of Allegations - patients A, B, C, E, F, G, H, I, J, K, L, M, N and O. Although charges concerning Patient P are included within the Statement of Allegations, the BORM did not present any evidence about Patient P, and the

parties agree that charges about Patient P are not to be considered. The Statement of Allegations also charges Dr. Ogoke with violating the standard of care by having routinely: mistreated his patients and his staff by yelling at them; maintained a messy office; had patients wait for overly long times to see him; failed to examine patients before prescribing opioid medication; and, failed to enforce the narcotics agreement that his patients signed. The Respondent filed his Answer to the Statement of Allegations on November 16, 2009, denying all the charges.

Three pre-hearing conferences were held after the Order of Reference to the Division of Administrative Law Appeals (DALA) was received, that led to the parties engaging in a long period of voluntary discovery until the parties were ready for hearing. Just prior to the start of the hearing, the parties filed witness lists and a few motions. The hearing was held on the following eighteen days: January 7, 10, 11, 18, 19, 20 and 21, 2011; February 18, 2011; March 28 and 29, 2011; April 1, 6, 14, 19, 20, 21 and 29, 2011; and, June 2, 2011, the last day of hearing. All the days of hearing were transcribed. The hearing was held at the offices of the Division of Administrative Law Appeals when it was located at 98 North Washington Street, Boston, MA 02114.

Exhibits

Various documents are in evidence. (Exhibits 1 – 113.) Among the Exhibits is a disc, Exhibit 43, that contains Dr. Ogoke's medical records concerning the patients addressed in the Statement of Allegations (other than patient P) that the BORM copied into the disc. The breakdown per patient (Pt.) within Exhibit 43 is: Pt. A, bate nos. 1-123; Pt. B, bate nos. 124-494; Pt. C, bate nos. 495-680; Pt. E, bate nos. 681-1129; Pt. F, bate nos. 1130-1869; Pt. G, bate nos. 1870-2425; Pt. H, bate nos. 2426-2605; Pt. I, bate nos. 2606-2763; Pt. J, bate nos. 2764-3335; Pt. K, bate nos. 3336-3542; Pt. L, bate nos. 3543-3733; Pt. M, bate nos. 3734-3863; Pt. N, bate.nos.

3864-4319; and, Pt. O, bates nos. 4320-4650. There are a number of Exhibits that are paper copies of documents also contained within Exhibit 43. The Exhibits include paper copies of these patients' medical records kept by Dr. Ogoke that were not bates stamped and contained within Exhibit 43. The Respondent did not dispute the authenticity of the medical records. Rather, the Respondent disputed that the order of the medical records as set-forth in Exhibit 43 were copied by the BORM in the same order that Dr. Ogoke maintained each patient's medical records at his office. (Transcript, Vol. I, 39.)¹ Some of the fourteen patients listed in the Statement of Allegations filed written complaints with the BORM concerning their care with Dr. Ogoke. Not all the patients who filed complaints with the BORM testified at the hearing. These were admitted into evidence over the objection of the Respondent (Exhibit 83). The BORM's investigative interview with Dr. Ogoke was admitted into evidence (Exhibit 84). Various guidelines and policies were admitted into evidence as having bearing on the determinations of whether or not Dr. Ogoke had violated any standards of care.

The Statement of Allegations is marked Exhibit A. The Order of Reference to DALA, the Order to Use Pseudonyms, and the Voluntary Agreement Not to Practice are marked together as Exhibit B. The Respondent's Answer is marked Exhibit C. The BORM's written Motion in Limine, addressed at the first day of hearing, along with the Respondent's written response are marked Exhibit D.

Witnesses

Testifying at the hearing were the following witnesses presented by the BORM: Dr.

¹ Until I began to review the voluminous medical records for each patient on the disc, Exhibit 43, I did not realize how very out of any order the medical records were for each patient. And, I encountered many more pages on the disc that were faintly copied, more than I had encountered during the hearing process as the hearing transcripts reveal. It was deciphering faint copies and pulling together in chronological order each patient's hundreds of pages of medical records that was remarkably time-consuming. I found this necessary to do to be able to make findings on the course of care each of the fourteen patients received from Dr. Ogoke and his staff.

Ogogke; Pt. F; Pt. H's mother; Pt. H's attorney, Thomas O'Grady, Esq.; Pt. I; Pt. J; and, the BORM's expert witness, Paul Satwicz, M.D. The Respondent presented the testimony of Maria Pacitti and Georgia Dawes, former employees of Dr. Ogoke. The Respondent also presented the testimony of Patrick Benvenuto and Jacquelyn Demers, former patients of Dr. Ogoke who addressed only the office conditions and Dr. Ogoke's demeanor that they encountered and not the propriety of their course of care with Dr. Ogoke. The Respondent presented the testimony of Philip Beattie, Jr., the BORM's investigator on this case, and the Respondent's expert witness, Andrea Trescot, M.D. Dr. Ogoke testified again on his own behalf.

Motions

The BORM had filed a motion to change the venue of the hearing to the Springfield Courthouse to make it more convenient and more of a possibility for the patients involved in the Statement of Allegations to testify as they were all located not far from the Springfield area. This motion was denied, but, in denying this motion, I allowed the parties to move to do a deposition of a patient unable to come to Boston to testify, to be placed in evidence in lieu of the patient's testimony at the hearing. This did not happen.

The BORM filed a Motion in Limine to exclude the Respondent's witnesses, or in the alternative, some of the Respondent's witnesses, including its expert witness. In addition to the parties written arguments on the Motion in Limine, the parties both made arguments on the record at the first day of hearing. The motion was fully denied.

At the first day of hearing, the Board moved to sequester witnesses. The ruling made was to sequester any patient who testified along with Pt. H's mother and Pt. H's attorney, Thomas O'Grady, Esq., who testified concerning an effort to secure Pt. H's medical records from Dr. Ogoke. At the first day of hearing, the Respondent moved to limit the medical records in

evidence to only the parties who testified at the hearing. This motion was denied with the objection going to weight on the quality of proof.

During the eighteen days of hearing, there were various times when the parties made further motions, and objections to the admission of certain testimony or of further Exhibits. Rulings were made on the record.

Briefs

The parties filed briefs by April 3, 2012 when the record closed.

BORM CLAIMS AGAINST BENTLEY OGOKE, MD

The BORM's charges against Dr. Ogoke as set forth in the Statement of Allegations include engaging in misconduct in violation of the BORM's Disruptive Physician Behavior Policy, adopted in June 2001 (Ex. 19), including yelling at patients and staff, maintaining an overly crowded and messy office, and patients sometimes having to wait hours to see him. The Statement of Allegations also charges that Dr. Ogoke provided substandard care to the fourteen patients listed for which evidence was presented: Patients A, B, C, (no Patient D), E, F, G, H, I, J, K, L, M, N & O.² Dr. Ogoke's specific conduct with each of these fourteen patients is addressed within the sections of this Recommended Decision about each patient. Those sections follow this section concerning the more general charges about how Dr. Ogoke conducted his pain management practice, his protocols, his monitoring of patients on long-term opioid therapy, his use of multi-level bilateral lumbar spine injections within one interventional procedure, his use of a narcotics agreement, his use of urine drug screen testing, his medical recordkeeping practices, and the differences in opinions on practicing a pain management specialty among Dr.

² Since no evidence was presented at all concerning Patient P, although the Statement of Allegations has charges against Dr. Ogoke concerning Pt. P, this patient's case is not addressed in this Recommended Decision. This is understood/ acknowledged by both parties in this case. The BORM presented no evidence concerning Pt. P.

Ogoke, Dr. Trescot and Dr. Satwicz. The findings of fact made in this section of the Recommended Decision are followed by a discussion with recommendations concerning the charges contained in the Statement of Allegations.

Findings of Fact

The following findings of fact address these general areas of alleged substandard care. The findings are based on the documentary and testimonial evidence presented, and the reasonable inferences drawn therefrom. The findings also address the opinions of Dr. Ogoke, Dr. Trescot and Dr. Satwicz on overall required conduct, including practice guidelines, recordkeeping practices, and prescribing practices with narcotics for long-term use.

Dr. Ogoke's Medical Training Background

I. Bentley Ogoke, M.D. is an interventional pain management specialist treating patients with acute but also with chronic pain. He was first licensed to practice in Massachusetts in 1994. He is certified by the American Board of Anesthesiology and has the subspecialty certification in pain management with the American Board of Interventional Pain Physicians. Dr. Ogoke is active in this newer field of pain management medicine and specifically, interventional treatments. This field started to emerge and grow around 2000. Dr. Ogoke is a founding member of the American Society of Interventional Pain Physicians (ASIPP). The practice of interventional pain management has been defined by the American Medical Association as the diagnosis and treatment of pain-related disorders primarily using interventional techniques to manage subacute chronic persistent and intractable pain. Interventional techniques include doing injections of medications into the lumbar, thoracic and cervical spines. During the time period Dr. Ogoke treated the fourteen patients listed in the Statement of Allegations, doing these techniques involved use of the fluoroscopy machine by the

skilled interventional specialist pain management physician to guide the injection to the targeted spinal location. Interventional procedures also include simpler injections into the knees or shoulder areas. (Statement of Allegations, Biographical Information & Answer. Ex.-84. Testimony of Dr. Ogoke, Vol. IV, 788-789; 791-792 & Dr. Trescot, Vol. XIV, 2630, 2646-2647, 2652-2653, 2659-2660.)

2. Dr. Ogoke received his medical education at the University of Nigeria, securing his M.D. degree in 1981. He then did a year of a transitional internship covering such areas as internal medicine, pediatrics, surgery, and OB-GYN. He did post-graduate work in anesthesiology at the University of Benin in Nigeria, and also did a residency there in anesthesiology. He came to the United States in 1986 and continued his medical training. He received his ECFMG (Educational Commission for Foreign Medical Graduates) certification in 1987 when he also passed the federal licensing exam. He did a residency program in internal medicine from July 1988-July 1991 at Harlem Hospital in New York City run by Columbia University Hospitals. In July 1991, he began a residency in anesthesiology at Beth Israel Medical Center in New York City, starting that program with six months of credit granted by the American Board of Anesthesiology. He finished the last six months of this residency at Montefiore Medical Center in the Bronx, New York. After this, Dr. Ogoke had a private practice in pain management in Allentown, Pennsylvania. In January 1995, he did a twelve month fellowship training in the field of pain management at Baystate Medical Center in Springfield. By 1995, performing injection procedures was part of a pain management practice. After this fellowship, Dr. Ogoke did "a number of jobs" to ready himself to start his own private practice in the field of pain management that included interventional procedures. He also did internal medicine moonlighting at Montefiore Medical Center in New York City and at Mercy Medical

Center in Springfield. He started working at Wing Memorial Hospital in Palmer when it opened a pain management clinic that Dr. Ogoke set up. He worked at Wing from 1996 until the latter part of 2001 or the start of 2002. He also opened his own pain management practice at 125 Liberty Street in Springfield by the latter part of 2001 or the start of 2002. He maintained this location for his private practice through the time of this case. He has held privileges, including admitting privileges, at BayState Medical Center, at Noble Hospital, and at Mercy Medical Center. When BayState Medical Center opened its own pain management clinic and Dr. Ogoke had his private practice in Springfield, he did not perform his pain management procedures there, but had Department of Internal Medicine privileges there. (Answer. Ex. 84.)

3. Dr. Ogoke's private practice was called Pioneer Valley Pain Management when he first opened it. Around 2003, he changed the name to Northern Pain Management with this same name through the time of this case. He gained patients by referrals from internal medicine doctors, from general practitioners, from family physicians, and from orthopedic physicians, neurosurgeons, and spine surgeons. He also had patients come to his practice without any referral. His practice grew and became one of the oldest and most well known interventional pain management practices in western Massachusetts. His pain management practice treated patients with chronic pain, acute pain, cancer pain, and injury-related pain. Dr. Ogoke's practice did not have many cancer patients. Most of his patients had already been treated by other physicians for pain control. Dr. Ogoke treated non-cancer chronic pain patients with both interventional procedures and medication regimens, including opioid medications. For his chronic non-cancer pain patients, Dr. Ogoke would typically combine a medication regimen with a variety of minimally invasive interventional procedures to treat or to numb the sources of the pain. (Exs. 7 & 84. Testimony of Dr. Ogoke, Vol. IV, 764, 780, 791-793; Dr. Trescot, Vol. XIV,

2652-2653 & Mr. Beattie, Vol. I, 3336-3339.)

4. Starting around 2000, Dr. Ogoke became involved nationally with other physicians with an interventional pain management specialty. The group he particularly worked with had anesthesiology credentials like he did. His work included addressing the use of opioid therapy for chronic non-cancer pain control as an ancillary treatment along with interventional procedures. Along with others, Dr. Ogoke became an author of articles for the physician community on guidelines to employ in engaging in a pain management practice that included ongoing opioid therapy. (Exs. 84 & 85.)

5. The pertinent time period when the fourteen patients listed in the Statement of Allegations were treated by Dr. Ogoke covers 1997 into 2008, although each patient's treatment by Dr. Ogoke covered a specific time span with this eleven year time period. (Statement of Allegations & Exhibit 43.)

Practices of Dr. Satwicz, Dr. Trescot, and Dr. Ogoke

6. Both Paul Satwicz, M.D. and Andrea Trescot, M.D. are qualified and experienced in the field of interventional pain management, as well as opioid therapy. Both are certified anesthesiologists like Dr. Ogoke. Both treat non-cancer chronic pain patients with medication regimens and with interventional procedures. But, they have practiced their specialty in different settings. Dr. Satwicz has practiced pain management in a clinic hospital setting, and since 1993, has been the Director of the Pain Management Clinic at Newton-Wellesley Hospital. Dr. Trescot has practiced in a hospital setting, but like Dr. Ogoke, has also practiced in a private office setting.

During the time period involved in this case, there were significant differences in how pain management was practiced in the private office setting versus in the hospital setting. Both

kinds of practices treat both short term acute pain patients and long-term chronic pain patients. The hospital practice more often has the primary care physician (PCP) engage in any long-term medication regimen prescribing, whereas the private practice more often handles the long-term medication regimen prescribing. The hospital pain management patient may see a number of pain management physicians over the course of treatment for pain whereas the private practice pain management patient will primarily be treated by one physician. A patient with chronic non-cancer pain often also suffers from related on-going issues of sleep difficulties, depression, and stress connected with family, social relationships, and continuing to work. In Dr. Ogoke's practice during the period of time covered by the Statement of Allegations, his chronic non-cancer pain patients often did not have a PCP. For the hospital practice, medical record keeping has to comply with standards of the Joint Commission on Accreditation of Hospitals. Dr. Satwicz's experience was to have computerized templated medical records. Those standards do not reach the private office practices of the kind operated by Dr. Trescot and Dr. Ogoke. Dr. Ogoke would have most of his patients' visit reports transcribed/typed-up, although he also kept medical records in handwriting.

There are also philosophical differences in pain management practices between Dr. Satwicz on the one side and Dr. Trescot and Dr. Ogoke on the other side that were prevalent during the time periods covered by this case. Their differences in protocols for patients with chronic non-cancer pain reached how they prescribed opioids to treat the pain. Their differences reflected the varying viewpoints at the time within the broad pain management community on the use of opioid therapy for patients with chronic non-cancer pain. Dr. Satwicz opposed the use of escalating opioid doses over time and commencing opioid prescribing with initial high doses, such as he found had occurred with the patients Dr. Ogoke treated. Even if effective, he opposed

using the powerful fast-acting opioid Actiq during an interventional procedure as Dr. Ogoke had done with some of his patients to address their pain or discomfort complaints during an injection procedure. For Dr. Satwicz, the use of that cancer drug violated the standard of care as having a risk for difficult side effects or for abuse of it due to its properties. Dr. Trescot and Dr. Ogoke viewed opioid therapy as a great benefit to many non-cancer chronic pain patients with high levels of intractable pain. The use of opioid therapy was most often for them an adjunct to treating their patients with interventional procedures. Dr. Satwicz, Dr. Trescot and Dr. Ogoke all acknowledged the need to engage in careful monitoring of patients taking opioid medications for long time periods and at high doses. (Exs. 82, 84 & 102. Dr. Satwicz, Vol. IX, 1654, 1662; Vol. XII, 1871-1877, 1930-1931, 2025-2026, 2299, 2304, 2314-2317, 2354-2355, 2349, 2405-2412, 3606-3608 & Dr. Trescot, Vol. XIV, 2634-2635, 2637-2638, 2666-2668.)³

7. Unlike Dr. Ogoke or Dr. Trescot, Dr. Satwicz would not have used opioid medication in increasing doses in the long-term care of the chronic non-cancer pain patients included in the Statement of Allegations. He opined that the risk of adverse impacts was too great in such patients, in terms of the known long-term side effects of taking opioids and the very real risks of over dependence, abuse, and addiction. For Dr. Satwicz, even careful monitoring of such patients would not overcome these significant risks. He also would not have administered four or five bilateral steroid injections within one interventional procedure with many sharp needles left in the body at one time during the procedure, as Dr. Ogoke did with some patients covered by the Statement of Allegations. Dr. Satwicz was concerned about the large narcotic doses the patient was receiving at one time and the risk of the patient moving while having too many sharp needles in the body at one time. Dr. Satwicz opined that having patients with

³ There is no dispute between the parties that both Dr. Satwicz and Dr. Trescot are pain management specialists who provide both pain medicine and interventional procedures to patients with chronic non-cancer pain.

chronic non-cancer pain treated for years with increased doses of opioids and/or with multiple injections during one procedure, was outside the standard of care in the treatment of these patients' pain, even acknowledging the ongoing debate at the time among pain management specialists on the use of narcotic therapies for chronic non-cancer pain, and even though there was no absolute standard of care on the number of multiple injections that could be administered during one procedure. (Testimony of Satwicz, Vol. X, 1871-1877, 1930-1931; Vol. XII, 2290-2293, 2329, 2335, 2366.)

8. Dr. Trescot thought that Dr. Ogoke providing long-term opioid therapy to the patients listed in the Statement of Allegations was within the standard of care. This included her opinion that increasing doses of opioids over time due to significant intractable chronic non-cancer pain was within the standard of care. For Dr. Trescot, if a patient could not engage in alternative treatments very effectively for pain control, such as physical therapies and exercises, or was not a surgical candidate to address the core area causing the pain, or was not sufficiently benefitting from periodic interventional procedures, then there was no prohibition against careful prescribing and monitoring of opioid medication for pain relief to improve the patient's quality of life. During the time period under consideration, so long as the patient's condition was sufficiently assessed on a case-by-case basis, Dr. Trescot recognized the worth and the need for ongoing opioid therapy, even with increased doses. Dr. Trescot opined that Dr. Ogoke had done this and as a result, had not engaged in substandard care. During the time period when Dr. Ogoke treated the fourteen patients listed in the Statement of Allegations, Dr. Trescot opined that use of this kind of opioid therapy, in addition to providing interventional procedures, even those done with multiple injections within one procedure, against a background of having done a sufficient evaluation of these patients' conditions, was proper and within the standard of care.

Dr. Trescot opined that going about locating the core areas of chronic non-cancer pain can take time and involve various diagnostic tests and numerous interventional procedures. Even when the pain sources can be located for targeted treatment using interventional procedures, the patient does not always experience sufficient pain relief and might need further pain relief that only opioid therapy could provide. This was the multi-dimensional approach that Dr. Ogoke took in treating his patients with chronic intractable non-cancer pain at high levels in order to provide them with an improved quality of life. For Dr. Trescot, this kind of pain management care included periodic re-examinations of the patient, and doing the monitoring needed to ensure that all red flag conduct by the patient was investigated with careful monitoring of the patient's use of the prescribed opioids. Dr. Trescot opined that Dr. Ogoke met these standards of pain management practice. (Ex. 84. Testimony of Dr. Trescot, Vol. XV, 3055, 3059, 3064, 3066, 3069-3070 & Vol. XIV, 2660-2679.)

9. In terms of initiating an opioid medication regimen during the time period involved in the Statement of Allegations, both Dr. Satwicz and Dr. Trescot opined that this should have been done with caution by Dr. Ogoke. Dr. Satwicz opined that opioids,

are the hallmark drug for drugs of abuse ... and [before] we undertake an opioid trial for a patient ... it's appropriate to screen the patient for signs or evidence that they may not be appropriate for an opioid trial. And there are a variety of very simple screening tools that can be used.

Dr. Satwicz did not "see any evidence that any of the screening tools were used" by Dr. Ogoke, any discussion of the risk/benefit analysis of this potential abuse before prescribing opioids initially without always starting at low levels and for short trial periods. Dr. Trescot opined when it was appropriate to prescribe opioids for a non-cancer chronic pain patient:

Unfortunately, the best we can usually do is look at the risks involved and balance that with potential benefit. And, if there appears to be benefits that outweigh the risks, then we offer them a trial of the medication. If they function better on the

medication than they functioned off the medication, and if over time they show an ability to manage these medications effectively, we continue them on it. If ... the risk is too high or the benefits too low or the subsequent side effects of the medicine too great, then we take them off the medicines.

Dr. Trescot acknowledged that there are no “fixed tables” to determine the amount of opioid the particular patient should receive. She explained:

[I]t’s extraordinarily variable. It is not based on weight but rather based on how the patient absorbs the medicine, how the body metabolizes the medicine, what type of pain problem they have. Different pain problems respond differently to different opioids. And it depends on the other medications that they are taking. So there is a genetic component and there is a pharmacologic component and then there is an absorption and excretion component.

(Testimony of Dr. Satwicz, Vol. X, 1856-1857 & Dr. Trescott, Vol. XIV, 2668-2669, 2676-2677.)

10. Both Dr. Satwicz and Dr. Trescot recognized that once opioid therapy began to be used in the practice of pain management for non-cancer chronic pain patients, the long-acting opioid medication could become a vehicle for abuse, with this recognition coming in the mid-2000’s. Dr. Trescot explained this process. She noted that initially, this field had,

become more liberal over time ... more and more physicians [were prescribing opioids] long term ... [based on] the recognition that a group of patients can function extremely well on these medicines.

So the experience we had was with short-acting medicines that appear to have a much higher addiction and abuse potential than the long-acting medicines.

[B]y giving medicines that are long-lasting, we decrease the high levels in the bloodstream, the buzz that is associated with addiction and instead, keep the medicines at the level where they provide pain relief. And so this revolutionized our ability to prescribe opioids, and there was an explosion of prescribing of long-acting opioids.

Dr. Trescot addressed how this reliance on long-acting opioids became problematic:

[People] figured out if you bite or crush or chew the long-acting medicines, you can get all the medicine at one time and so there started being abuse of medicines that we thought were not abusable or not prone to be abused.

That was about 2005 ... when ... it started hitting the newspapers ... the hillbilly heroin started being bandied about in both the professional and lay literature.

(Testimony of Dr. Trescot, Vol. XIV, 2669-2674.)

11. Dr. Trescot has known Dr. Ogoke as a collaborator with her in their work with the ASIPP that overlapped the pertinent time period involved in this case. This developed into a friendship over the years. Dr. Trescot provided a reduced rate for serving as an expert witness for Dr. Ogoke in this case. Dr. Trescot has never held licensure with the BORM, and is not holding herself out as an expert in the specifics of the provisions of Massachusetts statutes and regulations pertinent to this case. (Testimony of Dr. Trescot, Vol. XIV, 2659-2660 & Vol. XV, 3029-3032.)⁴

Dr. Ogoke's Use of Guidelines

12. The BORM adopted the "Model Policy for the Use of Controlled Substances for the Treatment of Pain" in 2010. This is a policy of the Federation of State Medical Boards of the U.S., Inc., first issued in 2004. The worth to patients of prescribing opioids to treat acute pain from trauma or surgery, or for chronic non-cancer pain at high levels, was acknowledged by the policy, but with the need to treat pain promptly and to monitor the use of opioid medications by adjusting the quantity and frequency of doses. The policy noted the difficult issues for patients of tolerance, physical dependence, and addiction that can accompany the long-term use of opioids. The policy did not separately define cancer pain and chronic pain. (Ex. 95, Appendix

⁴ The BORM moved to strike Dr. Trescot's testimony as an expert pertinent to the charges Dr. Ogoke faces due to her not being a licensed BORM physician and due to her acknowledgement that she is not an expert in Massachusetts law and regulations. I denied that motion. I found that the field of pain management practice during the pertinent time period involved in the Statement of Allegations contained national standards for this new specialty practice, and that Dr. Trescot was an expert in this specialty practice covering this pertinent time period that included experience in practicing this specialty in a private practice, which is what Dr. Ogoke had, and with treating patients with intractable non-cancer high level pain, including soldiers who had sustained shrapnel injuries and other traumas causing such pain.

D, pgs. i through l.)

13. The Federation policy defined chronic pain as:

[A] state in which pain persists beyond the usual course of an acute disease or healing of an injury or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

(Ex. 95, Appendix D, pg. l.)

14. These Federal Guidelines called for gaining a full background on the patient's history, psychological issues, any prior use of controlled substances, and any red flags of potential prior addiction or diversion of drugs and use of illicit drugs. It advised physicians to perform a comprehensive physical examination to uncover the clinical correlation to the claimed chronic non-cancer pain. This thorough background investigating was viewed as a prerequisite to starting any opioid prescribing. Maintaining detailed and evaluative medical recordkeeping on the patient's progress or issues in being on an opioid medication regimen was a necessary requirement for treating the patient on long-term narcotic medication. This included maintaining full details on each pain medication prescribed. (Ex. 95.)

15. The BORM adopted a Prescribing Practices, Policy and Guidelines in August 1989. It was last amended in December 2001. Chronic pain was defined as:

[A] pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

In contrast, acute pain is defined as:

The normal predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time limited and is responsive to opioid therapy among other therapies.

(Ex. 20, Attachment B, pg. 4.)

16. Both Dr. Trescot and Dr. Ogoke opined that their viewpoints on proper use of opioid

therapy for chronic non-cancer pain satisfied the Federation's model policy (Ex. 95) and satisfied the BORM Guidelines on prescribing practices (Ex. 20). They have both contributed to peer reviewed articles expounding the viewpoint that the use of opioid medication for treating significant intractable non-cancer pain was good medical practice so long as careful monitoring of the patient's use of the narcotics was done. (Exs. 20, 84, 85, 95, 102, 108 & 109. Dr. Trescot, Vol. XIV, 2630-2632, 2673-2675 & Vol. XV, 3024, 3031-3032, 3052-3053.)

17. Dr. Satwicz does not think there is much of a difference between the definitions of chronic pain in the Federation's definition in 2010 and in the BORM's Prescribing Practices, Policy and Guidelines last amended in 2001. For him,

the new[er] one [BORM prescribing practices] just has some time factor. The semantics of chronic pain being long-term, generally not an acute tissue injury. Those are the major concepts [separating chronic and acute pain].

In addressing chronic pain in the earlier definition, noting how it could be connected to a disease process, Dr. Satwicz recognized that chronic pain is not just malignant pain. But, for him, chronic non-cancer pain and malignant pain involve distinct prescribing considerations. Dr. Satwicz opined:

[A] patient with cancer can divert, still abuse [prescribed medication], but the likelihood of that is much less than a person with non-malignant pain. These guidelines are intended not for the patient with cancer. There is a whole separate world of management of cancer pain.

(Testimony of Dr. Satwicz, Vol. XII, 2385.)

18. Dr. Satwicz, Dr. Trescot and Dr. Ogoke all agree with the BORM's 2001 policy (Exhibit 20) regarding prescribing practices - that the use of opioid analgesics can be an essential part of treating acute pain that is the result of surgery, or of trauma and chronic pain that can be due to cancer or to non-cancer conditions. The policy calls for the amount and frequency of medication doses to be adjusted to be consistent with the strength and duration of the patient's

pain. The policy instructs treating physicians to recognize that the patient can develop tolerance and physical dependence as a normal consequence of a sustained taking of opioid medications, and that this is not the same as becoming addicted to these medications. All three physicians also agree with the prescribing policy's explanation of addiction as the abuse of a drug to gain only the effect of that drug and not to help a medical need for the drug. (Exs. 20 & 84. Testimony of Dr. Ogoke, Dr. Trescot & Dr. Satwicz.)⁵

19. The BORM prescribing policies echoed the concerns of the Federation model policy guidelines regarding engaging in protocols that reflected thorough and on-going evaluations of the patient on an opioid medication regimen to have shown good faith support for keeping the patient on such a regimen long-term, and to be mindful of adjusting the doses of the opioids to the lowest doses necessary for adequate pain relief. (Ex. 20.)

20. Dr. Satwicz believes the BORM prescribing policies (Ex. 20) and the model policy (Exhibit 95) support restricted use of opioids for long-term use and oppose escalating doses for non-cancer chronic pain patients. Dr. Satwicz's hospital pain management practice has a "[v]ery small percentage" of patients who stay on a "sustained [long-term] dose of opiates." His patients on sustained doses of opioids tend to be "in the acute phase of their problem." Dr. Satwicz's practice is to work with a patient's PCP to avoid having the patient on long-term and escalating doses of opiates. Dr. Satwicz's hospital practice treats about 50% - 80% chronic pain patients. Some of them have been treated by the practice for years for their conditions such as spinal stenosis (arthritis) not amenable to surgery. Dr. Satwicz opined that he and others involved in the debate on the use of opioids for chronic non-cancer pain patients, do not view the use of opioids as the "first line of treatment for those chronic conditions." For Dr. Satwicz, this is

⁵ The opinions of these three physicians show this agreement throughout the case.

because of the risks associated with the long-term use of opioids, especially in escalating doses.

Included are,

immune issues ... some of the psychological issues ... tolerance and dependence; those are manageable. The others are not easily manageable.

The other issue with opioid administration is sedation, constipation that comes with it. ... [I]t's not a benign treatment. It's treatment that has significant side effects.

[T]he best long-term routes are behavioral therapies, weight loss, physical therapy, things like that rather than opioids. You look at opioid use in the long term for these kinds of conditions. It's very difficult or even impossible to find evidence that there is a sustained benefit in activity level, and decline in pain scores, [and] that quality of life is improved. So in general, for this kind of chronic pain, opioids are not the mainstay. They should not be the mainstay ...

Even in large doses initially for acute pain [it is best] to not go to large doses initially, but to go in a stepwise fashion from non-opioids to the milder opioids to the stronger opioids for treatment of acute pain ...

The use of opioids is a very hotly debated topic in all of medicine ... The concerns over abuse and diversion are huge. Even in a very carefully guided practice trying to be as conscientious as possible, several studies have looked to 20% in terms of diversion. And these are university groups that do intense screening pre-opioid trial, rigorous urines [for drug screens], [opioid] pill counts, still even in those situations diversion is a problem ...

Dr. Satwicz acknowledged that there are some few chronic non-cancer pain patients who will need to be on opioids long-term, but they are,

very carefully screened and carefully followed and paying attention to red flag things, unreasonable escalation of tolerance or request for more medication that is beyond what we would expect ... I want to make sure the opioids that we're prescribing ... stay with the patient and they are used appropriately.

(Exs. 20 & 95. Testimony of Dr. Satwicz, Vol. XII, 2318, 2360, 2393, 2399, 2402-2412.)

21. Dr. Ogoke, along with Dr. Trescot and others, were collaborating authors in producing "Opioid Guidelines in the Management of Chronic Non-Cancer Pain," published in 2006 by the ASIPP within the publication "Pain Physicians." Both physicians refer to these

guidelines in conducting their pain management practices. The guidelines were not intended to be and were not used as the standard of care for every patient, but were intended to be and were used by both physicians as providing useful guidance in making decisions about a particular patient's treatment plan, in determining opiate-medication regimens for pain control, and in performing interventional procedures. The guidelines defined interventional pain management as a discipline of medicine devoted to the diagnosis and treatment of pain and related disorders using interventional techniques to manage subacute, chronic, persistent, and intractable pain, either independently or in conjunction with other treatment modalities. (Exs. 84 & 85.

Testimony of Dr. Ogoke & Dr. Trescot.)⁶

22. Dr. Satwicz has not been a member of ASIPP. (Testimony of Dr. Satwicz, Vol. XIII, 2425.)

23. The ASIPP Guidelines recognized as controversial the use of opioids to control chronic non-cancer pain. The guidelines acknowledged the wide variance in the prescribing of opioids by physicians as well as the growing abuse of opioids by patients. The objective of the guidelines was to bring consistency in pain management philosophy on the use of opioids, reduce misconceptions among care providers and patients about opioids and pain relief, improve patient compliance with treatment plans, and improve the treatment of chronic non-cancer pain using opioids wisely by reducing the chances of drug diversion, misuse, and abuse behaviors. The goals of the guidelines were to improve the quality and appropriateness of patient care, improve patient access to care, improve patient quality of life, improve the efficiency and effectiveness of opioid therapy, and achieve cost containment. The guidelines were intended to improve cooperation among patients, providers, and regulatory agencies in dealing with the use of opioids. (Ex. 85.)

⁶ These ASIPP Guidelines were often referred to throughout the testimony of Dr. Ogoke and Dr. Trescot.

24. The guidelines explained that the under-treatment of pain was a major health problem and that opioids could help to treat unabated pain. Nevertheless, the guidelines recognized that the United States was “in the throws of an epidemic of controlled substance prescription drug abuse and addiction,” that was “occurring in patients receiving both long-acting and short-acting opioids.” The guidelines called for flexibility in the use of opioids for these chronic pain patients with case-by-case determinations of what was appropriate for a particular patient. The guidelines acknowledged they “do not represent a standard of care,” and that “the decision to implement a particular management approach should be based on a comprehensive assessment of the patient’s overall health status, disease states, patient preferences, and the physician’s training and skills.” (Ex. 85 pgs. 1-2, 4-5, 17.)

25. These guidelines called for caution in prescribing long-term use of opioids for pain relief and advised prescribing them in the smallest effective doses toward guarding against tolerance and physical dependence problems. But, the guidelines also recognized that,

in some well selected patients with long-lasting or recurrent pain that is severe enough to markedly reduce their quality of life, and for whom no other more effective and less risky therapies are available, opioid analgesics may reduce the intensity of pain, increase functioning, and improve quality of life for prolonged periods.

The guidelines emphasized the importance of addressing the potential adverse impacts of long-term opioid therapy:

The adverse effects of long-term opioid therapy for the treatment of chronic pain may be avoided or reduced by multiple means. These include limiting the opioid dose, changing the drug formulation, opioid rotation, and understanding that despite all the changes and strategies, escalation of the opioid dose may fail.

(Ex. 85, pgs. 17, 20.)

26. These guidelines acknowledged Dr. Satwicz’s concern about keeping chronic non-cancer patients on long-term and escalating opioid therapy:

[I]t is well known that prolonged use of opioids may result in adverse consequences, including tolerance, hyperalgesia, hormonal effects, and immunosuppression ... It is postulated that prolonged use of high doses of opioids is likely to be more toxic than short-term use of low doses, and hormonal effects are most likely to occur in patients ... who receive high dose opioid therapy ... [T]he management of opioid therapy in patients with complex problems is time consuming and difficult.

(Ex. 85, pg. 16-17. Testimony of Dr. Satwicz.⁷)

27. The guidelines emphasized the need for careful monitoring of patients on opioid therapy. The guidelines identified what Dr. Ogoke, Dr. Trescot, and Dr. Satwicz labeled as red flags, including: a diagnosis of opioid misuse or abuse; the patient expressing a need for an excessive amount of opioids; deception or lying to obtain opioids; doctor shopping for opioid prescriptions; non-functioning status; exaggerating pain; unclear pain etiology; forging prescriptions; stealing or borrowing drugs; frequent loss of prescriptions; seeking prescription refills early; resisting changes to treatment of pain despite adverse effects from medications; aggressively expressing a need for more drugs; hoarding of drugs; unsanctioned dose escalating; and, unwillingness to taper opioids or to try alternative pain treatments. (Ex. 85, pg. 22. Testimony of Dr. Ogoke, Dr. Trescot and Dr. Satwicz.)⁸

28. The guidelines discussed the use of urine drug screens (UDS) to detect in a patient the absence of prescribed medications and/or the presence of illicit drugs. The guidelines recognized that a UDS was one of a number of monitoring tools used to gauge whether the patient was compliant with the prescribed medication regimen. The guidelines called upon pain management specialists to establish a protocol regarding how to address the results from UDSs when they showed non-compliance in taking prescribed medications, or when they showed the

⁷ Dr. Satwicz opined many times that this caution was inadequately addressed by Dr. Ogoke in his care of the patients listed in the Statement of Allegations.

⁸ There is no dispute among these physicians that these behaviors are red flags to address as noted within the sections on each of the fourteen patients listed in the Statement of Allegations.

use of illicit drugs:

This may include referral to an addictionologist or psychologist, or may result in the refusal to prescribe opioids. However, it usually does not warrant dismissal of the patient.

(Ex. 85 pg. 23.)

29. If Dr. Ogoke uncovered or learned that one of his patients was a drug abuser or diverting use of medications he prescribed, he provided opportunities for the patient to get help for the addiction and/or diversion. He provided the names of area caregivers (addictionologists, psychologists and detoxification centers) to help the patient address these matters. If the result of that consultation and/or treatment was that the patient had the addiction and/or diversion under control, Dr. Ogoke would consider resuming his care of the patient with opioid medication therapy. But, Dr. Ogoke would stop prescribing opioids to the patient without that issue under control, and would consider terminating care with the patient. Dr. Ogoke believed that a need to end care was not a negative reflection on his treatment decisions because he did not cause or foster the unabated drug abuse and/or diversion. He knew he could not treat a patient properly with pain management care who was abusing his opioid medications and/or using illicit drugs. He could not contribute to the drug abuse. To avoid such patients continuing in his care, he took measures that included extra monitoring in addition to his routine monitoring practices to catch them in any non-compliance in taking their narcotics or in using illicit drugs. He had the option under the narcotics agreement his patients signed to terminate his care with them upon discovering that a patient had used an illicit drug or had not been taking the medications as prescribed. He did not attempt to treat drug abuse or illicit drug use because that required an expertise he did not have. (Ex. 84. Dr. Trescot, Vol. XV, 2882-2884 & Pt. I, Vol. II, 442.)

30. The ASIPP Guidelines called for periodic reviews of how well a patient was doing

on opioid therapy in terms of reaching pain control goals. If goals were not met, the guidelines called for re-evaluating the patient's condition and care plan, including re-evaluating the medication regimen. Dr. Ogoke conducted such re-evaluations of his patients' conditions, especially after a new injury or with the emergence of a new health condition or pain complaint. He used a brief pain inventory form and an opioid renewal form with the patients listed in the Statement of Allegations for some of the time period covered by the allegations. The opioid renewal form disclosed whether the patients had any narcotic agreement violations, when they last had a UDS and the results of the UDS, and if there were changes in their medication regimens. (Exs. 43, 158/2583 & 43/2468, both for Pt. H;⁹ 84 & 85.)

31. The guidelines recognized the "significant confusion among the many definitions" of tolerance, physical dependence, and addiction. These guidelines defined tolerance as:

[T]he need for an increased dosage of a drug to produce the same level of analgesia that previously existed ... also suspected when a reduced physiologic effect is observed with constant dosing. Analgesic tolerance is not always evident during opioid treatment, and is not to be confused with addiction, which occurs as a dysfunctional craving of a drug action by physiologic action and psychologically driven factors.

These guidelines defined physical dependence as:

[A] state of adaptation manifested by a drug class specific withdrawal syndrome that can be produced by drug cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist ... [It] is a normal adaptation to the drug, reinforced by continued use ... [It] is most commonly associated with withdrawal symptoms when the substance is abruptly discontinued.

These guidelines defined addiction as:

Compulsive use of a drug despite physical harm, and the terms of tolerance and addiction are not interchangeable. The terminology may share similar characteristics, as many addicts do become tolerant of their chosen drug, which can be expected with regular use. Addiction is a dysfunctional use behavior that includes one or more of the following: impaired control over drug use,

⁹ This is an example of the opioid renewal screening form and of the brief pain inventory form.

compulsive use, continued use despite harm and craving; however, tolerance is a physiologic alteration of metabolism.

These guidelines addressed the intersection of these conditions:

In a chronic pain state, a patient may be exposed to a controlled substance for a prolonged period of time, developing tolerance and physical dependence. Addiction may occur, but is an unlikely event. Dependence does not foreshadow harm, or intent at self-destructive behavior. It is therefore, incumbent upon the pain management physician to determine that these definitions and their physiologic undertones are well understood, and that the overlap of these definitions does not necessarily define a controlled substance risk, or an inappropriate patient. In other words, tolerance and dependence share many common physiologic characteristics, and addiction may be associated with, but not defined by, either or both. Physical dependence, addiction, and tolerance are physiologic, social, and psychological considerations with prolonged substance management.

(Ex. 85 pgs 18-19.)

32. The guidelines discussed the “Influence of Psychopathology on Opioid Effectiveness.” Psychopathology was discussed as “very common” in patients being treated for chronic pain “with major depression and anxiety seen in as high as 80% of these patients, a factor that may have a negative effect on opioid analgesia.” Concerns included “increased pain intensity and poorer function, regardless of the treatment modality.” For patients suffering from chronic low back pain, “psychopathology predicts poor opioid analgesia.” Recognizing a need for more studies, the guidelines noted:

[I]n some well selected patients with long-lasting or recurrent pain that is severe enough to markedly reduce their quality of life, and for whom no other more effective and less risky therapies are available, opioid analgesics may reduce the intensity of pain, increase functioning, and improved quality of life for prolonged periods.

(Ex. 85 pg. 20.)

Dr. Ogoke’s Protocols for Patient Care

33. Most of the patients Dr. Ogoke treated who had chronic non-cancer pain started

care with him after having some degree of pain management care at other pain centers and/or with other physicians. Many of these patients complained of persistent and at times severe pain that had lasted for a long period of time. A new patient was asked to come to Dr. Ogoke's office with documentation such as test results, CT scans, MRIs, X-rays, and medical information relevant to his or her overall health profile and current pain complaints. The new patient completed a number of background forms, including forms addressing a general consent to treatment, accepting financial responsibility, and listing insurance coverage. The new patient completed a questionnaire covering medical and social history, current condition, current medications, and specific pain complaints. The form had a diagram of the body for shading in the areas of pain. Psychological and psychiatric conditions were part of the information sought. This exploration process also helped to uncover whether the patient had any history of substance abuse or opioid dependence. (Exs. 22¹⁰ & 84. Testimony of Ms. Dawes, Vol. XI, 2115-2116, 2119-2122.)

34. Dr. Ogoke relied on his prior experience as an internist when he developed the template used for the initial physical examination of a new patient. The physical examination was comprehensive, but it also focused on the areas of the body pertinent to the patient's pain complaints. The most prevalent core pain areas for most of Dr. Ogoke's new patients involved musculoskeletal, neurologic, and psychologic complaints. The comprehensive initial evaluation process fostered conversation with the new patient to gain valuable information for developing a treatment plan and/or for determining if additional diagnostic tests would be beneficial in uncovering the sources of the pain. Some but not all new patients came having taken or were currently using opioid medication. (Exs. 22 & 84. Testimony of Ms. Dawes, Vol. XI, 2120-2122.)

¹⁰ Exhibit 22 is an example of a patient's initial questionnaire.

35. Results of this comprehensive initial evaluation, including the medical and social histories, were included in the new patient's initial visit report. Also included were accounts of the physical examination and the review of systems done, the diagnoses or impressions reached, and the treatment plan developed. Reports on the patient's subsequent visits used a template to uncover current pain complaints and an evaluation of how well treatments had helped with pain control, results from a physical examination, sometimes another review of systems, a list of the ongoing impressions or diagnoses the patient carried, and the resulting current treatment plan. The visit report on this comprehensive initial evaluation, if the patient was referred for care by another physician, would be sent to this referring physician. If there was a need to inform this referring physician about a significant matter that was uncovered during Dr. Ogoke's care of the patient for pain management, Dr. Ogoke's practice was to inform the patient's other pertinent physician(s) about that. But, Dr. Ogoke would be in charge of the patient's pain management care. (Exs. 43¹¹ & 84. Testimony of Dr. Ogoke, Vol. IV, 797-780, 7789-794, 799, 804, 806-807 & Ms. Dawes, Vol. XI, 2122.)

Dr. Ogoke's Medical Recordkeeping on Prescriptions

36. In terms of his recordkeeping on prescriptions a patient received, including for opioids, Dr. Ogoke's practice was to have a legible copy of the written prescription placed into the patient's medical records. His practice was to state in a visit report whether the patient's medications were being renewed, and to name a medication being added or discontinued. If a dose of an existing medication was being increased or decreased that medication would be named in the visit report. This was also the practice of the physician assistants who worked for him. The visit report would not routinely contain the exact dose and strength of a medication

¹¹ All the patients listed in the Statement of Allegations had initial comprehensive evaluations done. See the specific patient sections.

prescribed even if the medication was listed in the report. (Exs. 43¹² & 84. Testimony of Ms. Dawes, Vol. XI, 2122, 2126-2129.)

37. Neither the ASIPP Guidelines nor the Federation Model Policy for the Use of Controlled Substances for the Treatment of Pain, nor the BORM's Prescribing Practices, Policy and Guidelines, specifically call for always writing up in the report of a visit, the details about each medication prescribed, including each opioid prescribed, at each patient visit, i.e., date, type, dose, and quantity. Dr. Ogoke's obligation was to ensure that this specific information was within the patient's medical records and was reasonably accessible. (Exs. 20, 85 & 95.)

38. The BORM's Prescribing Practices, Policy and Guidelines address recordkeeping:

Beyond documenting of appropriate medical histories and physical examinations, physicians must maintain medical records that are detailed enough in nature that the physician's clinical reasoning is implicit in his or her documentation. Treatment plans should be explicitly recorded. All patient visits and telephone calls relating to treatment should be documented. Prescriptions should be documented and changes in medications or doses should be explained. These are, of course, just some of the rudiments of complete medical records.

(Ex. 20, Attachment B.)

39. Dr. Satwicz relied on the BORM Prescribing Guidelines to show that over-prescribing controlled substances was to be avoided, and that Dr. Ogoke violated the standard of care for some of the fourteen patients listed in the Statement of Allegations through prescribing too many opioids at escalating doses for the kinds of conditions these patients had. Those guidelines called for the physician to exercise skill and good judgment when prescribing controlled substances toward preventing any illicit drug use, or any diversion, and toward

¹² The medical records on the disc, Exhibit 43, were not in any kind of chronological or any order other than by patient. The BORM also did not copy in any order on the disc all the ancillary reports connected to a particular patient visit report, or even bundle together all the copies of prescriptions written. Nevertheless, although time consuming, I was almost always able to locate legible copies of the prescriptions written at the patients' visits. No evidence was presented to show that Dr. Ogoke kept his patients' medical records in no order at all just as they appeared on the disc, Exhibit 43.

minimizing any development of drug dependence. In addition, the guidelines called upon the physician to be cautious about giving into any unwarranted demands of a patient for controlled substance prescriptions to guard against contributing to drug abuse situations. Dr. Satwicz opined that Dr. Ogoke's practice of just including the copy of the prescription in the patient's medical records "doesn't explain the thought process behind it." He concluded the medical records on Dr. Ogoke's patients did not sufficiently address in the reports of the patients' visits why providing increased doses of opioids and/or prescribing more opioids at a visit was not these patients engaging in diversion or abuse. This is why he found standard of care violations. (Ex. 20. Testimony of Dr. Satwicz, Vol. XII, 2363-2366.)

Interventional Procedures

40. The reason for having care with Dr. Ogoke was for the patient to receive interventional procedures, his specialty in pain management. Any opioid therapy was an adjunct to the interventional procedures. Most of Dr. Ogoke's chronic non-cancer pain patients received interventional procedures for addressing their pain. If after Dr. Ogoke evaluated a chronic non-cancer pain patient and came to the conclusion after investigation of the patient's conditions that the patient was not a good candidate for interventional procedures, he would often recommend only a medication regimen for the patient's PCP to provide. The interventional procedures were intended to target the pain generators in the body by injecting medication at the source of the pain. If that injection helped to relieve the pain, there would likely be less need for a high pain medication dose to further address the pain. Sometimes a patient had multiple pain generators. The procedures would often involve a series of one kind of interventional procedure or involve various kinds of interventional procedures. (Ex. 84.)

41. Dr. Ogoke insisted that his patients be compliant with their entire treatment plan.

The patients were not able to decide to just have opioid therapy and refuse the interventional procedures that were part of their treatment plan. This combination approach was in Dr. Ogoke's opinion, good and proper pain management practice and the purpose in seeing him for pain management. Dr. Ogoke was aware that his practice of pain management in chronic non-cancer pain patients was not "magical" with the same outcomes expected for all such patients. He found that some patients would get better pain control "quickly," with no need for his further specialty care. The care of others would require various diagnostic tests and interventional procedure blocks, as well as epidural steroid injections and transforaminal steroid injections. Often in a chronic non-cancer pain patient, the pain might be reduced from the interventional procedures, but return over time. Dr. Ogoke opined for chronic non-cancer pain patients:

[I]t's bad practice of medicine to just do shots [interventional procedures] ... without providing analgesic relief ... Sometimes it may take awhile to finally reach a diagnosis ... [It can be] a journey of treatments to locate and treat these pain generators.

(Ex. 84, pg. 160.)

42. If a patient had questions about having a particular interventional procedure, Dr. Ogoke would discuss the concerns with the patient. If the patient refused to have the planned injection procedure and just wanted a renewal of opioid medications, that would trigger a discussion about the need to be compliant with Dr. Ogoke's full treatment plan. He would be sure the patient understood why interventional procedures were needed. If the patient continued to insist on just being on a medication regimen, he would explain that the patient would need to seek pain management care elsewhere. (Ex. 84.)

43. In terms of administering the interventional procedures, Dr. Ogoke set up an educational system for the patient to learn about all procedures that were part of the treatment plan. He had a website with information explaining the procedures as well as paper forms with

information on the procedures. The information about the procedure covered risks or possible complications that could arise. Dr. Ogoke, and/or his trained staff would answer questions the patient might have about a procedure. It was important for Dr. Ogoke to have his patients appreciate in advance what the interventional procedures would entail. The patient signed the information form on the procedure following a review of the form. The patient signed a consent form to agree to have the procedure. (Exs. 84.)

44. Dr. Ogoke wrote a clinical and administrative manual with protocols for his staff to use. The manual contained information on the interventional procedures and the staff person's role to support/assist him during an interventional procedure. The manual also had the various consent and general forms used for patients. He used the manual's training section for his medical assistant and physician assistant staff. All staff were expected to be familiar with the office protocols and to understand how Dr. Ogoke was administering and operating his practice. (Ex. 84.)

45. When performing almost all the interventional treatment procedures, Dr. Ogoke used a fluoroscopy machine. Use of this machine required his specialty skills. Its use meant the injections were pinpointed to the locations the injection was intended to reach. He completed a fluoroscopy form and a procedure form listing what was done during a procedure using that machine, and listing whether the procedure was accomplished with the intended result. These forms became part of the patient's medical record. Dr. Ogoke used a hospital setting to perform some procedures involving implants. Some procedures did not require use of a fluoroscopy machine because they were simple injections. The only injection procedures he might allow his physician assistants to perform were injection procedures that did not carry very much of a risk. An example was a simple knee injection. (Exs. 8 & 84. Testimony of Ms. Dawes, Vol. XI,

2132-2135; Ms. Demers, Vol. V, 925-928 & Dr. Trescot, Vol. XV, 3032-3035.)

46. The ASIPP Guidelines provided the suggested frequency of giving certain kinds of injection procedures and how far apart a series of injections should be. Dr. Ogoke found these recommendations useful to follow. Dr. Ogoke opined that in the past, injection procedures, even a series of the same procedure, were considered one time occurrences for a condition. That protocol changed over time so that such procedures were repeated after periods of time had gone by due to the return of the core pain. This change occurred by the time Dr. Ogoke treated the fourteen patients listed in the Statement of Allegations. He repeated interventional procedures in accordance with the suggested guidelines and after evaluating what was good practice for the particular patient. (Exs. 84 & 85.)

47. When doing multiple lumbar spine injections during one procedure, there were always risks of infection and of side effects, major or minor ones, from the amounts of drug injected. Dr. Ogoke acknowledged this. On the other hand, a properly performed injection procedure was safe to do, after an evaluation the patient was done, and when using accepted guideline recommendations, as found in the ASIPP guidelines for the frequency of performing the procedure, and following the recommendations on the amount of the drug to inject. Properly done, these treatments could be part of an effective on-going pain treatment regimen for chronic non-cancer pain patients. Dr. Trescot also followed these ASIPP guidelines when performing multiple lumbar spine injections during one procedure. (Exs. 84 & 85. Testimony of Dr. Trescot, Vol. XIV, 2788-27899 (Pt. E), 2849-2853 (Pt. G).)

48. The drug injected during the interventional procedure is a steroid. Steroids are, biomedically engineered tools ... [M]any of those steroids are in micro globules ... [and] when you inject ... [them], they don't just get released in the patient right away, they pop, pop. That's why you do it every two or three weeks apart, so the popping [of] each of those ... feed that area and allow the anti-

inflammatory process to do its job.

Dr. Ogoke opined that 20 milligrams of Depo-Medrol [the injected steroid] is not too risky to inject at one location on the spine. He testified that he stayed within the accepted guidelines for administering such steroids during injection procedures, including when he administered multiple injections at a number of sites during one procedure, or when doing a series of the same injection procedure at specific spaced-out times.

The doses that have been administered to my patients are within the guidelines of the ASIPP and also within the guidelines of ... [other] organizations ... in pain medicine ... They are very safe and they are considered very standard.

Remember, that you are targeting the pain generator. As long as you fall within the guidelines that are already established ... and you don't deviate from them, as long as it's been shown to be safe, these patients will do well ... and will not have an issue with bone mass, will not have an issue with fracture issues.

Nevertheless, Dr. Ogoke also opined that there are patients whose medical profile requires caution when performing interventional procedures.

You cannot combine somebody with ... for instance, chronic oral Prednisone with a lot of these [drugs]. It quickly spikes the incidents. So I'm constantly watching out for those sub-group of people that may fit into that profile to see, make sure that I don't give other than a limited quantity. And in terms of safety, the safety profile is good.

(Ex. 84, pgs. 151-153.)

49. In terms of concerns about the steroids injected accumulating in the body over time and negative impacts that might occur, Dr. Ogoke opined that the steroids stay in the joints or space or epidural canal where they are injected. They will pop "gently" for a period of time in the area of the injection. To "accumulate in the area" of injection is what you want to occur so the drug "can do its job over a long period of time." The drug will slowly leave the body. By the time the patient is due for the next injection procedure, the injected drug is gone from the body. The guidelines provided times between different kinds of interventional injection

procedures to avoid the accumulation concern. The injected drug has an anti-inflammatory effect. The injected drug can have a mineralocorticoid effect, which is a sex hormone effect. The drug can have a glucocorticoid effect when the patient is pre-diabetic, possibly causing the patient's sugar level to go up temporarily. That impact can be countered by using more insulin for awhile. Most patients will not experience the glucocorticoid effect. Another possible side effect can be hirsutism.¹³ "Mineralocorticoid can lead to fluid retention ... pedal edema and other fluid retention issues." There can be in some patients an anti-psychologic response and the patient can become "aggressive" or show a "character shift." (Ex. 84, 154-158.)

50. Dr. Satwicz differed with the opinions of Dr. Ogoke, Dr. Trescot, and the ASIPP Guidelines about use of an interventional procedure that involved as many as four or five lumbar spine bilateral multiple injections. He was especially concerned when the needles administering the medicine remained in the body even though each injection was done separately. He did not find sufficient support in Dr. Ogoke's medical records to justify this kind of interventional procedure being done for those of the fourteen patients in the Statement of Allegations who had such interventional procedures. Dr. Satwicz opined that Dr. Ogoke had taken too great a risk of harm to those patients in giving them such large steroid doses at one time, thus making their treatment beyond proper standard of care practice in pain management. Dr. Satwicz opined that two bilateral injections during one procedure is common, to do three is considered thoroughly before being done, doing four is "borderline" too many, and five is potentially harmful as that is injecting during one procedure, 200 milligrams of Depo-Medrol. Dr. Satwicz explained his concerns:

[T]he systemic side effects [are] immunosuppression, the potential excess, CNS side effects, the brain side effects of excitation, steroid psychosis, the sugar elevation, all of the side effects steroid doses are related. This is yet another

¹³ Excessive hair growth. (Wikipedia.)

increment of doses and it's excessive.

Dr. Satwicz supported this opinion based on the trainings he received on best practices for doing multi-level injections. He acknowledged that there was no specific standard of care on just how many lumbar spine bilateral multi-level injections were too many to do within one procedure. Nevertheless, he opined that there had to be sound clinical judgement to back-up doing such an interventional procedure. He opined that Dr. Ogoke doing five lumbar spine bilateral multi-level injections suggested that his patient's diagnosis needed to be examined very carefully. He did not see evidence of a discussion about this in any of the visit reports of the patients who had these interventional procedures. Dr. Satwicz included among the dangers, leaving multiple sharp needles in a patient during a procedure when the patient was not under anesthesia, but was conscious with just sedation. The patient could be harmed with any moving around.

There is a risk of damaging the joint at the muscle. These are sharp spinal needles that are into the outer portion of the spinal canal.

Dr. Ogoke did leave these sharp needles in the patient during the procedure. (Testimony of Dr. Satwicz, Vol. X, 1895-1905, 1919-1926.)

51. When Dr. Ogoke did these bilateral multi-injections during one interventional procedure, even if multiple needles were kept in place and not removed, the patient was only injected with the medication one site at a time. The patient was not injected with medication at many sites at the same time. The needles left in place helped with pinpointing the location next to be injected. (Testimony of Dr. Ogoke, Vol. VI, 1328-1335.)

52. Dr. Trescot disagreed with Dr. Satwicz's opinion that Dr. Ogoke's practice in giving four or five multi-level lumbar spine injections within one procedure and leaving in some needles to help pinpoint the next location to inject, was outside the standard of care. She disagreed that he could only have undertaken such procedures if he justified in detail within his

visit reports why he was doing such procedures. She concluded that Dr. Ogoke was within the standard of care in injecting five lumbar sites within one procedure to inject a total of 200 mg. of Depo-Medrol. Although on the high end, it was within the acceptable range of 80 mg. to 260 mg., to inject within one procedure. This was based on studies done and assessed by the ASIPP. (Testimony of Dr. Trescot, Vol. XVII, 3251-3253.)

53. The reason why Dr. Ogoke prescribed high dose opioid medications while also providing interventional procedures for some of the fourteen patients listed in the Statement of Allegations, was that the patients required “analgesic relief” for the pain that the injection procedures did not sufficiently control. Dr. Ogoke was aware that he was at times providing considerable narcotic treatment to the patient, but opined that he was well within recommended guidelines in doing so to help improve the patient’s quality of life. He also recognized the need to do follow-up after the interventional procedure to determine if the procedure had helped the patient. If it had, he would know that he likely had reached a core pain area with the procedure. If the procedure had not led to pain relief after giving the procedure time to work, then he might do a different procedure, or investigate a diagnostic block injection procedure, or perform some other interventional procedure. Dr. Ogoke also recognized the need to give extra care to monitoring the patient’s compliance with a treatment plan that included high doses of pain medications. He needed to monitor whether the patient was taking pain medications as prescribed. For instance, he needed the patient not to accelerate use of a pain medication when the patient wanted better pain control. He needed to learn at each patient visit whether the pain medication taken properly was helping to relieve the patient’s pain level. To reach a point of useful pain control for these fourteen chronic non-cancer pain patients listed in the Statement of Allegations was difficult at times, and very dependent on the particular physical conditions and

pain thresholds of each patient. Also complicating Dr. Ogoke's ability to have his patient fulfill the treatment plan, was the patient's insurer not approving use of particular medications, or refusing coverage for an implanted pain control device, or refusing approval of a particular interventional procedure. If at a patient visit following an injection procedure the patient reported the pain level had not lessened, that was not unexpected, because the procedure might need more time to make a difference. Another reason for no significant pain relief might be because the procedure had not adequately addressed the pain generator, or because another pain generator was now the focus of the patient's pain complaints. This other pain generator might require a different injection procedure to provide pain relief. Or, the continuing significant pain might have shown the need to come to another diagnosis to explain the cause of the pain such as discogenic pain, a condition that would not show up on MRIs or CT scans or x-rays. Doing interventional procedures is not always a clear path to pain control, and was why Dr. Ogoke also had as part of a patient's treatment plan a pain medication regimen. (Exs. 43 & 84. Testimony of Dr. Ogoke & Dr. Trescot.)¹⁴

54. The interventional procedures could cause a patient pain during them, especially when the injection reached a targeted core area of pain. Dr. Ogoke acknowledged that he would not prohibit a patient wanting to, to bite into pillows during the interventional procedure to help them cope with their pain or uncomfortable sensation. But, there was a wide range of reactions among patients that were dependent upon the patients' personalities and expectations about experiencing pain or uncomfortable sensations. Dr. Ogoke's practice was to provide the patient a sedative, Ativan or Valium, to take prior to having the procedure so the patient would not be tense, and to lessen reactions during the procedure. Dr. Ogoke would sometimes prescribe Actiq

¹⁴ See the sections on each patient listed in the Statement of Allegations to examine the course of care and the kinds of interventional procedures given and why they were done, as well as the reasons for continuing opioid medication therapy after the patient had an interventional procedure.

(unless the patient's insurer did not cover that medication for this use) for the patient to take for pain control during the procedure. If the injection reached a core pain generator, Actiq's fast acting narcotic properties would address this. Dr. Ogoke never prescribed Actiq for use other than during an interventional procedure. For Dr. Ogoke to have brought in an anesthesiologist to have the patient be under anesthesia during the procedure could have occurred, but the patient's insurance would not likely have covered that cost. Also, Dr. Ogoke's office would have needed to be certified as an ambulatory surgery center. It was not common practice within the field of pain management during the time Dr. Ogoke treated the fourteen patients listed in the Statement of Allegations to use an anesthesiologist when doing interventional procedures. Rather, it was common practice to have the patient conscious, but sedated, during interventional pain management procedures. No one would hold a patient down during a procedure that Dr. Ogoke administered. The medical assistant would be guiding the C-arm of the fluoroscopy and Dr. Ogoke would be examining the picture achieved using this device to pinpoint the injection site. The medical assistant would talk to the patient to give reassurance as the procedure was occurring. After an interventional procedure, a patient went to the recovery room for maybe ten to fifteen minutes. (Exs. 84 & 92. Testimony of Dr. Ogoke, Vol. IV, 786-787; Dr. Trescot, Vol. XIV, 2652-2653, 2763-2764, Vol. XV, 2924-2926; Ms. Dawes, Vol. XI, 2135-2140; Ms. Demers, Vol. V, 925-928; Pt. F, Vol. III, 605-606 & Pt. J, Vol. I, 166, 195-196.)

Urine Drug Screen Testing

55. Prior to 2007 and often continuing after that, Dr. Ogoke would have urine specimens collected from his patients that were sent to outside laboratories for test results and analysis to determine whether or not his patients were compliant in taking their medications as prescribed, and whether they were using any illicit drugs. He often experienced delays in receiving back the

results of the UDS tests from the outside laboratories in the Springfield area. In 2007, Dr. Ogoke began to do UDS testing in his own in-office laboratory. He had laboratory assistants on staff to do the testing. He used proper analyzer equipment to perform UDS testing from urine specimens his patients provided. There was a chain of custody protocol set up to ensure safe storage for the urine specimen containers as they awaited testing. There was a protocol after test results were received for proper placement of them for viewing by Dr. Ogoke and the medical assistant and physician assistant staff. The laboratory assistants performing this UDS testing in-office all had pertinent training and certifications to do this work. The in-office laboratory was also certified as satisfying the standards set by the Clinical Laboratory Improvement Act (CLIA) which provides the guidelines to follow for quality control and the formats to employ. The equipment was inspected every two years. Dr. Ogoke always had framed on the wall the certificate showing passage of the inspections. Dr. Ogoke used a consultant on a quarterly basis to ensure that all the recordkeeping on the testing was up to CLIA standards and that the equipment was properly calibrated for use. The turn-around time for initial UDS results for the in-office laboratory testing was generally a few days. If a non-compliant UDS result emerged, Dr. Ogoke's UDS testing protocol allowed for doing further UDS testing of the same urine specimen. (Exs. 84, 86, 87, 88 & 89. Testimony of Ms. Pacetti, Vol. XI, 2077-2109.)

56. Dr. Trescot opined that just as UDS testing began to be a tool more frequently used for monitoring patients on opioid therapy, in and around 2005-2006, insurers became less inclined to cover the additional expense. Blood testing can also detect the presence of medications, but covering a shorter time span than the UDS testing can cover, and blood testing may be harder to decipher to determine if the patient is using illicit drugs such as cocaine. (Testimony of Dr. Trescot, Vol. XV, 3065-3066, 3071-3073.)

57. An Article from 2010 from the publication, *Pain Practice*, Vol. 10, Issue 6, pgs. 497-507, addressed the role of doing UDS tests for patients on opioid therapy. UDS testing was widely available by then and had become a familiar method for monitoring opioid use in patients having chronic non-cancer pain. The monitoring was to check for abuse, misuse, and diversion of opioids by the patient. A UDS test was not a mandated, standard of care practice when treating patients with opioid therapy, but was practical to use. The cost of a UDS assay with a confirming test could be expensive to explain why it was not always covered by insurers, but as of the time of this article in 2010, that had changed and reimbursement by insurers became more prevalent. The article recognized several useful reasons for UDS testing: use of illicit drugs; taking too much of the opioid at a time; selling the drug; not taking the opioid prescribed for fear of becoming addicted to it; securing pain relief on a lower amount of the opioid dose; and, avoiding the side effects from the opioid. The article emphasized the need to do confirmatory testing when faced with unexpected UDS results. Some reasons for confirmatory testing included that the UDS results did not match the patient's explanation of how the drug was being taken, and some patients could be hiding a prior addiction. A history taken from the patient could be used to help determine how to address a non-compliant UDS result that needed first to be confirmed. The article concluded that UDS testing was not the only or necessarily best way to check for non-compliant patients on opioid therapy, and that there was no clear-cut way to identify patients at risk for aberrant drug-connected behaviors. The article explained that a patient suspected of substance abuse should be immediately referred to a substance abuse expert for evaluation, counseling and/or treatment. The Article stressed that in most cases, such substance abuse should end the opioid therapy and cause a tapering-down program to avoid withdrawal symptoms. (Ex. 112.)

58. This article emphasized the need to have a physician-patient relationship from the outset that included an earnest discussion about the objectives and goals of treatment. The physician's responsibility was to set realistic expectations for pain control from using opioids; that the use of the them and other medications might not provide complete pain relief, and that other therapies such as modifying the patient's lifestyle, exercise and diet, might also be necessary. The article counseled that the medical records kept on the patient should include the patient's observations about their pain control and their reactions to the particular opioid medication being taken. Such behaviors as the patient seeking higher and higher medication doses, frequently seeking early refills, and reporting lost prescriptions, were described as suspicious for misuse of pain medication. The article counseled on the need for discussions with a patient showing non-compliant behaviors. In addition, the article cautioned that the UDS test should not be viewed by the patient as just a punitive measure to uncover illicit substances, but should be viewed as an overall monitoring tool. The article called for the physician to have a protocol to follow when a UDS result showed non-compliance or use of an illicit drug.

(Ex. 112.)

59. This article had definitions for addiction, dependence, abuse of opioids, misuse, and pseudo-addiction that were mostly consistent with the definitions of these conditions found in the BORM prescribing practices guidelines (Exhibit 20), in the Federal Guidelines (Exhibit 95), and in the ASIPP Guidelines (Exhibit 85).¹⁵ The views of Dr. Ogoke, Dr. Trescot and Dr. Satwicz on various definitions pertinent to opioid therapy and on the use of UDS testing, were in agreement

¹⁵ The Article defined addiction as a complex neurobiological disease of the brain reward centers with genetic, psychosocial, and environmental dimensions characterized by continual and compulsive use of the drug despite detrimental effects and craving for the non-therapeutic effects of the drug. Dependence was defined as a psychological tolerance for a drug associated with addiction or with dependence on it. Tolerance was defined as a state that could occur over long-term use of a drug without any psychological attachment to the drug. Tolerance was associated with withdrawal symptoms when the drug was

with the article's information on these topics. (Ex. 112. Testimony of Dr. Ogoke, Dr. Trescot and Dr. Satwicz.¹⁶)

Statement of Allegations at #s 2-15

These findings of fact address the charges about Dr. Ogoke's general office conduct and operations. They address whether he performed physical examinations of patients before prescribing them pain medication. They concern the use of a narcotics agreement. The BORM alleged the following facts to support these charges:

- Dr. Ogoke engaged in conduct in violation of the BORM's Policy 01-001 regarding disruptive physician behavior. This policy recognizes that "disruptive behavior by a physician has a deleterious effect on the health care system and increased the risk of patient harm." This policy was adopted by the BORM on June 13, 2001.
- Dr. Ogoke's office was disorganized and dirty.
- Dr. Ogoke's patients often waited for hours to see him, or he left his office for hours, leaving patients waiting for their treatment, and sometimes not returning at all to the office that day.
- Persons, including patients, within the waiting area of Dr. Ogoke's office, often heard screaming patients undergoing injections being administered to them by Dr. Ogoke.
- Dr. Ogoke provided towels to some patients to bite into during painful injection procedures.
- Dr. Ogoke often yelled at his staff and at his patients in front of other patients.
- Dr. Ogoke failed to perform physical examinations on patients before he prescribed them opioid medications.

discontinued. Abuse of opioids was defined as a willful misuse of the drug including diversion. Misuse was defined to be broader than abuse and to include a wide range of abnormal drug-taking and drug seeking behaviors for whatever reason. Pseudo-addiction was defined as a patient showing drug-seeking conduct typical of an addict but for reasons of inadequate analgesia and not because of addiction. This diagnosis was primarily made retrospectively because the diagnosis resolved when the dose was increased versus genuine addiction that becomes progressively worse. (Ex. 112, pgs. 498-499.)

¹⁶ This agreement is found within the discussions by these physicians contained within the sections on each of the patients where UDS testing was involved.

- Dr. Ogoke used a narcotics agreement for his patients receiving opioid treatments from him that required the patient not to consume excessive amounts of alcohol with narcotics, and not to purchase or use any illegal drugs.
- Dr. Ogoke's narcotics agreement prohibited receipt of any early refills for narcotic prescriptions.
- Dr. Ogoke's narcotics agreement called for unannounced urine or serum toxicology screens to be done on a patient in his care. The presence of unauthorized substances found from doing the screen could result in the patient's discharge from care with Dr. Ogoke.
- Dr. Ogoke's narcotics agreement stated that the failure of the patient to abide by its terms could result in cessation of therapy with the controlled substances Dr. Ogoke had been prescribing.
- Dr. Ogoke failed to enforce the terms of the narcotics agreements his patients signed.

Dr. Ogoke's Office Conduct

60. The BORM has had a disruptive physician behavior policy since June 2001. It references the American Medical Association's (AMA) definition of disruptive behavior "as a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care." (AMA H-140.918 Disruptive Physician Policy.) The policy also references an Institute of Medicine study highlighting the need for,

health care systems ... [to] promote teamwork, the free exchange of ideas, and a collaborative approach to problem solving if medical errors are to be reduced. Disruptive behavior by a physician has a deleterious effect upon the health care system and increases the risk of patient harm.

The policy instructs physicians,

to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care [citing to AMA H-140.918].

Behavior by a physician that is disruptive, and compromises the quality of medical care or patient safety, can be grounds for BORM discipline. The policy provides examples of problematic conduct taken from the AMA policy: "foul language; rude, loud or offensive

comments; and intimidation of staff, patients and family members.” The policy “distinguishes this behavior from criticism that is offered in good faith with the aim of improving patient care.” (BORM Policy 01-01, Disruptive Physician Behavior, adopted June 13, 2001 (Ex. 19).)

61. In terms of managing his staff and how he interacted with his patients, Dr. Ogoke did not yell at his staff or at his patients. He needed his patients to cooperate with him. Yelling at them, even if they were agitated, would not be in his best interests for successfully managing their care. He would not yell at his staff, but would not hesitate to tell them to stop an activity involving a patient if that activity appeared to be potentially harmful to the patient. Safe care and alert attention to patient needs was the conduct Dr. Ogoke expected of his staff.

[I]f I think somebody is doing something immediately I need to stop them [if] that will create harm on my patients. If it takes [that to have the action end] I say, stop, I will do it. Because they don't know what I know, I can't blame them.

Dr. Ogoke needed to have staff who could work in a “structured setting,” with the staff following the office and patient care protocols. He could not allow a work environment that permitted “laughing, gossiping,” or inappropriate interactions with patients. In terms of the charge that patients in the office waiting area heard Dr. Ogoke talk while he was in a treatment or examination room, the waiting area was soundproofed. In addition, no one in the wait area was able to see if a patient was receiving a painful injection and screaming, or if Dr. Ogoke was yelling at a patient. Dr. Ogoke would need to approve the actions taken by a physician assistant and took responsibility for supervising them. Dr. Ogoke did not yell or have an inappropriate tone of voice in addressing any of his assistants, and his tone was consistently professional. Dr. Ogoke did not yell at patients when terminating their care with him. (Exs. 83 & 84. Testimony of Dr. Ogoke, Vol. II, 940, Vol. IV, 854, 944; Pt. F, Vol. III, 604-605, 612-618;¹⁷ Pt. H's mother,

¹⁷ Pt. F testified that she heard patients screaming who were receiving a painful injection. Her claim was not credible and not proven. (Testimony of Pt. F, Vol. III, 604-605.)

Vol. I, 110-112; Pt. I, vol. II, 370, 425-439, 442; Ms. Paccitti, Vol. XI, 2092-2094; Ms. Dawes, Vol. II, 2156-2157, Vol. XI, 2156-2158; Ms. Demers, Vol. V, 923-925; Mr. Benvenuto, Vol. II, 302-304, 315 & Dr. Trescot, Vol. XV, 2882-2884.)

Patient Wait Times

62. Patients who came to Dr. Ogoke's office for a scheduled visit usually had no longer a wait than about a half-hour. But at times and not as a routine matter, the wait might be hours to see Dr. Ogoke who might have needed to spend more time during a prior appointment with a patient. If that occurred, patients would be given the opportunity to reschedule their appointments, and the staff would inform them if the wait was expected to be a long one. Some of the fourteen patients listed in the Statement of Allegations chose to wait to see Dr. Ogoke and not reschedule their scheduled appointments, and they waited for two hours or more. If the existing patient was a walk-in without a scheduled appointment, the wait could be long, including an hour or two, due to scheduled patients being seen first. Dr. Ogoke's practice was to re-schedule patients if he had to be out of the office such as for a meeting. A patient might choose to wait anyway to have the appointment with Dr. Ogoke upon his return, but that would not necessarily be possible, and the patient was so informed. (Exs. 43, 42/1911, 416/2285 (Pt. G) 83 & 84. Testimony of Pt. H's mother, Vol. I, 98-99, 110; Mr. Benvenuto, Vol. II, 312; Pt. F, Vol. II, 381-382, Vol. III, 611-613; Pt. I, Vol. 381-383; Ms. Demers, Vol. V, 920; Dr. Ogoke, Vol. VII, 1393-1403; & Ms. Dawes, Vol. XI, 2117-2119.)

Spaces and Cleanliness in Dr. Ogoke's Office Waiting Area, and Staff Escorting of Patients

63. The waiting area in Dr. Ogoke's office had a number of chairs for sitting, a large fish aquarium against a wall, a television, candies in containers on tables, and some reading materials. At times, the waiting area could become crowded because patients often came with

persons providing their rides to and from the office. They often came with family members or personal care assistants. Dr. Ogoke had a cleaning service come once a week, and had a staff member pick up the waiting area debris during the day. (Exs. 3, 5, 83 & 84. Testimony of Pt. H's mother, Vol. I, 99-101; Ms. Dawes, Vol. XI, 2117-2118, 2161; Pt. I, Vol. II, 382-383; Pt. J, Vol. I, 145-146; Mr. Benvenuto, Vol. II, 304 & Ms. Demers, Vol. V, 919-920.)

64. A patient in Dr. Ogoke's office waiting area would leave that area to go into a closed-off examination room accompanied by a medical assistant. If an interventional treatment was scheduled, the patient would be accompanied by the medical assistant into the procedure room where the medical assistant would prepare the patient for Dr. Ogoke's treatment procedure. Persons in the waiting area could not see into the examination or procedure rooms, or recovery area. There was also a medical records room and a laboratory area for performing tests. If a UDS was to be done, the medical assistant would walk with the patient to the bathroom and give the patient a urine specimen cup to fill. Although alone in the bathroom, the patient could not take a bag or pocketbook or purse, etc., into the bathroom to decrease the chance that the patient could contaminate the urine specimen by putting in another substance or water or another's urine, etc. The medical assistant would wait outside the bathroom until the patient exited. The medical assistant would take the specimen cup and put it into a holding container. Then, the staff person handling the UDS would take it out of the container to do the testing in the in-office laboratory or send off the specimen for testing at an outside laboratory. (Exs. 6, 8, 84, 86, 87, 90, 91 & 92. Ms. Dawes, Vol. XI, 2135, 2154-2156, 2167-2169; Mr. Benvenuto, Vol. II, 302-304 & Pt. F, Vol. III, 604-605.)

Dr. Ogoke Protocol for a Physical Examination and Opioid Prescribing

65. Dr. Ogoke generally saw and scheduled a patient for a monthly visit evaluation by

him or by his physician assistant. At this visit, the routine protocol was to: discuss the patient's current pain level; investigate for any new injuries or new medical conditions; learn whether the treatment plan, that could include interventional procedures as well as a medication regimen, was helping to control pain levels; and, to then do a physical examination. The physical examination would be followed by addressing the on-going conditions the patient had as well as addressing whether any had resolved, or if any new conditions had emerged. Then, a renewed or revised treatment plan would be addressed with the patient. This would include the medication regimen, including the use of opioids in on-going, or in decreased or increased dosages. Only after all this was done would the patient receive prescription scripts in-hand to have filled by the patient's pharmacy. All this information would be included in a visit report, whether typed or in handwriting, and kept in the patient's medical records. Copies of the prescriptions written would be placed into the patient's medical records. (Exs. 43 & 84. Testimony of Dr. Ogoke.)¹⁸

Dr. Ogoke's Use of a Narcotics Agreement/Termination of Care Protocol

66. Dr. Ogoke used a narcotics agreement for his patients who were prescribed opioids as part of a pain treatment regimen. Both Dr. Trescot and Dr. Satwicz agree on the need to use such agreements with patients taking opioids for pain management. (Exs. 11 & 23. Testimony of Dr. Ogoke, Vol. V, 1068-1071; Testimony Dr. Trescot & Dr. Satwicz.)¹⁹

67. Dr. Ogoke's narcotics agreement was comprehensive in addressing a number of

¹⁸ I did not find many occasions when I did not view all these steps having occurred at a patient's visit, including the physical examination with results contained in the visit report and all this within the medical records (Exhibit 43). This is the protocol that Dr. Ogoke described in his interview with the BORM investigators (Exhibit 84). This is the protocol he described at various times during his testimony at the hearing about particular patients.

¹⁹ Exhibits 11 and 23 are representative of the narcotics agreement Dr. Ogoke used for the patients involved in this case. Dr. Satwicz often opined that Dr. Ogoke had not enforced the terms of his narcotics agreement adequately with some of the patients in the Statement of Allegations. See the specific patient sections.

issues concerning the use of opioids. Patients were required to become familiar with the requirements of the agreement. Included within it were warnings, such as the need to obtain the prescriptions for narcotics only in-hand upon being written by Dr. Ogoke's office. Prescriptions would not be made over the telephone to a pharmacy other than in exceptional and rare circumstances. The narcotics agreement warned patients that it was their responsibility to protect the prescription scripts and medications they received. This was explained to mean that they were not entitled to early refills, and only a police report in rare circumstances might justify receipt of a substitute prescription. Patients had to agree to undergo random UDSs to confirm compliance in taking their prescribed medications properly. And, the agreement warned that the patient might have to undergo an evaluation by a specialist to ensure there was no improper use of narcotics or to determine whether addiction was occurring. If a patient violated the narcotics agreement, the patient would need to be cleared by the addiction specialist before Dr. Ogoke would consider resuming care for the patient with narcotics. The patient acknowledged that narcotic medications could be discontinued or not refilled beyond a tapering dose if the patient was assessed to be at risk for psychological dependence or addiction. The agreement had the patient appreciating "that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined and that ... treatment may change at any time." This was in line with the patient's acknowledgement,

that the main treatment goal is to reduce pain and improve my ability to function and/or work ... that I am being given a potent medication to help me reach my goal ... [and that] I must also comply with the treatment plan as described by my physician.

The narcotics agreement made clear to patients that violating its terms could lead to immediate termination of care. The agreement warned that if the violation involved securing controlled substances from others, or the use of non-prescribed illicit drugs, then the patient could be

reported to all treating physicians, to all pertinent medical facilities, and to appropriate authorities. (Exs. 11, 23 & 84.)

68. The narcotics agreement concluded with the following information the patient acknowledged before signing:

I have been fully informed by Dr. Ogoke and his staff regarding psychological dependence (addiction) of controlled substance medications, which I understand, is rare. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve the desired effect, and that there is a risk of becoming physically dependent on the medication. This will occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I have read this contract and the same has been explained to me by Dr. Ogoke. In addition, I fully understand the consequences of violating this agreement.

(Exs. 11 & 23.)

69. When Dr. Ogoke terminated care with a patient, including for a narcotics agreement violation, or for refusing to undergo interventional treatments that were part of the overall treatment plan, a termination letter was given to the patient. This letter set forth alternative pain management providers in the area for the patient to use instead of Dr. Ogoke. In addition, Dr. Ogoke agreed to provide care within the next thirty days, including providing a thirty day medication supply as a bridge to establishing the alternative care. (Ex. 43; 16/1145 for Pt. F, 494/2363 for Pt. G & 65/2670 for Pt. I²⁰ & 84.)

70. Dr. Ogoke's medical assistants and physician assistants who learned of a patient's narcotics agreement violation were required to call this to Dr. Ogoke's attention. The violation by a patient of the narcotics agreement might be a first time violation, or it might be an ongoing problem for the patient. One response Dr. Ogoke used was to initiate random pill counts in

²⁰ These are examples of the form termination letters that Dr. Ogoke's office used.

which the patient would bring the medications to the office and Dr. Ogoke's staff would follow a protocol to count the pills. Another response when the violation involved an illicit drug found in a UDS result was to trigger Dr. Ogoke discussing this with the patient, which could end the patient's care with him. Or, the patient could be sent for an assessment by an addiction specialist that could include care with the addiction specialist or at a detoxification facility. If the patient succeeded with addiction treatment, Dr. Ogoke might allow a return to care with him, including resuming opioid therapy. A UDS result showing non-compliance or use of an illicit drug, might not mean an end to care immediately, although it was always treated by Dr. Ogoke as a red flag and as an occasion for discussion with the patient about the seriousness of being non-compliant with the treatment plan. (Exs. 11, 23 & 93. Testimony of Dr. Ogoke;²¹ & Ms. Dawes, Vol. XI, 2141-2155.)

71. Dr. Trescot opined that Dr. Ogoke's use of his narcotics agreement with the patients listed in the Statement of Allegations was proper even if a violation did not immediately lead to a termination of care. Dr. Trescot thought that the narcotics agreement permitted varied responses to a violation and not just automatic termination of care. (Testimony of Dr. Trescot, Vol. IV, 2679-2680.)

72. Dr. Ogoke required that he and his patient be in a comfortable doctor-patient relationship. He needed to feel confident his patient was compliant with the treatment plan he developed, including taking the medications as prescribed and not taking non-prescribed or illicit drugs. If events occurred and discussions were held with the patient that caused Dr. Ogoke to feel uncomfortable with the doctor-patient relationship, and he lacked trust that the patient was sticking to the treatment plan, then he would inform the patient to seek out an alternative

²¹ See the discussions in the sections on particular patients and their narcotic agreement violations that Dr. Ogoke discussed in their medical records and in his testimony.

caregiver. This would not necessarily mean an abrupt stop in care, and his care could continue with time given to the patient to locate alternative care. While the individual secured alternative care, if to do so was not a concern, Dr. Ogoke would provide a thirty day renewal of medications, including opioids at the ongoing doses, and even another thirty days of medications after that. Although his practice was a resource in the Springfield area, Dr. Ogoke was not the only available source for receiving pain management care in the community. (Ex. 84.)

DISCUSSION

Standard of Care and Recommendations

Standard of care is the degree of care and skill that the average qualified practitioner must possess when caring for his patient taking into account the advances in the medical profession. *Brune v. Belnikoff*, 354 Mass. 102, 109 (1968). The standard of care for a medical specialist is the care and skill of the average member of that specialist profession. *Palandjian v. Foster*, 446 Mass. 100, 104 (2006); *McCarthy v. Boston City Hospital*, 358 Mass. 639, 643 (1971); *Brune*, *supra* at 109. And, the standard of care will evolve with time with consideration of the resources available to the physician. For Dr. Ogoke's practice, the pertinent time period for the standard of care covers the time period of the Statement of Allegations, 1997-2008. *Heinrich v. Sweet*, 308 F.3d 48, 63 (1st Cir. 2002); *Stepakoff v. Kantar*, 393 Mass. 836 (1985); *Brune*, *supra* at 109.

The prevailing standards of care during the time period that Dr. Ogoke treated the fourteen patients listed in the Statement of Allegations included the BORM prescribing guidelines (Exhibit 20) and the Federation of State Medical Board model guidelines for prescribing (Exhibit 95). These are the two documents most relied upon by the BORM and its expert, Dr. Satwicz, to support its charges that Dr. Ogoke engaged in substandard care of these fourteen patients. Dr. Ogoke and Dr. Trescot were participants in the ASIPP's publishing of its

guidelines on pain management practices (Exhibit 85) that reached interventional procedures as well as prescribing practices when engaged in pain management practices, including for treating chronic non-cancer pain. Dr. Satwicz had no disputes with the purpose of the ASIPP guidelines that were used by Dr. Ogoke and his expert, Dr. Trescot, to guide them in their pain management practice. All three documents were central to my evaluation of whether Dr. Ogoke engaged in substandard care as a pain management specialist with any of the patients listed in the Statement of Allegations.

Given the general agreement among Dr. Satwicz, Dr. Trescot and Dr. Ogoke on how to have engaged in proper pain management practice with these fourteen patients, the determinations as to whether Dr. Ogoke violated the standard of care for any particular aspects of the care he provided to any of these fourteen patients, was resolved by first establishing the course of care he gave each patient, including the protocols he followed in carrying out his care. Once the course of care he gave each patient was established, I relied on the expert testimony of Dr. Satwicz and Dr. Trescot to address whether Dr. Ogoke met the standard of care for his specialty. I found that Dr. Ogoke did not ignore any of the necessary guidelines set forth in these three documents (Exhibits, 20, 85 & 95), in performing his interventional procedures or in prescribing narcotic regimens for these patients. These guidelines all called for careful monitoring of patients on narcotic medications from the initial examinations and assessments, through the treatment time period, and with increased monitoring necessary for any red flag conduct shown by patients receiving prescribed opioid medication. These guidelines also called for monitoring of the patient's condition as a result of the interventional procedures received. I found that Dr. Ogoke engaged in these monitoring practices in his treatment of the fourteen patients listed in the Statement of Allegations.

Within the pain management community during the time period Dr. Ogoke treated the fourteen patients, there was a debate about the propriety of the use of long-term opioid therapy and of prescribing high doses of opioids for treating chronic intractable non-cancer pain. There were no guidelines or rules preventing such prescribing practices. Both Dr. Satwicz and Dr. Trescot addressed this debate in their testimony and how the debate informed their opinions. Just because Dr. Satwicz supported the BORM's contentions with his conservative position in this debate about the use of opioid therapy on a long-term basis, particularly in high doses, did not make Dr. Satwicz's viewpoint the standard of care. *Barrette v. Hight*, 353 Mass. 268, 276 (1967).

The level of proof needed to find a violation of the standard of care is a preponderance of the evidence. *Craven v. State Ethics Commission*, 390 Mass. 191, 200 (1983). Preponderance means more likely than not probable, and with an actual belief in its truth. *Sargent v. Mass. Accident Co.*, 307 Mass. 246, 250 (1940). To address whether the required level of proof was met, it was essential to uncover the underlying facts showing the specific course of care, evaluation, and decision-making that Dr. Ogoke engaged in while treating each of the patients addressed in the Statement of Allegations. Then, Dr. Ogoke's good faith as a skilled pain management specialist, particularly in his narcotic prescribing, was determined. Did he cut corners in evaluating his patients before providing them with high dose opioid medical regimens? Did he over-prescribe opioids for the kind of conditions they had? Did he engage in sufficient monitoring of their use of opioid medication or did he fail to do enough to uncover opioid abuse or diversion? *Commonwealth v. Pike*, 430 Mass. 317 (1999); *Commonwealth v. Miller*, 361 Mass. 644 (1972); *Commonwealth v. Noble*, 230 Mass. 83 (1918); and, *Arthur E. Baer*, Adjudicatory Case # 205, Board of Decisions, Vol. 1 (1978) (*Baer Standards* adopted in

Arthurs v. Board of Registration in Medicine, 383 Mass. 299, 312, footnote 25 (1981) as a basis for physician discipline.)

The BORM can discipline a physician for misconduct in the practice of medicine. 243 C.M.R. § 1.03(5)(a)18. Misconduct is “more than that conduct which comes about by reason of error of judgment or lack of diligence.” *Hellman v. Board of Registration in Medicine*, 404 Mass. 800, 804 (1989). It is “willed and intentional” conduct that is “determined from the facts surrounding the act, the nature of the act, and the intention of the actor.” *Id.* If Dr. Ogoke was intentionally over-prescribing opioid medication or knowingly side-stepping risks known to be too dangerous for any particular patient in prescribing opioids long-term, or if he was putting the patient at unsupportable risk in doing multi-level lumbar spine injections, then that is misconduct. Also, if Dr. Ogoke practiced medicine with any of his patients incompetently, then that is a violation of standard of care for which he can be disciplined. He could also be disciplined for gross misconduct, practicing fraudulently, practicing beyond his authorized scope of training and experience, practicing with gross incompetence, practicing with gross negligence, and practicing negligently repeatedly. *See* G. L. c. 112, § 5(c).

Insensitive, exploitative treatment of patients is tantamount to conduct that undermines the public confidence in the medical profession and renders the physician subject to discipline by the BORM pursuant to *Sugarman v. Board of Registration in Medicine*, 422 Mass. 338 (1996); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982); and, *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979).

A prescription for a controlled substance to be valid must be issued for a legitimate medical purpose by a practitioner acting in the usual course of his professional practice. M.G.L. c. 94C, s. 19(a). Dr. Ogoke is charged with violating this statute. *See* 243 C.M.R. 1.03(5)(a)2

and 11.

Dr. Ogoke is charged with failing to maintain a medical record on his patients adequate to let him provide on-going proper diagnoses and treatment. He is also charged with failing to permit a former patient and a successor physician caring for that patient, to access pertinent medical record information of that former patient. These alleged failures are charged as violations of G. L. c. 112, § 5(h), 243 C.M.R. 1.03(5)(a)11, and 243 C.M.R. 2.07(13)(a).

Dr. Ogoke is charged with failing to provide in a timely manner a copy of a former patient's medical records to the successor physician at that former patient's request in violation of G. L. c. 112, § 5(h), 243 C.M.R. 1.05(5)(a)11 and 243 C.M.R. 2.07(13)(b).

Dr. Ogoke is charged with failing to supervise his physician assistants, including not reviewing their prescribing of medications to patients at least every three months, and failing to provide them with ongoing direction in carrying out their duties with his patients in violation of 243 C.M.R. 2.08(2)(a), (d), and (e).

Even if violations of standard of care were proven, the BORM has a number of options for discipline aside from revocation or suspension of the license. These include "admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training or other restrictions upon the Respondent's practice of medicine." *In the Matter of Walter L. Kaufman, M.D.*, Board of Registration in Medicine, No. 98-12-XX, pg. 5 (April 15, 1998). When the BORM determines an appropriate discipline for substandard care, it considers: how far the physician deviated from the standard of care; how many patients were involved; and, whether there were any mitigating circumstances. The Board can impose discipline based on each violation of standard of care found. See *In the Matter of Viorel Boborodea, M.D.*, Board of Registration in Medicine, No. 04-61-DALA (RM-04-1164) (March

15, 2006).

This long hearing process involved assessing numerous witnesses, making credibility determinations, and considering much documentary evidence to reach my conclusions on the course of care received by each patient addressed by the evidence. *Morris v. Board of Registration in Medicine*, 405 Mass. 103 (1989). With respect to the conflicting expert testimony on standard of care, overall, I found Dr. Trescot's opinions to be more persuasive than Dr. Satwicz's. This was because Dr. Trescot, more often than Dr. Satwicz, provided more detailed analyses about the course of care a patient received to support her opinions. In *Robinson v. Contributory Retirement Appeal Board*, 20 Mass. App. Ct. 634, 639 (1985), the Massachusetts Appeal Court held:

[T]he probative value of the expert testimony is for the fact-finding tribunal to decide, and where there is conflicting testimony, the fact finder may completely discount the testimony of one expert and rely exclusively on the other.

In *Mancini v. Board of Registration in Medicine*, 390 Mass. 1002, 1002-1003 (1983), the Supreme Judicial Court held that an adjudicatory agency is not required to believe expert testimony even if it determines that the expert has the appropriate qualifications. In *Woolfall's Case*, 13 Mass. App. Ct. 1070, 1071 (1982), the Massachusetts Appeals Court held that a fact-finder may completely discount sections of testimony of an expert witness based on other testimony. This was the situation with Dr. Satwicz's testimony in terms of his strongly-held general opinion on never prescribing certain opioids or opioids at high doses on a long-term basis for non-cancer chronic intractable pain during the time period involved in the Statement of Allegations, and in terms of his opinion on the quality of Dr. Ogoke's overall practices regarding what he included in a patient's visit report.

The BORM argued that the expert testimony of Dr. Trescot was not reliable because of

her professional and friendship connection with Dr. Ogoke. To the BORM, this was a reason to never rely on Dr. Trescot's testimony about the propriety of Dr. Ogoke's conduct. This was not a persuasive contention. I found her testimony to be reliable, understandable, and persuasive. The BORM's contention was an exaggeration. She was more thorough than Dr. Satwicz was when assessing the significance of the details involved in each patient's overall care as gleaned from the medical records, including addressing the significance of the patient's pain complaints over time. I found her analyses about the propriety of Dr. Ogoke's decisions on treatment plans, including about his opioid prescribing, in general, more persuasive than Dr. Satwicz's analyses. She had experience in a private practice pain management setting that Dr. Ogoke had unlike Dr. Satwicz. The BORM argued what it considered to be examples of Dr. Trescot testifying in ways that were purely meant to protect Dr. Ogoke, and as an extension, the ASIPP that both she and Dr. Ogoke were so involved with. I found such examples by the BORM unpersuasive. Although Dr. Satwicz was not a member of ASIPP, he did not have standard of care disputes with the ASIPP guidelines that Dr. Trescot and Dr. Ogoke relied upon.

The BORM also argued that Dr. Trescot's testimony was not all that useful since she lacked knowledge of Massachusetts statutes and regulations on the practice of medicine. She is not licensed in Massachusetts. This was not a persuasive reason for discounting her testimony. I found her testimony believable and reliable when she pointed out how the debate over the use of opioid therapy was a national issue at the time the patients listed in the Statement of Allegations were treated. Dr. Satwicz did not testify that the prevailing standard of care for pain management physicians during this pertinent time period was substantially different for Massachusetts specialist physicians when addressing prescribing practices, monitoring of patients' use of prescribed narcotics, and performing interventional procedures.

When Dr. Satwicz provided his opinions, he recognized he was at one end of the spectrum of thought at the time on treating chronic non-cancer pain patients with opioid medications for long time periods and at high doses, and that Dr. Trescot and Dr. Ogoke were at the other end of the spectrum that all three physicians acknowledged existed. He did not testify that the Massachusetts prescribing policy forbid such opioid prescribing. Rather, he opined that he would not have done what Dr. Ogoke did when he engaged in long-term opioid prescribing for chronic pain conditions. Dr. Trescot explained well that opioid medications during this time period were viewed as providing an improved quality of life for chronic non-cancer pain patients whose pain was often under-addressed, and to prescribe them was standard of care practicing as a pain management specialist, especially when used as an adjunct to helping control pain generators using interventional procedures.

Dr. Trescot explained the importance of monitoring patients on opioid therapy with UDSs, pill counts, requiring police reports to support a need for an early refill when the patient claims narcotics were stolen or lost, holding conversations with patients about their use of the prescribed narcotics, and using a narcotics agreement. These were all important protocols Dr. Ogoke incorporated into his practice that Dr. Satwicz agreed were important.

Overall, I did not rely on many of the conclusions and opinions of the patients who testified who are listed in the Statement of Allegations to decide whether or not Dr. Ogoke violated the standard of care in the treatments he provided to them. Rather, their testimony at times was able to confirm the course of treatment that emerged from examining and organizing their medical records in chronological order, including regarding what opioid medications they took and for how long. Their testimony confirmed the reactions to the medications and interventional treatments they received under Dr. Ogoke's care as set forth in their medical

records. I did not rely on the patient complaints (Exhibit 83), even the ones with lots of written details. Without a chance to hear the patient's complaints in person and to have their claims subject to cross-examination, I did not give any of them much weight in determining violations of standard of care.

I relied on Dr. Ogoke's testimony, which I found to be forthright and credible. He did not evade answering questions, including during his interview with the BORM (Exhibit 84). If he did not recall exactly the details of the care he gave to the patients listed in the Statement of Allegations at all times, he explained that he needed to view more medical records to be able to answer the question he was asked. If he was shown a medical record to refresh his recollection about a particular time period and specific office visit, I found him honest and open in explaining what he recalled and what he did not recall in terms of specific facts, and about what else he would need to review in order to answer the question with useful detail.

In the case of *Feldstein v. Board of Registration in Medicine*, 387 Mass. 339, 341 (1982), the Supreme Judicial Court held: "[T]he purpose of a disciplinary proceeding is protection of the public, not retribution" In *Keigan v. Board of Registration in Medicine*, 399 Mass. 719, 722 (1987), the Supreme Judicial Court explained:

While we have stated that suspension or revocation of a license to practice medicine is not designed to punish the physician involved, we have recognized that the Legislature through the board has provided for the imposition of sanctions "to protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." *Levy v. Board of Registration & Discipline in Medicine*, 378 Mass. 519, 527-528 (1979), quoting *Matanky v. Medical Examiners*, 79 Cal. App. 3d 293, 306 (1978). *Arthurs v. Board of Registration in Medicine*, 383 Mass. 299, 317 (1981).

243 C.M.R. §1.03(5)(a)10 permits the BORM to discipline a physician for practicing medicine deceitfully, or engaging in conduct with the capacity to deceive or defraud. This kind

of conduct can be shown “by proof that a party knowingly made a false statement and that the subject of that statement was susceptible of actual knowledge.” *Fisch v. Board of Registration in Medicine*, 437 Mass. 128, 139 (2002). This deceptive or fraudulent behavior may also be due to a lack of good moral character that undermines public confidence in the integrity of the medical profession and as a result is subject to discipline.

A physician, however skillful, who is guilty of deceit ... in the practice of his profession even though not amounting to an offense against the criminal laws, well may be thought to be pernicious in relation to the health of the community.

Lawrence v. Board of Registration in Medicine, 239 Mass. 424, 429 (1921).

I found a lack of proof that Dr. Ogoke engaged in any manipulation of his patients' care for his own monetary gain or otherwise to benefit himself at their expense and needless suffering. When Dr. Ogoke engaged in long-term opioid therapy for his patients whom he believed needed that and had not had their pain controlled sufficiently from interventional procedures, he was acting in good faith with the intention of following pertinent prescribing and interventional procedure guidelines and opioid monitoring practices. If he overstepped the standard of care, then that was not his intention. The findings made on each of the patients within the Statement of Allegations about Dr. Ogoke's evaluation and treatment of them show what he did in detail in providing each of them pain management care. This analysis should assist the BORM in assessing for any possible discipline or sanction by showing the underlying facts involving each patient's care by Dr. Ogoke, and by explaining what portions of the Statement of Allegations were not proven.²²

²² The BORM is not bound by a Division of Administrative Law Appeals recommendation as to sanction. *Fisch v. Board of Registration in Medicine*, 437 Mass at 139-140; *Herridge v. Board of Registration in Medicine*, 420 Mass. 154, 166-167 (1985); *Waisbren v. Board of Registration in Medicine*, 418 Mass. 756 (1994).

Application of Standards of Care to the Findings of Fact

Practices of Dr. Satwicz, Dr. Trescot and Dr. Ogoke - Use of Guidelines

Dr. Satwicz recognized that when Dr. Ogoke was treating the fourteen patients listed in the Statement of Allegations, the field of pain management was the subject of a debate over just how to use opioid therapy in the treatment of chronic non-cancer pain. He agreed that he was on the side that did not endorse administering long-term opioid therapy, especially with increasing doses, due to the growing public crisis involving the misuse and abuse of opioids that are hard to monitor well enough so that misuse and abuse will not occur. He favored treatments that were alternatives to long-term opioid use for controlling chronic non-cancer pain, such as behavior modification, physical therapy, exercise, and weight loss. He recognized that Dr. Trescot and Dr. Ogoke represented the other side's viewpoint at the time these patients were treated. They focused on the fact that chronic non-cancer pain was a condition under-treated to a great degree, and that the proper and well monitored use of opioid therapy could lead to a significantly improved quality of life and pain control for such patients' suffering. Dr. Ogoke dealt with chronic non-cancer pain patients who had sought his specialist care because they had not found sufficient pain relief when they were treated more conservatively or less aggressively at pain centers connected to hospitals or with other physicians. Many sought Dr. Ogoke's care without a referral from another pain center or physician. Dr. Ogoke was well known as a pain management specialist in the Springfield area.

Dr. Satwicz's hospital pain management practice uses opioids for the care of cancer patients. He also treats patients with opioids for acute pain connected to injury or surgery. He treats chronic non-cancer pain patients, but he primarily has the patient's PCP prescribe on-going opioid medications after counseling that physician against strong doses and long-term use of

opioids. The practices of Dr. Trescot and Dr. Ogoke show a very different arrangement as a consequence of them being in the private practice of pain management. There were patients listed in the Statement of Allegations who Dr. Ogoke saw with chronic non-cancer pain who had already taken opioid medication for pain control that the patients found to be inadequate, arriving at their initial evaluations with high level pain complaints. Both Dr. Trescot and Dr. Ogoke thought their care of such patients was within standard of care when their treatment plans included long-term and increasing doses of opioids in addition to undergoing interventional procedures to try to uncover the core pain producers. Their methods to provide better pain control and a subsequent better quality of life for chronic non-cancer pain patients are valid reasons for the use of opioid therapy. Their methods are not prohibited outright by any of the guidelines in evidence pertinent to the time period under consideration. Both Dr. Trescot and Dr. Ogoke engaged in this kind of pain management practice that recognized the need at the same time to engage in comprehensive monitoring of these patients to avoid the pitfalls of misuse and abuse of opioid medications.

For Dr. Satwicz, based on his review of the medical records, none of the patients listed in the Statement of Allegations had underlying conditions causing pain that was able only to be adequately treated for relief by the methods employed by Dr. Ogoke. Dr. Satwicz concluded those methods relied too heavily on high and on-going opioid doses, on the use of Actiq, and with giving the patient at one lumbar spine interventional procedure four or five bilateral multi-level injections. Dr. Satwicz explained his opinions on finding violations of standard of care that it was not so much that these patients were shown to have become drug addicts, but that the high risk for abuse, diversion and addiction, along with the serious side effect risks of such large amounts of medications in the body at one time, were unacceptable as they persisted over long

time periods.

I found Dr. Satwicz's testimony understandable, and based on his expert review of the medical records on each patient in the Statement of Allegations. He supported each of his conclusions with clear explanations. The trouble I encountered with some of his conclusions assessing whether Dr. Ogoke failed to satisfy the standard of care at the time he treated each of these patients, was that Dr. Satwicz's pain management practice centered on what the record showed to be a different kind of pain management practice. This difference at the time periods pertinent to this case of a hospital pain management practice and Dr. Ogoke's private practice, did not alter at all Dr. Satwicz's assessment of Dr. Ogoke's care. Nevertheless, I was persuaded to the contrary by the testimony of Dr. Ogoke and also by the expert testimony of Dr. Trescot.

The evidence proved that the private practice of the kind Dr. Ogoke and Dr. Trescot were experienced in operating, centered on the pain management specialist as the primary opioid prescriber for pain management, as the only physician administering interventional procedures, and often addressing the patients' overall care because these patients often lacked PCPs. Dr. Satwicz's hospital pain management clinic practice involves a patient most often being treated by a number of physicians within the clinic, and with the patients' PCP doing the longer term opioid prescribing, if that was involved in the care. Dr. Satwicz explained well how he counsels and partners with the patient's PCP on appropriate opioid prescribing, if any, for the chronic non-cancer pain patient he or his clinic colleague physicians are also giving care to.

Dr. Satwicz explained his position on avoiding prescribing opioids long-term with increased opioid doses of medications for this kind of patient. He emphasized the worth of non-medication care such as interventional procedures and the use of diet, exercise, physical therapy, and behavior modifications. No evidence showed that either Dr. Ogoke or Dr. Trescot avoided

investigating the worth of such non-medication treatments for their patients. Dr. Satwicz did not sufficiently explain why for any of the patients listed in the Statement of Allegations pursuing these non-medication driven treatments would likely have been sufficient for the patients with perhaps only modest opioid prescribing needed that could have been safely done by the patients' PCPs.

I conclude, that Dr. Satwicz's opinion against long-term opioid therapy with increased doses for non-cancer chronic pain was an important but not always persuasive opinion about the propriety of Dr. Ogoke's pain management care of the particular patients listed in the Statement of Allegations. For the patient who was proven to have been well monitored by Dr. Ogoke in the use of prescribed narcotics, I found that the opinions of Dr. Ogoke and Dr. Trescot on the appropriateness of treating the patient with long-term opioid therapy in order to provide a better quality of life overcame Dr. Satwicz's opposite viewpoint. In making this determination, I acknowledge that Dr. Satwicz formed his opinions on whether there were violations of standard of care after reviewing the details of each patient's care as best he could determine them from the medical records. In reaching his opinions, Dr. Satwicz was greatly relying on his general viewpoint opposing the use of long-term opioid therapy with increased doses, especially because the patients listed in the Statement of Allegations did not suffer from cancer pain. The opinion of Dr. Trescot regarding these same considerations proved to be based on more detail addressing whether or not the particular chronic non-cancer pain patient was achieving adequate pain relief. Whether Dr. Satwicz's opinion overcame the contrary opinion of Dr. Trescot as to each patient, is addressed in the findings made and conclusions reached in each patient's section with this Recommended Decision.

These chronic non-cancer pain patients listed in the Statement of Allegations had tried

other routes of pain management care before coming to Dr. Ogoke. Dr. Trescot explained why that was significant when assessing whether Dr. Ogoke was over-prescribing pain medication to such patients at initial and early visits. Dr. Satwicz did not think this point all that significant in his assessments of the prescribing done for such patients at initial and early visits. Many of these patients had come to Dr. Ogoke's care already on opioid medication and already having undergone interventional procedures. The record also showed how Dr. Ogoke called for x-rays, CT scans and/or MRIs and other diagnostic procedures to help to uncover the sources of the intractable pain complaints. And, at times Dr. Ogoke prescribed physical therapy treatments and care with a counselor, or psychologist, or psychiatrist, and counseled the patient to pursue specialist treatment for other physical or psychiatric conditions. The record does not show Dr. Ogoke had a set pattern for how he treated all his chronic non-cancer pain patients by always prescribing only high dose opioids along with interventional procedures. The detailed attention given to each of the fourteen patients listed in the Statement of Allegations is shown in the course of care within the findings of fact reached on each of the patients.

Dr. Ogoke's Protocols for Patient Care and Medical Recordkeeping

Dr. Satwicz opined that the medical records Dr. Ogoke kept on the patients in the Statement of Allegations were insufficient and at times in violation of the prevailing standard of care. Neither Dr. Ogoke nor Dr. Trescot disputed the need to have medical records that satisfied the same standards that Dr. Satwicz testified were necessary. They disagreed on how the medical records needed to be maintained in terms of the recordkeeping on medications prescribed.

Dr. Satwicz opined that the details of each prescription issued at a patient visit had to be contained within the visit report when the prescriptions were written. In addition, Dr. Satwicz

opined that to satisfy the standard of care, the visit report had to contain reasons why the medication had been prescribed and in the dose it was prescribed, including if any changes in a medication regimen had been made at the visit. He opined that the visit report had to contain a patient's full medical profile at that time and he did not observe that level of necessary detail in Dr. Ogoke's visit reports. Dr. Satwicz explained that without such detail in a visit report, another physician taking over the patient's care or involved in another aspect of that patient's care, could not easily follow Dr. Ogoke's course of care for the patient's pain complaints.

Dr. Trescot and Dr. Ogoke testified that the details on a prescription written at a patient's visit had to be included within that patient's medical records and be reasonably accessible, but did not need to be set-forth within a visit report when the medication was issued. Dr. Ogoke's practice was to have legible copies of all a patient's prescriptions placed into the patient's medical records. They believed that Dr. Ogoke's visit reports contained necessary medical profile information about the patient at the time of the visit, including assessments of how well medications and injection procedures were helping with pain control, the results of the physical examination the patient was given at the visit, and the details of the treatment plan that included any changes to it including any changes to the medication regimen. I found Dr. Trescot's opinion that Dr. Ogoke's recordkeeping practices to be more persuasive than Dr. Satwicz's. This was especially in regard to the recordkeeping regarding the prescriptions written, since no guideline at the time Dr. Ogoke treated the fourteen patients listed in the Statement of Allegations contained any recommendation that details of each prescription appear within the report of a patient's visit; that sufficient was to have such details contained within the patient's medical records and be reasonably accessible.

I was able to locate for each patient, pertinent medical records within Exhibit 43 covering

a chronology of care by Dr. Ogoke for each of the patients listed in the Statement of Allegations, albeit spending a great deal of time and organization to sift through the out-of-order medical records on each patient. Such out-of-order medical records typically covered monthly visits over multiple years per patient. Nevertheless, I was able to arrive at a chronology of care for each patient, connecting the reports on office visits with various test results, consults, interventional procedure reports, and copies of the prescriptions.

The BORM did not prove that Dr. Ogoke's recordkeeping on each patient fell below the standard of care and that a patient's medical records were not reasonably accessible. No burden of proof shifted onto Dr. Ogoke on this issue.

The BORM failed to show that any prevailing rule, regulation, or guideline required that the precise details on prescriptions written at a visit had to be included within a report of the visit. It also did not show that the information provided by ancillary documents pertinent to a particular patient visit had to be included within that particular visit report. No evidence was presented that any other treating physician for any of these patients thought Dr. Ogoke maintained inadequate medical recordkeeping on his patients. I agree with Dr. Trescot's testimony, and it is self-evident within the pertinent guidelines, that there was no requirement to include prescription details and ancillary report details in a visit report so long as the patient's medical record contained that information and that information was reasonably accessible. This last point of being reasonably accessible was not adequately addressed by the BORM. Specific concerns were raised by Dr. Satwicz about particular patients and whether or not Dr. Ogoke had adequately addressed all pertinent issues in his visit reports. Such concerns often involved a patient's red flag conduct. These concerns are addressed within the sections on the particular patients in this Recommended Decision.

Multi-Level Lumbar Spine Injections within one Interventional Procedure

Receiving interventional pain management procedures is the reason for treating with an interventional pain management specialist, but having such treatments would not prevent the patient from also receiving long-term opioid therapy for pain control. How much opioid medication such a patient should have to achieve improved pain control and quality of life has to be evaluated against the very real and serious issues of diversion, addiction, and use of illicit drugs to which such patients on long-term opioid care are very susceptible. All three pain management specialists agree on the importance of this balancing for chronic non-cancer pain patients. That is why the findings made as to each patient showing the course of care with Dr. Ogoke are key to determining whether the BORM has met its burden of proof to show violations of standard of care in the treatment by Dr. Ogoke of any of the patients as to any aspect of the care he gave them.

Dr. Satwicz provided understandable explanations about the various risks to patients who are on long-term opioid therapy while also receiving multiple bilateral spinal injection procedures. He explained how there were no guidelines at the time the patients listed in the Statement of Allegations were treated that prevented doing four or five bilateral lumbar spine injections during one procedure. Rather, he thought that for some of these patients their particular conditions and ongoing opioid therapy at high doses made them at too high a risk to receive so many injections within one interventional procedure. He opined that a safer route would have been to break down the number of injections into more than one procedure. For Dr. Satwicz, the risks for having in the body at one time such large doses of steroids was placing on that patient too great a risk of suffering serious side effects. In addition, he saw in the medical records for some of the patients, that Dr. Ogoke would leave in the patient during these

procedures, too many needles not at the moment being used to inject the steroid, a technique he thought was too risky to do with the patient just under sedation. If the patient moved, those sharp needles could cause serious harms. Dr. Satwicz did not think there was a need to have more than an extra needle in place as a way to help guide where to do the next injection.

Dr. Ogoke did not dispute in his testimony the risks associated with doing multi-level bilateral lumbar spine injections during one procedure. Neither did Dr. Trescot. They simply disagreed with Dr. Satwicz that the risks were too great to take for any of the particular patients listed in the Statement of Allegations who received them. With proper equipment and skill both Dr. Ogoke and Dr. Trescot opined that such injections within one procedure can be and were done successfully and to the benefit of the patient, a benefit they maintained was shown in the fluoroscopy report on the patient's procedure addressing the patient's success in going through the procedure, as well as within the patient's medical records on the pain relief achieved. Dr. Satwicz did not opine that Dr. Ogoke caused the patient damage during these procedures. No evidence showed such damage had occurred as a result of such interventional procedures.

Dr. Ogoke engaged in careful monitoring of his patients following their interventional procedures that was always documented with details within each patient's medical records. He scheduled follow-up visits with each patient to address how well or not the interventional procedure was helping with pain control. He elicited whether the patient had suffered from any side effects from the interventional procedure. At each patient visit, generally monthly because the patient received thirty day supplies of medications, the patient's medical record would describe the purpose of the visit. Almost always a new physical examination would be given, a history taken from the patient to uncover any new injuries or complaints, and the patient would need to rank the level of pain being experienced, what triggered the pain, and what the pain felt

like. Included in a report of a patient visit following an injection procedure would be the patient's pain complaint levels to help determine whether the injection procedure had led to pain relief. The record showed that his physician assistants were also mindful of the need to do proper monitoring of patients on long-term opioid medications and who were undergoing injection procedures.

Statement of Allegations, #s 2 – 8

The BORM did not prove the charges that Dr. Ogoke violated the standard of care based on the general complaints about: how Dr. Ogoke ran his office; how he talked to his patients and staff; whether he gave patients towels to bite into for pain relief and prevent them from screaming during interventional procedures; whether patients in the waiting areas of the office could hear patients screaming in pain; whether his office was kept messy; whether patients routinely had to wait excessive hours before receiving their treatments; whether he and his physician assistants gave physical examinations to patients before prescribing opioids; and, whether he enforced the terms of the narcotics agreement his patients receiving opioid medications had to sign. For this particular group of allegations, the arguments made by Dr. Ogoke in his brief were persuasive and reflected my views from hearing and reviewing evidence on these general claims. The findings made reflect this. The findings made in this portion of the decision do not show any violations of standard of care in the practice of medicine by Dr. Ogoke.

Dr. Ogoke was not a disruptive physician in his conduct as alleged. He did not violate the BORM Policy 01-001 on Disruptive Physician Behavior (Exhibit 19). His office was not kept messy due to a regular cleaning service and due to a designated staff person who picked up debris during each workday. He did not yell at his staff or at his patients.

Due to soundproofing, patients/persons in the waiting area could not hear what was going

on in examination and procedure rooms. If a patient wanted to hold onto something during an interventional procedure or to bite into a towel or pillow, Dr. Ogoke would allow this, but did not require a patient to do that. He just wanted the patient to be calm and cooperative during the procedure. He did not give a towel or pillow to a patient to stop their screams from being heard by those in the office. He would not have the patient held down during the procedure.

Dr. Ogoke or his physician assistants at scheduled office visits gave physical examinations to patients before prescribing medications to them, even renewals of medications. No evidence proved otherwise or shifted the burden of proof on this claim. If the visit report contained what was done in a physical examination, then the examination occurred.

Dr. Ogoke followed the terms of his narcotics agreement that his patients signed. If Dr. Satwicz at times opined that Dr. Ogoke should have addressed a narcotics agreement violation differently, Dr. Ogoke's alternative actions involved conduct permitted by the terms of the narcotics agreement. If Dr. Ogoke, for instance, did not do on-going UDS tests, that did not mean he did not engage in additional monitoring of the patient's intake of the prescribed pain medication in reaction to a likely narcotics agreement violation. UDS tests were useful tools for monitoring, especially when illicit drug use was suspected after it was uncovered once by a UDS test, but UDS tests were not the only way to secure a patient's proper taking of prescribed medication when illicit drug use was not an issue. For instance, Dr. Ogoke and his physician assistants held discussions with the patient about a need to take medications only as prescribed, required random pill counts, and learned about any monitoring of how the medications were taken at home.

Patients would be asked to reschedule appointments if Dr. Ogoke was unable to see them or to only see them after long waits due to an unforeseen delay involved in another patient's

office visit. If a patient with a scheduled visit faced a long wait, the patient would be informed that the visit could be rescheduled. If a patient appeared at the office for an unscheduled visit, the patient could face a long wait because scheduled appointments would have priority. Sometimes, such a patient would be informed that Dr. Ogoke would not be able to see the patient that day and the visit would need to be scheduled.

The BORM's chief investigator, Philip Beattie, testified that none of Dr. Ogoke's staff were interviewed concerning these general allegations about how the office was run and how patients and staff were dealt with by Dr. Ogoke. The BORM never sent an investigator to examine the office set-up and observe staff-patient-Dr. Ogoke interactions. I find insufficient support for these allegations from the patients who testified on some of these issues and/or filed written complaints raising these issues. The BORM's evidence did not shift the burden of proof onto Dr. Ogoke on these charges. The findings made in this portion of the Recommended Decision are incorporated into the findings made about the care by Dr. Ogoke of each of the fourteen patients that are addressed in separate sections of the Recommended Decision.

The charge that Dr. Ogoke or his physician assistants would not examine patients before prescribing opioid medication was not proven. The opioid medications tended to be prescribed for thirty day supplies, and required as a general protocol, receipt of a new or renewed prescription in-hand. The patient would need to show-up for an office visit. At this office visit, the findings show in the sections on each of the fourteen patients addressed in the Statement of Allegations that the patient would receive a physical examination and an evaluation in addition to receiving the opioid prescription scripts. This charge was not proven by the BORM.

Importance of Monitoring Patients Adequately/Narcotics Agreement/Termination of Care

Dr. Satwicz, Dr. Trescot and Dr. Ogoke are each experienced specialists and experts in

the field of pain management. They are each board certified anesthesiologists in terms of their backgrounds in coming into the specialty field of the practice of pain management. All three do interventional procedures and prescribe medication to achieve pain relief for their chronic non-cancer pain patients. Dr. Satwicz and Dr. Trescot were practicing in this field at the time Dr. Ogoke treated the patients whose care is addressed in the Statement of Allegations. All three agree that any patient receiving long-term opioid therapy, especially with increased doses over time, must be subject to a narcotics agreement forbidding the taking of any illicit drugs and forbidding the use of opioids other than as prescribed. All three agree on the need for patients to be adequately monitored to ensure they take the opioids as prescribed.

They each agree on the need to periodically re-assess a patient's opioid needs. All three recognize the very real and high risks for patients on long-term opioid therapy of developing serious health risks including addiction. All three agree on the basic definitions of the conditions that can develop as a result of taking opioids long-term of pseudo-addiction, dependence, tolerance, diversion, and addiction. All three agree on the kinds of monitoring activities that a pain management specialist with a patient on opioid therapy should engage in as a matter of course, and especially triggered and enhanced when the patient engages in red flag behaviors. All three agree on what these pertinent red flag behaviors are. All three agree on monitoring practices that include periodic and random UDS testing, pill counts, discussing how well or not the patient's pain control is at each visit and recording that information within the patient's medical record, and being mindful of patients' psychological health and of a family or the patient's own prior history of addiction. All three agree on the need to refer a patient showing evidence of drug diversion or use of illicit drugs to an addiction specialist for an evaluation and for any needed treatment.

All three physicians recognize that satisfying the standard of care can be challenging when involved is a patient who is difficult to treat because of pain that will always be present despite injection procedures and opioid medications offering some measure of pain relief. Such patients may face a danger in becoming overly dependent upon and even reaching addiction to their opioid pain medication. Such patients may engage in diversion, or turn to illicit drug use in a quest to secure more pain relief. The profile of such patients often included social, family and work stresses that complicated use of high dose opioids for long time periods. Such patients may require psychiatric evaluation and on-going care. Most of the patients listed in the Statement of Allegations carried this profile. Whether Dr. Ogoke provided any substandard care to them is addressed in the findings made in each patient's section in this Recommended Decision.

During the time period reflected in the Statement of Allegations, Dr. Ogoke made each patient on opioid therapy enter into a narcotics agreement with him. He had to be sure the patient understood the terms and conditions necessary to follow to be prescribed opioids. Dr. Ogoke had to engage in pertinent monitoring of the patient's ongoing proper use of the prescribed opioids, and he had to periodically re-evaluate the patient's pain before continuing to prescribe high dose opioid medications. Dr. Ogoke had to engage in an increase in monitoring if any red flag conduct by the patient emerged. Such red flags included: a suspect UDS showing even with re-testing of the urine specimen, the use of an illicit drug or not taking the prescribed opioid medication properly; asking for early medication refills; claiming lost medication and wanting another prescription; and, refusing the interventional procedures but wanting to continue on opioid therapy including higher dose opioid medications. To be within the standard of care, Dr. Ogoke had to turn to monitoring tools such as: random pill counts; securing a police report to support claims of stolen or lost medication (as a first step to any consideration for receiving a

substitute prescription); discussing with the patient the red flag conduct with a warning on the need to stay compliant in taking medication as prescribed; administering UDS testing and having a protocol in place for what to do if the UDS results were showing the patient was being non-compliant or even using illicit drugs (such as evaluation by an addiction specialist); and, at times terminating the patient for violating the narcotics agreement (including when the patient refused to comply with the treatment plan by refusing to have interventional procedures, but wanting to continue with the high dose narcotics regimen).

Dr. Satwicz thought, at times, that when the patient appeared to have engaged in red flag behaviors, he wanted to read within the medical records such concerns sufficiently addressed by Dr. Ogoke. He opined that Dr. Ogoke violated the standard of care when he failed to adequately explain in a visit report after a red flag behavior was uncovered, why he had continued to prescribe opioid medications to the patient. Whether in all circumstances involving the patients listed within the Statement of Allegations Dr. Ogoke satisfied the standard of care in adequately addressing red flag behaviors is addressed in the separate sections on each patient included in this Recommended Decision.

I conclude that Dr. Ogoke did not engage in overall practices that left his patients with no reliable options for continuing pain management care, including continuing narcotics therapy with other caregivers, when he terminated them from his care. His method of terminating care was not proven to be inherently dangerous to these patients. Dr. Ogoke provided these patients with a list of alternative pain management providers, detoxification facilities or addictionologists if that was needed, and thirty days of continuing care with his office as a bridge for them to establish new on-going care. If detoxification was not an issue, Dr. Ogoke would continue on-going opioid prescriptions so patients would not face withdrawal symptoms before establishing

new on-going care. He expected such patients to seek alternative care options, and to pursue his suggested alternative locations for pain management. He not give a patient terminated from his care months and months of opioid medication, even if the patient refused to pursue alternative care.

The charge that Dr. Ogoke needed to always taper patients terminated from his care off their opioid medications before ending their care was not proven to be necessary to avoid a violation of standard of care. No evidence proved these alternative pain management providers in the same geographical area did not exist, or were closed to new patients, or that no physician could be found in the region by the patient to take over care from Dr. Ogoke. If a patient failed to pursue alternative care and Dr. Ogoke had just cause for the termination of care, then there was no automatic violation of standard of care by Dr. Ogoke for not first tapering patients off their opioid medication.

The testimony of Dr. Ogoke and Dr. Trescot was relied upon to prove this conclusion. Dr. Ogoke did not mislead his patients on long-term opioid therapy that he would taper them off their opioid medications when he had cause to terminate them from care because they had narcotics agreement violations, usually more than one such violation and usually due to use of illicit drugs, or because they refused for long time periods to have the injection treatments that were an integral part of their treatment plans. Dr. Ogoke explained credibly that he is not an expert in treating addiction to prescribed opioids or in addressing patients' use of illicit drugs. Dr. Ogoke explained well that a patient not agreeing to have injection treatments that were part of the treatment plan meant that patient would not need his expert pain management care, and that the patient's pain medications were able to be addressed by other physicians. When a patient was compliant in satisfying the treatment plan but wanted to taper-off opioid medications,

Dr. Ogoke would not refuse to do that. The sections in the Recommended Decision on the particular patients listed in the Statement of Allegations, when there was a charge made against Dr. Ogoke in how he terminated care, contain specific findings and conclusions about why and then how the care ended. When this was an issue, the findings showed patients who insisted on receiving their on-going opioid medications with no interest in being tapered-off opioid medications. Or, the findings showed patients who wanted pain medication, but insisted on not having injection procedures.

Summary

This case had charges against Dr. Ogoke that I conclude did not hold-up to scrutiny when the underlying documents and medical records were examined in full along with the testimony presented. Often the evidence to support an allegation of substandard care did not cover the full picture of the course of care the patient received and why Dr. Ogoke engaged in particular treatments for a patient. This included addressing: why he prescribed as he did; engaged in a particular interventional procedure; the kind of monitoring he did of his patients receiving an opioid medication regimen; why he chose a route to either terminate a patient's care or to permit a patient to continue in his care and to receive further opioid therapy; and, why he did not taper a patient off opioids before terminating care such as when a patient refused to have further interventional procedures that were part of the treatment plan and just wanted to have opioid therapy. The following sections on each patient's care with Dr. Ogoke are intended to support my conclusions on whether particular charges made against Dr. Ogoke regarding a particular patient were proven. In reviewing each patient's course of care with Dr. Ogoke, this section's findings of fact and my conclusions reached on them, are incorporated into the following sections of this Recommended Decision.

Patient A

Summary

Patient (Pt.) A did not testify.

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine below the standard of care for having:

- prescribed an excessive dose of Methadone to Pt. A;
- insisted that Pt. A receive injection treatments despite warnings from Pt. A's primary care physician and cardiologist not have them because he had to remain on Coumadin, a blood thinner medication;
- told Pt. A he would no longer provide him with pain medications because he would not have injections;
- was not available to be reached by Pt. A's wife or by hospital personnel when Pt. A presented at a hospital emergency room in October 2005, which occurred after he had started taking Methadone that Dr. Ogoke prescribed.

The facts the BORM alleged to support its contentions that Dr. Ogoke violated standard of care in the practice of medicine include the following:

- Pt. A, born in 1950, saw Dr. Ogoke for pain relief for chronic back and lower extremities pain.
- Pt. A carried diagnoses of: lumbar sprain; lumbar facet arthropathy; lumbar degenerative disk disease; lumbar spine post-laminectomy syndrome; sacroiliitis; cervical strain; cervical disk herniation at C7-T1; and, paraplegia of the bilateral lower extremities status-post spinal cord injury.
- Pt. A suffered injuries in a motor vehicle accident in 2000 which left him wheelchair dependent.
- When Dr. Ogoke began to treat Pt. A in December 2004, he prescribed Oxycontin 80 mg. to take three times a day for pain relief (240 mg. a day).
- Dr. Ogoke informed Pt. A that he was going to add injections to his pain management regimen. Pt. A was on Coumadin medication and informed Dr. Ogoke that his primary care physician and cardiologist advised him not to have interventional procedures.
- Dr. Ogoke informed Pt. A that he would need to end his care if he did not want to have the injection procedures.
- By October 2005, Pt. A was having difficulty getting his insurer to approve his Oxycontin prescription. Because he could not secure the insurer's approval for this medication, Dr. Ogoke converted his Oxycontin prescription

to Methadone. This new prescription of Methadone 40 mg. to take three times a day (240 mg.) was an excessively large dose for Pt. A.

- After Pt. A had taken the first few doses of Methadone, he became somnolent and was seen at a hospital emergency room. Pt. A's wife tried while at the emergency room without success to reach Dr. Ogoke's office.
- Within his visit reports on Pt. A, Dr. Ogoke did not include the full information on his opioid prescriptions.

Findings of Fact

1. Pt. A was born in 1958. He was referred to Dr. Ogoke by his primary care physician (PCP), Dr. Shirley Whitaker, to "evaluate" him "for better pain control" for chronic neck and low back pain. Pt. A was status-post lumbar and cervical laminectomies, had sacroiliitis, and suffered from lower extremities parathesias (burning, pins and needles sensations). He had been in a car accident in 2000, after which he was wheelchair dependent. Dr. Ogoke evaluated Pt. A on December 27, 2004. He saw a list of the medications Pt. A was taking. He was on opiates: Oxycontin 80 mg. (270), three tablets taken three times a day, and Percocet 5/325 mg. (360), two tablets taken every four hours. Dr. Ogoke opined that these were high amounts of opiates taken each day. At the same time Pt. A was taking other non-opioid medications: Selaxin 800 mg. two tablets taken two times a day; Lanoxin .25 mg. two tablets taken three times a day; Zanaflex 4 mg. one tablet taken three times a day; and, Neurontin 800 mg., the high end dose for this medication. (Ex. 43: 28/2; 31/31; 33-35/33-35 & 70-75/70-75. Exs. 96 & 97. Testimony of Dr. Ogoke, Vol. V, 931-933.)

2. In 2004, according to Dr. Trescot, it was not unusual to have PCPs prescribing opioids at these doses before referring the patient to a pain management specialist. She noted that now that would not likely occur, and the PCP would not be prescribing high opioid doses. A referral to a pain management specialist would occur before that would happen. (Testimony of Dr. Trescot, Vol. XIV, 2701-2702.)

3. At his initial evaluation with Dr. Ogoke, Pt. A completed a number of new patient forms including consent to treatment, health insurance information, pharmacy information, and agreeing to the policies of Dr. Ogoke's practice that included undergoing injection treatments. Pt. A provided information about his condition and treatments, including information on his social, work and medical histories, current pain complaints, and accidents or injuries sustained. He signed Dr. Ogoke's Narcotic Prescription Policy & Agreement (narcotics agreement) to be compliant in taking medications as prescribed. Pt. A reported injuries from an October 2000 car accident triggering on-going pain in his low back and neck that could be sharp and shooting. He reported using a wheelchair since then. He also complained of lower extremity pain. He reported that pain symptoms were worse when he was not taking pain medications. He also reported having had surgeries in 1984, 1985, 1990, and 2000, including to his neck (in 1985) and two surgeries to his low back. He reported heart valve and gall bladder surgery in 2002. Pt. A noted he did not use alcohol and had some anxiety symptoms. He listed the level of his current pain as 8/10. He reported that he was not engaged in any workers compensation issues or any litigation in connection with the car accident. (Ex. 43: 23-24/23-24; 32-33/32-33; 46-49/46-49; 70-75/70-75; 83-84/83-84; 104-105/104-105 & 120-121/120-121.)

4. The day after the initial evaluation, Pt. A's wife, who accompanied him on medical visits and was aware of his pain issues and treatments, brought to Dr. Ogoke's office Pt. A's medication containers for a pill count to determine if Pt. A was taking his medications as prescribed. This procedure revealed that in mid-December 2004, Pt. A had prescriptions for Roxicet (Percocet) 5/325 mg. (360), Oxycodone SR 80 mg. (Oxycontin) (30), and then a few days later Oxycodone 80 mg. (270). (Ex. 43; 31/31 & 70/70. Exs. 20, 85, 95, 97, 111 & 112.)

5. At his first visit, Pt. A had completed a personal and medical background

questionnaire that included shading in the areas on a body diagram where his pain was located. Dr. Ogoke did a review of systems, conducted a physical examination, and took a comprehensive history from Pt. A. He ordered cervical spine x-rays and new MRIs of the cervical and lumbar spines. He had Pt. A undergo physical therapy from January 4-20, 2005 for knee complaints. Dr. Ogoke wrote new opioid prescriptions to substitute for his current opioid prescriptions; Oxycontin 80 mg. (120) and Percocet 7.5/325 mg. (90) for break through pain. The Percocet was at a higher dose level than Pt. A had been taking. This initial prescribing had Pt. A receiving a decrease in the amount of the long-acting opioid, the Oxycontin 80 mg., toward weaning Pt. A off a sustained high level of opioid medication. To avoid any issues with withdrawal symptoms, Pt. A received a higher dose level of the short-acting opioid, Percocet, as a bridge to reach a decreased level of opioid medication. Dr. Ogoke also prescribed Neurontin 800 mg. (90). Dr. Ogoke made diagnoses and plans for treatment that included interventional procedures to better target the core pain locations, and if successful, to allow for a reduction in the need for high doses of opioids. Before he had the new MRIs, Pt. A returned to Dr. Ogoke's office on January 5, 2005. Pt. A received prescriptions for Oxycontin 80 mg. (270) and for Percocet 5/325 mg. (360). These were the opioid medication doses and amounts to take per day that Pt. A had taken for about a year prior to first seeing Dr. Ogoke. Dr. Ogoke did not continue to prescribe for Pt. A, decreased amounts of the Oxycontin 80 mg. to take per day or the higher dose level of Percocet to take per day for break-through pain as initially prescribed. Dr. Ogoke did not explain why he did not give more time for Pt. A to taper down to lower daily opioid amounts. (Ex. 43: 14/14; 22/22; 27-30/27-30 & 51/51. Exs. 75, 78 & 81. Testimony of Dr. Ogoke, Vol. IV, 892-893; 949-950.)

6. Pt. A came to Dr. Ogoke's care already taking high opioid doses that in the opinion of

Dr. Satwicz were not appropriate for treating non-cancer pain of the kind Pt. A had, even if the pain was chronic. Dr. Satwicz opined that Dr. Ogoke did his evaluation of Pt. A before altering that medication regimen, and did not mention in his report of the evaluation whether Pt. A showed signs of hyperalgesia (an increased sensation to pain) despite this being a known side effect from taking high doses of opioids. According to Dr. Satwicz, because Pt. A came into Dr. Ogoke's care on high doses of opioids, a dramatic decrease made in his opioid level would have caused withdrawal symptoms. Dr. Satwicz expected to see in the medical records, and did not, a discussion in the initial evaluation report of a plan to taper-off or decrease Pt. A's doses of opioids. Dr. Satwicz testified that a general method used to do this tapering is to lower the dose of the long-acting opioid, here, the Oxycontin prescription, but at the same time keeping the break-through pain opioid medication, here Percocet, at a high level because that would be used only as needed. Although Dr. Satwicz acknowledged that Dr. Ogoke engaged in this general method at the initial evaluation, he did not maintain the tapering over a meaningful length of time. The February 8, 2005 prescriptions had the Oxycontin dose at 80 mg., but back to taking three tablets taken three times a day, while the Percocet prescription was decreased in strength to the 5/325 mg. level that Pt. A had been on before treating with Dr. Ogoke. June 20, 2005 prescriptions showed no changes in these two prescriptions. (Testimony of Dr. Satwicz, Vol. IX, 1750-1761 & Vol. XIII, 2448-2476.)

7. Dr. Ogoke opined that Pt. A presented,

with a very high dose of opioids ... considered to be very unusual in the kind of clinical situation that patient was ... in ... My initial response to that was to do a thorough review by getting all the records ... to make sure what was going on and initially decided to write an initial prescription for this patient that was only 80 milligrams of Oxycontin ... twice a day

Dr. Ogoke wanted Pt. A to rely more on the breakthrough opioid medication and rely less on the

longer-lasting opioid in a plan to decrease the overall dose of opioid, so he increased the Percocet dose to 7.5/325 mg. (360). (Testimony of Dr. Ogoke, Vol. V, 947.)

8. Dr. Trescot explained that Percocet is an Oxycodone medication. It is just a different formulation of Oxycodone than Oxycontin. Dr. Trescot explained why she did not think that Dr. Ogoke was overprescribing Percocet due to the acetaminophen (Tylenol) component in it. Dr. Trescot noted that in 2005, Dr. Ogoke was prescribing within FDA guidelines by having Pt. A take the acetaminophen at 325 mg. with one or two tablets every four to six hours. In 2005, Tylenol had not been accepted as a clear risk for liver damage when prescribed in high doses; that this was first acknowledged in 2006. (Testimony of Dr. Trescot, Vol. XVI, 3086-3102.)

9. Pt. A had a cervical spine MRI on January 14, 2005, a lumbar spine MRI on January 17, 2005, and cervical x-rays on January 21, 2005. The cervical MRI showed:

Questionable bilateral foraminal stenosis at the C2/3 level. C3 through C5 fusion with obscuration of the neural foramina by metallic artifact. Minimal anterior extradural defect at C5/6 with improvement since 3/30/02. Small central disc herniation at C7/T1 of doubtful significance. Stable small area of presumed myelomalacia at C4/5.

The cervical x-rays showed: "No evidence of instability. Status post fusion at C3, 4, 5." The January 2005 lumbar MRI showed:

Status post left laminectomies at L3-L4 and L4-L5 levels with some postoperative changes. No significant scar is seen. No disk herniation, stenosis or neural foramen narrowing.

No significant interval changes as compared to prior study.

(Ex. 43; 7-8/7-8 & 18-24/18-24. Exs. 70, 76 & 78.)

10. Dr. Trescot reviewed the January 14, 2005 cervical MRI and addressed Pt. A's prior cervical surgery:

A laminectomy takes off that whole arch [where the muscles attach to the spine] leaving a spinal cord exposed and leaving the joints in the neck which are called

facets now responsible for moving but without any of the limits that the back of the spine bones help provide, so you end up with too much movement. And as a result, when those surgeries are done, there is usually also fusion of the joints so those joints don't move. But that means then all the neck since it's designed to move, all the movement of the neck then has to occur either above or below that.

It also means that it limits severely the types of interventional pain procedures that we potentially can do since most of what we do is working in that space between the bone and in the back of the neck and the spinal cord which is called the epidural space. When that laminectomy surgery is done, the epidural space gets scarred down and that space is no longer available for us to put in medications, stimulators or catheters ... [I]t negates the vast majority of interventional procedures we can do to help the patient.

Dr. Trescot opined Pt. A would be a "severely traumatized patient" after undergoing this cervical laminectomy and the motor vehicle accident. (Testimony of Dr. Trescot, Vol. XIV, 2695-2697.)

11. Dr. Ogoke reviewed Pt. A's May 24, 2002 lumbar MRI for low back, bilateral leg and foot pain that showed:

[M]inimal scar associated with the thecal sac. Lateral recess stenosis most severe at L3-4 on the right and L4-5 on the left. No evidence of syrinx.

Dr. Ogoke reviewed Pt. A's head MRI from April 13, 2003 that showed:

Mild atrophy. Minimal bilateral white matter disease and abnormal T2 signals within the basal ganglia. The findings suggest chronic ischemic changes. No acute infarct, hemorrhage or tumor.

(Ex. 43, 23-26/23-26. Exs. 79 & 80.)

12. Pt. A was evaluated again at Dr. Ogoke's office on February 8, 2005, including a physical examination. He reported pain at a 6-7/10 level in the neck and lower back that was moderate, achy and constant. He reported pain medications were very effective in controlling his pain. A report was produced on this visit that included a list of diagnoses:

1. Lumbar sprain.
2. Lumbar facet arthropathy.
3. Lumbar degenerative disk disease.
4. Post-laminectomy syndrome of the lumbar spine.
5. Sacroiliitis.

6. Cervical strain.
7. Post-laminectomy syndrome of the cervical spine.
8. Cervical disk herniation at C7-T1.
9. Cervical myelomalacia at C4-5.
10. Paraplegia of the bilateral lower extremities. Status post spinal cord injury.

The report included a list of plans:

1. The patient will continue with his current medications.
2. Need to speak with the patient's cardiologist prior to offering interventional procedures at this point.
3. Will maintain the patient on his current pain medications as they are effective in controlling the patient's pain..
4. The patient will follow up in four weeks or sooner if needed.
5. I reviewed the results of the cervical and lumbar MRI with the patient in full today. His questions were answered and his concerns were addressed.

Pt. A received prescriptions of Oxycontin 80 mg. (270) and Percocet 5/325 mg. (360). The report of this visit contained no discussion about why the reduced Oxycontin amount to take per week with the higher Percocet dose to take for break through pain was stopped. Pt. A's February 8, 2005 opioid prescriptions were renewed on March 8, 2005. By this time, Dr. Ogoke found a need for Pt. A to undergo interventional procedures and not to only stay on medications to treat his pain.

[T]he key for sending someone for interventional pain evaluation and treatment is to treat the pain generators and reduce the need for the patient's high dose of opioids as in this case.

(Exs. 43; 15-16/15-16 & 66-68/66-68. Testimony of Dr. Ogoke, Vol. V, 950-952.)

13. Pt. A was seen at Dr. Ogoke's office on April 5, 2005. He reported an 8-9/10 pain level and needed prescription refills. The refills were given and were filled following approvals to do this from Pt. A's health insurer; Oxycontin 80 mg. (270) and Percocet 5/325 mg. (360). Pt. A was complaining of knee pain and was having "multiple spasms involving lower extremities, as well as hamstrings ... can't feel both lower extremities because of his paraparesis

as opposed to flaccid.” The treatment plan was to do a sacroiliac (SI) joint injection. Pt. A was prescribed Ativan 2 mg. (2) for the procedure due to Pt. A’s anxiety condition. Pt. A was told that he would need to be off his Coumadin medication (blood thinner) for a few days before the procedure, but after the procedure he could resume taking the Coumadin. To briefly interrupt taking Coumadin for a few days to have an interventional procedure is not out of the ordinary and was recommended by Dr. Ogoke so long as Pt. A had the approval to do this from his PCP or from his cardiologist. Dr. Ogoke asked for a note or a call from either physician providing their agreement that Pt. A could stop the Coumadin for a few days. On April 7, 2005, Pt. A’s SI injection could not be given because Pt. A had not stopped the Coumadin. Pt. A informed Dr. Ogoke that he could not stop the Coumadin as per his PCP’s orders. This response was not accepted as a substitute for a call or letter from either the PCP or the cardiologist. On April 7, 2005, Dr. Ogoke’s office wrote Pt. A another prescription for Ativan 2 mg. (2) to use for the SI injection. The medical records listed no new date for the SI injection, and there was still the need to have the PCP or the cardiologist approve of stopping the Coumadin for a few days to permit the injection. (Ex. 43: 5-6/5-6; 9-13/9-13 & 63-64/63-64. Exs. 67, 68, 69, 70, 71, 72, 73 & 74. Testimony of Dr. Ogoke, Vol. V, 953, 956, 967-968.)²³

14. Dr. Trescot explained the importance of having Pt. A be off Coumadin in order to have the interventional procedure, and why Dr. Ogoke was within the standard of care in requiring that Pt. A provide direct information to him from the PCP or cardiologist:

[W]hen you are talking about working around or inside the spinal column, if there is bleeding inside the spinal column, then that puts pressure on the spinal cord and causes paralysis. So where we might be willing to leave somebody on

²³ The BORM contends that the physician assistant all on her own decided on April 7, 2005 to instruct Pt. A to stop taking the Coumadin and prepare for the SI injection by prescribing the Ativan. This was not proven. Whether Pt. A could have the SI injection was still dependent upon receiving approval from either the PCP or the cardiologist. It was not proven that the physician assistant received that okay by April 7, 2005 when the Ativan prescription was written.

Coumadin for a procedure outside the spinal column with a very low risk of bleeding, we are usually not willing to leave people on any kind of medicine that promotes bleeding when you are working around the spinal column.

...

In this situation it [is] appropriate [for Dr. Ogoke to be seeking direct information from the PCP or cardiologist] because ... Dr. Ogoke is being put between a rock and [a] hard place. He has a patient on very high doses of opioids that has something that might be treatable that might allow Dr. Ogoke to be able to lower the dose of pain medicine ... [Dr. Ogoke wants] something in my record that shows why I can't do interventions on this patient because you think it's not safe to come off the Coumadin.

(Dr. Trescot, Vol. XIV, 2710-2713.)

15. Dr. Satwicz opined that it would have been a better practice to have a patient off Coumadin for longer than just two days and closer to four to five days before an interventional procedure such as an SI injection would be given to a patient like Pt. A:

We like to keep the time [off Coumadin] to a minimum but long enough to get the INR down to a safe level.

Dr. Satwicz would have checked Pt. A's INR level (a blood test done to determine how long it takes for blood to clot) as close to the procedure being done as possible. This is because of the extraordinary variability of Coumadin and the difficulty of monitoring and following the INR to have it in a target range before doing the procedure. He did not find in Pt. A's medical record the reason Pt. A was on Coumadin, but Dr. Satwicz presumed it was due to peripheral vascular disease, narrowed blood vessels, coronary artery disease, or some other condition making Pt. A susceptible to blood clots. He did not take issue with Dr. Ogoke prescribing Ativan for use by Pt. A to lower his anxiety level before having the SI injection. But, Dr. Satwicz would have liked to see a discussion in the medical records why Pt. A was given another Ativan prescription on April 7, 2005 after Dr. Ogoke's office learned he was still on Coumadin and could not have the SI injection. (Testimony of Dr. Satwicz, Vol. IX, 1766-1779 & 1785-1788.)

16. The Coumadin issue continued to prevent Pt. A from receiving the SI injection. At a May 2, 2005 visit at Dr. Ogoke's office, Pt. A complained of a pain score of 9/10. He described worsening low back pain as the day progressed. Pt. A's wife was at this visit and explained that Pt. A's PCP, Dr. Price, recommended against the SI injection because it would be too risky for Pt. A to be off Coumadin for two to three days. She said that Dr. Price explained that, for instance, Pt. A might not notice symptoms of a blood clot in his legs when off Coumadin due to his lower extremity condition. Pt. A's wife noted that they had not spoken to Pt. A's cardiologist about this. Pt. A was counseled that Dr. Ogoke should be contacted directly by both Dr. Price and the cardiologist, Dr. Chircop, to discuss this issue. This was to be accomplished by Pt. A's next visit. At this May 2, 2005 visit, Pt. A received one month prescriptions for refills of the Percocet 5/325 mg. (360) and Oxycontin 80 mg. (270). No changes were made in the strength or doses of these ongoing opioid prescriptions. Authorizations for continuing to have the costs of these medications covered by Pt. A's insurer were addressed by Dr. Ogoke's office. (Ex. 43: 60-62/60-62; 118-119/118-119 & 122/122.)

17. At an office visit on May 23, 2005, Pt. A gave a urine specimen for a urine drug screen (UDS) to determine if he was taking opioid medications as prescribed, in accord with the narcotics agreement that he signed. The UDS result was positive for the opioids he was being prescribed and negative for any illicit drugs or alcohol. Also on May 23, 2005, Pt. A received prescriptions for the same doses of Percocet 5/325 mg. (360) and Oxycontin 80 mg. (270). This meant that his prescriptions were refilled within just three weeks of time that the prescriptions were written other than when they would have run out in four weeks' time. Dr. Satwicz would have expected to see some reason for early prescription refills in Pt. A's medical records. An early refill of an opioid prescription raises a red flag situation that the patient may not be in

compliance with taking medications. Dr. Ogoke's office continued to gain approval for the opioid prescriptions from Pt. A's insurer. On June 20, 2005, Pt. A again received the same prescriptions for Oxycontin 80 mg. (270) and Percocet 5/325 mg. (360). (Ex. 43; 110-116/110-116 & 118-119/118-119. Exs. 11, 20, 85, 95, 111 & 112. Testimony of Dr. Satwicz, Vol. IX, 1779-1781.)

18. Pt. A was seen at Dr. Ogoke's office on July 15, 2005. By then, neither Dr. Price nor Dr. Chircop had discussed with Dr. Ogoke or written to him anything about the Coumadin issue. Pt. A continued to verbally report that Dr. Price advised against stopping the Coumadin. A physical examination was done. As a result of this visit, no injection treatments were scheduled and no changes were made in terms of maintaining Pt. A on his ongoing opioid medications. At this visit, Pt. A reported a pain level of 7/10, and that use of the opioids was effective in controlling the pain. He reported having experienced "severe stomach pain" and was seen at an emergency room, and was having a workup and treatments with a gastrointestinal specialist. The same prescriptions for Oxycontin and Percocet were written for Pt. A on August 12, 2005. The same Oxycontin and Percocet prescriptions were written on September 2, 2005 along with a new opioid prescription for Oxycodone 15 mg. (90). Also at these three visits, Pt. A received a prescription for Zanaflex 4 mg. (180). (Ex. 43; 89-90/89-90 & 106-109/106-109.)

19. By an October 3, 2005, office visit, Pt. A had still not undergone any interventional procedures and none were planned because of no agreement to stop the Coumadin medication for a few days received directly from either Pt. A's PCP or cardiologist. Pt. A was prescribed the same opioid medications; Oxycontin 80 mg. (270), Percocet 5/325 mg. (360), and Oxycodone 15 mg. (120). He was also prescribed Lyrica 150 mg. (60) and 150 mg. (14). (Ex. 43, 96-103/96-103. Ex. 104.)

20. On October 25, 2005, Pt. A was seen at Dr. Ogoke's office complaining of a 7/10 pain level in his back and neck. The same issue remained that Dr. Ogoke had no report or call from Dr. Price or Dr. Chirop about being able to stop the Coumadin long enough to permit scheduling of any injection treatments. Dr Ogoke had also tried to reach both physicians by telephone without success. A physical examination was given. Pt. A had not tried the Lyrica that had been prescribed. He was going to continue to use Neurontin instead. (Ex. 43: 52/52; 76-78/76-78; 86/86 & 103/103.)

21. By October 25, 2005, the insurer stopped approving the Oxycontin prescription, an expensive medicine. The Oxycontin prescription was stopped. An updated treatment plan was determined for Pt. A. Pt. A was started on Methadone 40 mg. (180) two tablets three times a day to reach 240 mg. of this medication per day. A conversion process from Oxycontin to Methadone was done. The Oxycontin prescription had been a much larger opioid dose than this Methadone prescription was providing, and Pt. A was also on more Oxycodone based opioid through the Oxycodone 15 mg. and the Percocet 5/325 mg. Pt. A was instructed by Dr. Ogoke's office to return for a follow up visit in one week or sooner if he had any troublesome symptoms, including withdrawal symptoms, from taking the Methadone. The prescriptions for Oxycodone 15 mg. (120) and the Percocet 5/325 mg. (360) were not discontinued. Authorization was received from Pt. A's insurer for the Methadone prescription. At this meeting, Pt. A and his wife were told that care would need to end with Dr. Ogoke unless Pt. A had the interventional injection procedures. (Ex. 43: 86-87/86-87; 92-95/92-95 & 103/103. Exs. 83, 95, 98 & 103. Testimony of Dr. Ogoke, Vol. V, 991, 993.)

22. Dr. Satwicz testified about switching from one opioid to another when the opioid having been taken is at a high dose and amount per day as was Pt. A's Oxycontin prescription.

He noted it “is a major event ... a very difficult process.” He explained that taken “into account [is] the potency or how strong each medication is ... [T]here are a variety of tables that are used to compare the equal analgesic level of one opioid and another.” The “base unit that’s used as the converting factor is Morphine ... everything is compared to Morphine and discussed in Morphine equivalence.” Pt. A was at the time the conversion to Methadone was made, on very high doses of opioids from Oxycontin, Oxycodone and Percocet. The conversion to Morphine would result in a high amount. Dr. Satwicz opined that when this conversion to Methadone occurred, Pt. A was “dependent” on his opioid medications. Dr. Satwicz recognized that there are a variety of conversion tables to use to compare equal analgesic levels of different opioids.

Oxycodone is a bit stronger than Morphine, the Morphine number of milligrams would be greater with conversion by 20 or 30 percent.

If his opioid medication had been stopped, he would have suffered withdrawal symptoms. When converting to Methadone, Dr. Satwicz explained:

[W]e typically take that dose and knock it down by approximately 50%, 30% to 50%, because the tolerance that they had to Oxycodone, there’s incomplete tolerance to the other opioids so they need less of the new opioid.

Methadone ... is really in a class all by itself ... very different from any of the other opioids because of the extremely variable response to Methadone. And the relative response of Methadone is not linear with the Morphine equivalence.

[T]he Methadone is about four times as strong as a milligram, one milligram of Morphine ... [T]he higher the Morphine dose, the relative potency of Methadone increases ... Methadone of all the opioids that we prescribe is the most difficult to prescribe ... has the most variable metabolism in any patient.

[W]hen ... you do all the calculations, almost no matter what dose of Morphine equivalence they are on, it comes down to starting Methadone at maybe 5 milligrams three times a day. That’s the starting dose for somebody who has been on opioids.

Dr. Satwicz addressed the dose of Methadone that Pt. A was started on of 80 mg. taken 3 times a day, or 240 mg. of Methadone a day.

That is beyond an extraordinary high dose of Methadone. That's a supramaximal dose for anybody ... It's just beyond anything that is reasonable.

(Testimony of Dr. Satwicz, Vol. 9, 1790-1797.)

23. According to Dr. Trescot:

[M]ethadone ... [although] not formulated to be long acting ... is actually inherently long acting. The medicine itself lasts for a long period of time. That's why it was useful in treating addiction because ... you can give ... methadone once a day and wean ... [the patient] from withdrawal. We have since recognized it is a very good pain medicine. It usually needs to be taken two or three times a day, ... for pain. It works on a different mechanism than any of the other opioids do, ... There is a receptor that is near the opioid receptors that is associated with tolerance and with nerve pain ... Methadone, unlike almost any other opioid, blocks that receptor which makes it particularly useful for nerve pain, for nerve damage. It also uniquely is not associated with the euphoria that we see in other pain medicines. And it is uniquely cheap.

Dr. Trescot opined that this Methadone prescription was appropriate for Pt. A because it was more effective for nerve pain than Oxycontin, and because it was a medicine that was more affordable than Oxycontin. Dr. Trescot addressed the conversion that practitioners may do from the Oxycodone to the Morphine equivalence, and then to the Methadone dose. She explained that the conversion that was done for Pt. A's Methadone prescription was within an accepted conversion range. She explained that Oxycodone has a 2:3 Morphine equivalence. For Dr. Trescot, Pt. A was receiving a much lower Morphine equivalence for Methadone when he was taking 240 mg. of Methadone a day. He had been taking much higher doses of Oxycodone based medication each day when the Oxycontin, the Percocet and the Oxycodone prescriptions were totaled.

The higher the dose of Morphine, the more likely there is a ... hyperalgia [increased sensitivity to pain], and therefore the greater, the more potent, the more relevant potency the Methadone has. So at low doses it's as little as 1 to 1 [conversion rate], at higher doses it may be 3 to 1 [conversion rate], and even higher doses of Morphine equivalence it may be as much as 20 to 1.

Dr. Trescot testified that the conversion done for Pt. A to a Methadone prescription from the

Oxycontin prescription would have involved efforts to “individualize the dose” for him.

It is not done on a weight basis, it's influenced by the patient's prior opioid use, by their metabolism both genetic and the influence of other medicines that they are taking ... [W]e have some rough guidelines that we go by in terms of equivalents of medicines, and then we try to modify those.

So in general when we're trying to switch a medicine over, we try to put all the medicines into one unit, ... By convention we try to convert everything to what we call Morphine equivalents. So whether we are looking at Oxycodone or Oxymorphone or Fentanyl or Dilaudid or any of the medicines, when we are trying to switch, we try to figure out what the Morphine equivalent would be. At that time [October 2005] the recognized relationship ... was a ratio of two to three, that two milligrams of Oxycodone was equivalent to three milligrams of morphine. So to convert this into Morphine equivalence, you would take the number of milligrams which is 80 times nine and then you would ... multiply by three and divide by two.

It comes out to about 1100 milligrams of Morphine.

What has been done here is that the 1100 milligrams of Morphine have been converted to 160 milligrams of Methadone, so the dose has been cut by nearly 90 percent.

[T]hat's because Morphine and Oxycodone and many of these medicines actually cause what we are terming hyperalagia, a metabolite that's most clear on Morphine, that the metabolites on the drug cause pain and the higher the dosage of opioid, the more pain the patient ends up having.

So you can't do a milligram per milligram the way some old charts did because you would overdose, so you dramatically underdose and then you try to give some extra medicine in case you have underdosed enough that they would go through withdrawal without the extra medicine.

(Testimony of Dr. Trescot, Vol. XIV, 2717-2718, 2720-2725 & Vol. XVII, 3257-3265.)

24. In 2005, there was no single accepted conversion rate for Methadone. Dr. Ogoke's office gave a prescription to Pt. A on October 25, 2005 of Methadone 80 mg. taking two tablets three times a day for a total daily dose of 240 mg. This was a lower Morphine equivalency level than the Oxycodone in the form of Oxycontin, Oxycodone, and Percocet that Pt. A had been taking. This was done in light of cautions known by then that converting to high doses of

Methadone can be unpredictable and potentially dangerous. In addition, Pt. A was kept on the short-acting Percocet prescription and given an Oxycodone 15 mg. prescription in case the conversion to Methadone was too much of an underdosing and Pt. A experienced withdrawal symptoms. (Ex. 43, 94-95/94-95. Exs. 98 & 103. See Ex. 111 at p. 606, table 31-3. Testimony of Dr. Trescot, Vol. XIV, 2723-2724 & Dr. Satwicz, Vol. IX, 1791-1792.)

25. Issued in 2006 by the ASIPP, "Opioid Guidelines in the Management of Chronic Non-Cancer Pain" was an article in *Pain Physician* 2006; 9:1-40, ISSN 1533-3159, by physicians that included Dr. Trescot and Dr. Ogoke. At page 16 at 4.5 Drug Conversions, the article cautions:

While there have been multiple opioid conversion charts developed, none are reliable and none take into consideration the vast individual differences in effect and metabolism between patients and within medications ... It is ... important to recognize that "equipotent" doses of medications may have very different degrees of analgesia and side effects ... [T]he clinician must calculate a rough equivalent 24 hour dose, divide by the dosing schedule, and then "under-dose," with subsequent titration to effect ... For doses of Morphine under 100 mg., a ratio of 3:1 may be appropriate, while for higher doses of Morphine a ratio of 20 mg. of morphine for each mg. of Methadone may be appropriate ... It cannot be too strongly emphasized that the dosing of Methadone can be potentially lethal and must be done with knowledge and caution.

To Dr. Trescot, this guidance about converting to Methadone may be appropriate but was not mandatory to use to be within the standard of care in October 2005, noting that this guidance recognized that a consideration in doing the conversion for a particular patient is the vast individual differences among patients including metabolism differences. To just rely on the conversion calculations in 4.5 at page 16 would result in a range of 58.5 mgs to 390 mgs of Methadone per day. (Ex. 85. Testimony of Dr. Trescot, Vol. XVI, 3105-3112 & 3118-3121.)

26. Rai's *Practical Management of Pain*, Edition 4, was a learned treatise in 2005 for pain management specialists like Dr. Ogoke to go to for guidance when doing opioid

conversions to Morphine equivalents. At page 606, Table 31-3, there is a conversion formula range to use for guidance when converting from a particular opioid to Methadone. This conversion formula range differs from the formula calculations offered in "Opioid Guidelines in the Management of Chronic Non-Cancer Pain." Table 32-3 uses a range of 10 to 20, and yields a high dose conversion that is twice as much as what the "Opioid Guidelines in the Management of Chronic Non-Cancer Pain" at 4.5 at page 16 produces. (Exs. 85 & 111. Testimony of Dr. Trescot, Vol. XVII, 3260-3264.)

27. Pt. A began taking the Methadone prescribed. On October 30, 2005, Pt. A was seen at the Baystate Medical Center Emergency Room. He came with issues of somnolence/sleepiness. He had not at any time prior to this, gone to Dr. Ogoke's office about these symptoms. He was not hospitalized overnight. He received a discharge instruction sheet that listed his medical condition as "narcotic overdose." He was told to stop taking the Methadone. For the night of his hospital discharge, he was given a prescription for Oxycontin, or Dilaudid. He was instructed to follow-up with his PCP the next day. The next day, Pt. A went to Dr. Ogoke's office and not first to his PCP. (Ex. 43, 82/82. Ex. 83.)

28. Pt. A showed the hospital discharge instructions sheet he had been given. Dr. Ogoke's office gave Pt. A a prescription for what he had been taking prior to the switch to Methadone of Oxycontin 80 mg. (270). On November 4, 2005, Dr. Ogoke's office wrote Pt. A a prescription for Oxycontin 80 mg. (90). When Dr. Ogoke's office wrote to secure coverage of this Oxycontin prescription from Pt. A's insurer, the authorization form noted that Pt. A had an adverse reaction to Methadone listing "OD." Because Pt. A refused to have any injections, he understood his care with Dr. Ogoke was ending despite the new prescription for Oxycontin. No medical records on Pt. A show that Dr. Ogoke worked with Pt. A to taper him off high doses of

opioids before ending care with him. (Ex. 43; 79-82/79-82 & 91-93/91-93, Ex. 83.)²⁴

29. Dr. Trescot opined that Pt. A had not suffered an overdose of Methadone on October 30, 2005 as indicated on the hospital discharge instructions sheet, the only record of this visit available. She opined:

I suspect it was what I often will see which is reactions to a medicine ... such as sedation that is not an overdose of the medication but simply a potentially larger-than-expected effect. If the patient had truly been overdosed, they should have been admitted and monitored ... [I]t's very difficult to pick a dose of Methadone to start a patient [on] who is on such high doses of a medicine like Oxycontin, and so this was a reasonable attempt to do it. I don't know how much extra of the Oxycodone the patient took, and I don't know whether they actually may have taken more Oxycodone than they expected, because the Methadone, because it's long lasting, is also a very slow onset so you don't get the buzz that you get and would have come to expect from an Oxycodone or Oxycontin. So patients often are seen who have taken ... a pill, didn't get an immediate effect and so they took another pill.

If Pt. A had suffered an overdose, Dr. Trescot would have expected to see an admission with the hospital staff administering the drug Narcan to treat the overdose. Dr. Trescot would not have expected to have the hospital prescribe more opioid for Pt. A upon discharge. (Testimony of Dr. Trescot, Vol. XIV, 2729-30 & Vol. XVI, 3112.)²⁵

30. According to Dr. Trescot, the conversion Dr. Ogoke did for Pt. A from discontinuing his Oxycontin prescription to taking Methadone met “the recognized recommendations in the opioid guidelines and as were existing in 2005 for the conversion of a high-dose medication to Methadone.” Dr. Trescot also found supportive of Dr. Ogoke's conversion procedure and Methadone prescription, that Pt. A's insurer approved the October 25, 2005 Methadone prescription. (Ex. 43, 95/95. Testimony of Dr. Trescot, Vol. XIV, 2727 & Vol. XVII, 3264.)

²⁴ I could not locate a termination of care letter for Pt. A in Pt. A's medical records (Exhibit 43).

²⁵ The full hospital record on this visit was not found in Pt. A's medical records, just the discharge instruction sheet. The BORM did not offer the full medical record on this hospital visit. Neither Pt. A nor his wife testified. No evidence showed what medications and in what quantities and how frequently Pt. A took medication between receipt of the Methadone prescription and the hospital visit.

31. Dr. Satwicz found the Methadone 40 mg. taking two tablets three times a day as prescribed on October 25, 2005 was,

an extraordinarily high dose ... beyond anything reasonable,” and taking it was “a dramatic recipe for overdose ... Methadone accumulates over several days. Whatever you get from day one you get much more out of it by day seven or eight or ten.

He did not take issue with the hospital emergency room report that called what happened to Pt. A an overdose followed by an instruction to stop taking the Methadone. (Testimony of Dr. Satwicz, Vol. IX, 1776-1802.)

32. Dr. Ogoke opined that his conversion of the Oxycontin dose into the Methadone dose was not in violation of standard of care practicing. Dr. Ogoke noted his precautions given to Pt. A to return to him if he experienced any side effects with taking Methadone, but Pt. A did not return to Dr. Ogoke’s office as instructed when within the next five days, he did suffer troublesome symptoms. Within that time period, Dr. Ogoke’s office had no knowledge whether Pt. A was taking his medication regimen as prescribed. Dr. Ogoke had provided Pt. A with a bridge of his opioid prescriptions after terminating care with him over his inability to have interventional procedures, and he opined that this course of conduct was also appropriate. (Testimony of Dr. Ogoke, Vol. V, 993, 1003-1008.)

33. On behalf of Pt. A, his wife filed a complaint against Dr. Ogoke and his office with the BORM. Dated November 10, 2005, the complaint dealt with the care received at Dr. Ogoke’s office on October 25, 2005, and then about what happened at the hospital on October 30, 2005. She and Pt. A claimed that Dr. Ogoke could not be reached by them or by the hospital emergency room staff. Pt. A’s wife acknowledged that Pt. A’s health insurer was refusing to continue to approve the prescription for Oxycontin 80 mg. at three times a day. She acknowledged that once Dr. Ogoke terminated his care with Pt. A, that Pt. A returned to his PCP,

Dr. Whitaker, for help to get another pain management physician, and that this proved to be difficult. (Ex.83.)

Conclusion and Recommendation

The charges made against Dr. Ogoke that he violated the standard of care in treating Pt. A were not proven. These were: prescribing an excessive dose of Methadone; insisting Pt. A undergo injection procedures against the warnings of his PCP and cardiologist; ending care of Pt. A because he would not undergo injection procedures; and, being unavailable to Pt. A and his wife when Pt. A was at a hospital emergency room after he had started the Methadone prescription. Some of the facts set forth in the Statement of Allegations to support these charges were either not presented with significant mitigating background facts, were not fully accurate, or were not proven. The findings made about Dr. Ogoke's treatment and conduct with Pt. A do not prove that he violated the standard of care concerning any of the charges.

Pt. A was treated by Dr. Ogoke and his physician assistants. The visit reports show over time how Dr. Ogoke provided care to Pt. A. Dr. Trescot and Dr. Satwicz frequently did not agree with one another on the propriety of Dr. Ogoke's care of Pt. A. Pt. A's medical records were not easy to assemble. They were not copied in any order onto the disc, Exhibit 43, and there were faint copies, and parts of a document erased when redacting Pt. A's name or not centered when copied. The paper copies in evidence contain the same shortcomings of being often too faint or missing information from the copying and redacting process. Nevertheless, I was able to establish a course of care for Pt. A with Dr. Ogoke that helped me to conclude whether the charges had been proven.

Dr. Ogoke had to use another medication besides Oxycontin 80 mg. (270) that had been providing 240 mg. of Oxycontin to Pt. A per day. This was because Pt. A's insurer would no

longer cover its cost. When Dr. Ogoke approved a conversion of Pt. A's Oxycontin into a Methadone prescription, as Dr. Trescot persuasively explained, he reached a dose of Methadone 40 mg. (180), taking 2 tablets three times a day, that was within established conversion charts and guidelines. Despite this conversion result, Dr. Satwicz was adamant that only Methadone 5 mg. to take three times a day was acceptable, because of the risks that come with a conversion to Methadone. Dr. Ogoke recognized the risks of putting Pt. A onto Methadone, but as Dr. Trescot explained, there were also benefits in doing so, including Methadone's properties of providing good pain control and of not being as susceptible of abuse as Oxycontin.

Dr. Satwicz, Dr. Trescot and Dr. Ogoke agreed, that when Pt. A was prescribed Methadone, a careful conversion from having been on Oxycodone medications had to be done. They recognized, that at the time, there were various conversion charts that first converted the Oxycodone into a Morphine equivalence. Then, that Morphine equivalence was converted into a Methadone dose. They agreed that this final conversion into Methadone would not be a straightforward 1:1 conversion rate of the Morphine equivalence to a Methadone dose. They agreed that the overall Oxycodone opioid total that Pt. A was taking of Oxycontin, Oxycodone and Percocet was at a high dose level to require a lower dose of Methadone than the conversion process would provide due to the particular properties of Methadone. Dr. Satwicz held a strong opinion, that the Methadone Pt. A was taking after the conversion at 240 mg. per day, could not be justified as proper prescribing, and was a gross overdosing of Methadone for Pt. A. No statutes, or regulations, or guidelines about prescribing practices were proven to have been violated by Dr. Ogoke's approval of the Methadone conversion prescription given to Pt. A.

The BORM alleged that because the initial Methadone dose was excessive, Pt. A went to a hospital emergency room due to troublesome symptoms after have taken "the first few doses"

that resulted in an assessment of a drug overdose of Methadone. But, the findings show Pt. A had been on the Methadone for a few days before he went to the emergency room, so he had taken more than the first few doses. The hospital record does not show that any overdosing was from Methadone and not from, as Dr. Trescot opined, Pt. A taking too much Percocet and Oxycodone to make up for the diminished amount of long-term pain medication the Methadone dose delivered to him. If the BORM had more records from the hospital emergency room visit that had shown the drug overdose was from taking an excessive dose of Methadone after taking just a few initial doses of it, that record was not produced. Neither Pt. A nor his wife testified to how he had taken the prescribed medications before coming to the hospital. Without such evidence, I concluded that Dr. Trescot's opinion was persuasive, that if Pt. A had overdosed on Methadone, then he likely would have been admitted and given nalcron to reverse the drug overdose. Not only did this not happen, but Pt. A was discharged from the emergency room visit with the instruction to take a dose of Oxycontin or Dilaudid for the night and to see his PCP the next day. The BORM did not prove that Dr. Ogoke violated the standard of care by prescribing an excessive dose of Methadone to Pt. A.

Another claim connected to this emergency room incident is Pt. A's wife claim that neither she nor the hospital staff were able to reach anyone at Dr. Ogoke's office once Pt. A went to the emergency room. The source of this claim is the written complaint to the BORM filed after Pt. A's care ended with Dr. Ogoke, that Pt. A's wife wrote. (Ex. 83). Neither Pt. A nor his wife testified. I found this complaint information insufficient to prove any negligence or misconduct by Dr. Ogoke concerning that charge. Moreover, Pt. A was instructed to contact Dr. Ogoke's office to address troublesome symptoms experienced after starting the Methadone. This did not occur. Dr. Ogoke's monitoring plan that accompanied the Methadone prescription was

reasonable to help Pt. A achieve a successful transition onto Methadone.

Dr. Ogoke would not rely on just the statements of Pt. A and his wife that his PCP and cardiologist would not let Pt. A go off his Coumadin blood thinner medication to undergo injection procedures that Dr. Ogoke included in his treatment plan. Dr. Ogoke wanted to address this matter directly with either Pt. A's PCP or with his cardiologist. His office tried without success to reach either of these physicians. Dr. Ogoke only wanted Pt. A to be off the Coumadin for a few days to have an injection procedure. Dr. Ogoke was not trying to stop Pt. A from being treated with Coumadin. Dr. Ogoke provided a long time period for Pt. A to help him reach the cardiologist and/or his PCP about this issue. Only after a long time trying did Dr. Ogoke give up being able to continue to treat Pt. A. Having injection procedures was the reason for having Dr. Ogoke's specialty medical care given the kind of conditions Pt. A had causing him chronic pain. This decision to end care with Pt. A was due to not resolving whether he could receive the injection procedures. This was not misleading or negligent substandard care by Dr. Ogoke. Dr. Ogoke informed Pt. A that he could not continue to treat him with only medications around the same time he gave him the Methadone prescription. He explained to Pt. A that this end of care was due to no resolution of the matter of his need to be off Coumadin for a few days so he could undergo the planned injection treatment. At no time was there evidence of Dr. Ogoke in any way trying to force Pt. A to have interventional procedures while on Coumadin or to just follow Dr. Ogoke's advice and stop Coumadin for a few days to have the procedures even if his PCP and cardiologist did not approve of doing that.

When Dr. Ogoke ended his care with Pt. A, it was after the emergency room visit following the Methadone prescription. Dr. Ogoke provided him upon ending his care with a month of the Oxycontin medication at the on-going prescription he had been on before the

Methadone prescription that was not continued. Pt. A's insurer covered this Oxycontin prescription. After ending care with Dr. Ogoke, Pt. A returned to receiving pain management care elsewhere through his PCP, Dr. Whittaker. The fact that in her complaint, Exhibit 83, Pt. A's wife found it was not easy to find new pain management care for Pt. A, did not show that Dr. Ogoke violated the standard of care in terminating care of Pt. A as charged by the BORM.

Patient B

Summary

Patient (Pt.) B did not testify.

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine below the standard of care for having:

- failed to follow-up with Pt. B concerning her April 16, 2004 urine drug screen test that was negative for opiates despite having active prescriptions for some opiates, and then continuing to prescribe opiates for her; and
- documented with great detail within visit reports on Pt. B the results of complete physical examinations on Pt. B that were never performed.

The facts the BORM alleged to support its contentions that Dr. Ogoke violated the standard of care in the practice of medicine include the following:

- Dr. Ogoke treated Pt. B from 2000-2005 for head, neck and low back pain with diagnoses of: Reflex Sympathetic Dystrophy; cervical strain; cervical radiculopathy; lumbar strain; lumbar radiculopathy; degenerative disc disease; intercostal neuritis; cerviogenic headaches; sacroiliitis; and, myofascial pain syndrome.
- Dr. Ogoke prescribed Oxycontin and gave injection procedures including multiple epidural steroid injections.
- Dr. Ogoke did not consistently document the amounts and adjustments to the opioids in the reports on his patient's visits.
- Dr. Ogoke documented in progress notes detailed physical examination findings on several visits but never performed full physical examinations at these visits.
- Dr. Ogoke failed to address a negative urine drug screen test for opiates although he was prescribing Oxycontin, and this negative result is an indicator that Pt. B might have been diverting medication.
- Dr. Ogoke continued to prescribe opiate medication after the negative urine drug screen test result.

Findings of Fact

1. Patient B, a female, was born in 1959. Before starting care with Dr. Ogoke, she was treated by Dr. Michael John Daly, a pain management specialist at the Mercy Hospital Pain Clinic. She was referred to Dr. Ogoke by her primary care physician (PCP), Dr. Arthur King. Pt. B had a long history of pain in her left arm and shoulder. She sustained a fracture of her left navicular bone on November 12, 1991 as a result of a work injury. That injury occurred when, as a letter carrier, Pt. B was picking up a heavy tray with mail on it. The tray snapped back and she hurt her left wrist. She began treatment for pain with bier blocks, stellate ganglion thoracic epidural steroid injections, left thoracic sympathectomy, trigger point injections, and an infusion pump into the left axilla. She had a left thoracic sympathectomy in July 1993 involving levels T1 through T7 with the ganglions removed at these levels. Pt. B returned to work following this operation for about eight months, but the pain returned and kept her out from work. She became diagnosed with Reflex Sympathetic Dystrophy. Pt. B had pain relief after treatments for her injury, and returned to work. She stopped working when the pain returned in the left side of her neck, left anterior axilla, and left arm, with numbness and coldness in her arm and hand. Pt. B had a March 30, 1999 cervical MRI revealing:

Left C4-5 and right C5-6 disc herniations with root compression. Small left disc herniation at C3-4 with possible root compression. Small C6-7 disc herniation without root compression.

She had cervical spine x-rays showing degenerative disc disease with bilateral foraminal stenosis. Pt. B first saw Dr. Daly on July 9, 1999, complaining of a 10/10 pain level in her neck and left arm. She was taking Tylenol for pain. Dr. Daly had her undergo quantitative somatosensory testing, and wanted her to have a baseline psychological evaluation to determine what role her psycho-social health might be playing in her pain complaints. By August 27, 1999,

Dr. Daly diagnosed a complex regional pain syndrome in the left arm and left shoulder. On October 6, 1999, Dr. Daly performed an operative procedure, implanting a neurostimulator electrode that succeeded in providing "excellent" pain relief. Pt. B's spinal cord stimulator system disconnected and was removed by Dr. Daley on October 15, 1999. Pt. B was reluctant to have a permanent spinal cord electrode implanted, and this procedure was not performed. At a November 5, 1999 evaluation, Dr. Daly prescribed Oxycontin 10 mg. (60) and Oxycodone 5 mg. (180) for break through pain. He concluded: "If the patient tolerates Oxycontin, I will increase the dose at her next prescription refill." Pt. B had a lumbar MRI on December 22, 1999 revealing:

[M]ild diffuse disc bulge with tiny left sided annular tear at L5/S1 ... does not appear to be any impression on the thecal sac and the exiting nerve roots are not affected. Minimal disc bulge at L4/5.

On December 31, 1999, Dr. Daly performed thermal sensory testing on Pt. B with inconclusive results. Dr. Daly opined by January 31, 2000 that Pt. B was in need of a team approach to controlling her pain. He recommended a physical therapy evaluation, and continued to recommend a psychological evaluation due to her depression and anxiety. Pt. B was in a March 26, 2000 motor vehicle accident that led to back pain complaints, and she had lumbar spine x-rays showing:

Mild disc space narrowing at L3-4 level ... no evidence for acute fracture or dislocation ... mild degenerative changes of facet joints at L5-S1 and mild lumbar scoliosis.

By May 11, 2000, Dr. Daly referred Pt. B to her PCP because he was not finding her in need of his care.

This patient has been managed at the Mercy Pain Clinic for chronic pain complaints. At this time she is relatively stable on a moderate dose of pain medication which includes Oxycontin 20 mg. bid and Effexor 150 mg. 1 qd. It is our feeling that the patient does not require the services of the Pain Clinic at this

time and should be referred back to her primary care physician for pain management. If she required further evaluation or more interventional techniques for her pain problem we would be happy to see her again at a future date.

(Ex. 43: 14-24/137-147; 30-37/153-160; 48/171; 50/173; 316-317/439-440; 320-321/443-444 & 337-359/460-482.)

2. On June 5, 2000, Pt. B had a lumbar spine MRI that showed:

Degenerative disc disease and minimal disc bulges L4-L5 and L5-S1. No evidence for a stenosis or herniation. Lipoma of the filum terminale.

On July 24, 2000, Pt. B had a psychological evaluation at the Center for Adults and Families. She was seen by Beth Sjogren-Miller, RNPC, and found to have a major depression secondary to her "medical complications" of being treated for RSD with pain medications. Her Effexor dose of 75 mg. was increased to 150 mg. at this evaluation with a treatment plan to increase that dose to 225 mg. over the next two weeks. (Ex. 43, 32-33/155-156.)

3. On referral from her PCP, Dr. Paul Bothner, Pt. B saw Dr. Ogoke for her continuing pain management issues. She completed a number of new patient forms that included agreeing to interventional injection treatments, agreeing to Dr. Ogoke's office policies, and signing a Narcotic Prescription Policy & Agreement (narcotics agreement). Dr. Ogoke gave Pt. B an initial and comprehensive evaluation on August 24, 2000.²⁶ As part of this process, Pt. B completed an extensive background questionnaire on her health that included providing the medications she was taking. Pt. B provided a full medical and social history. She received review of systems and a full physical examination with the results set forth in the report of this initial evaluation that was sent to Dr. Bothner. Pt. B claimed constant pain and graded her pain complaints at an 8/10 level with the pain reaching at times, a 10+/10 level. Pt. B explained how

²⁶ Pt. B had begun some degree of evaluation of her pain issues with Dr. Ogoke's office before Dr. Ogoke did his initial comprehensive evaluation and examination of her. Dr. Ogoke's physician assistant on August 8, 2000, had written her a prescription for Celebrex 200 mg. (60).

stress over her pain issues had negatively impacted her work and her social relationships. She reported having had some pain relief from heat treatments. Dr. Ogoke was aware of Pt. B's RSD impacting her left upper extremity, and that this related to a work injury. In the report of his initial evaluation, Dr. Ogoke included a review of what the various tests had revealed, including x-rays and MRIs. He recorded her allergies to Codeine, Demerol, Morphine, Effexor, Celebrex, and sulfa medications. He noted she had a thoracic sympathectomy at T1-T7 in July 1993. He listed her current medications including Oxycontin 10 mg. In terms of the physical evaluation done, Dr. Ogoke's report included details on his findings from his neurological, musculoskeletal and psychological evaluations. Dr. Ogoke listed the following diagnoses in this report: lumbar sprain; lumbar radiculopathy; lumbar disc bulge; lumbar degenerative disc disease at L4-5 and L5-S1; cervical strain (aggravated); cervical radiculitis; cervical degenerative disc disease (aggravated), rule out herniated nucleus pulposus; and, sacroiliitis. Dr. Ogoke's treatment plans for Pt. B included: a series of cervical and lumbar epidural steroid injections (ESI) starting with a cervical ESI; a physical therapy evaluation with treatments to include "Bioelectric treatment with Matrix ProElec DT2;" and, taking high-dose non-steroidal anti-inflammatory drugs (NSAID), muscle relaxants, and tricyclic anti-depressant medications. At this visit, Pt. B was prescribed Vioxx 25 mg. (30), Skelaxin 400 mg. (60), Nortriptyline 25 mg. (30), and Oxycontin 10 mg. (40). (Ex. 43:14-24/137-147; 45-47/168-170; 67-73/190-196; 76/199; 79/202; 332-334/455-457; 336/459; 228-229/358-359; 360-361/483-484 & 366-371/489-494.)

4. Dr. Ogoke gave Pt. B another comprehensive evaluation on September 8, 2000 that focused on her left upper extremity condition that Dr. Ogoke understood was causally connected to her work injury on November 12, 1991. She reported a pain level in her left upper extremity of 10/10 that at times reached 10+/10. A review of systems and a comprehensive physical

examination were performed. The details of this review of symptoms and physical examination were included in the report of this evaluation. Dr. Ogoke recorded the following impressions concerning Pt. B's left upper extremity condition; sympathetic maintained pain of the left upper extremity and left acromioclavicular joint strain. Dr. Ogoke's treatment plan for this condition was to schedule Pt. B as soon as possible for stellate ganglion blocks, a set of five, each a week apart. After that, Dr. Ogoke would consider giving Pt. B a cryoneuroablation procedure. The plan also included having Pt. B continue to take Effexor and high-dose NSAIDs medications that would then be reviewed and titrated. Dr. Ogoke's office sought coverage by Pt. B's insurer for performing the stellate ganglion blocks. (Ex. 43; 216/339 & 218-225/341-348.)²⁷

5. Pt. B was seen at Dr. Ogoke's office on September 15, 2000. She reported severe pain at a 10/10 level. She claimed compliance in taking her medications as prescribed, including the Oxycontin 10 mg. at two tablets twice a day. She was scheduled to have a bone density test. She was given a physical examination. The report of this visit contained a detailed account of the findings from the physical examination Pt. B received. No different diagnoses were reached. She received prescriptions ; Nortriptyline 25 mg. (60) 1 to 2 p.o. q.h.s; Vioxx 25 mg. (30); Skelaxin 400 mg. (90) 1 i.t.d.; and, Oxycontin 10 mg. (40), 1 p.o.b.i.d. These prescriptions were set forth in detail in the report. Pursuant to her treatment plans, Pt. B was scheduled for three cervical ESIs and a series of lumbar ESIs. A prescription for Valium 10 mg. (1) was written to take in preparation for the first injection procedure to help with sedation and anxiety. (Ex. 43; 11-13/134-136 & 42-44/165-167.)²⁸

6. Dr. Satwicz opined that the write-up of the physical examination of the September

²⁷ I could not locate within Pt. B's medical records (Exhibit 43) copies of the prescriptions written on September 8, 2000 or before September 15, 2000.

²⁸ I could not locate within Pt. B's medical records (Exhibit 43) copies of prescriptions written or office visit reports after September 2000 and before Pt. B was seen by Dr. Ogoke's office in September 2001.

15, 2000 follow-up visit and other such write-ups of later physical examinations in the visit reports, often by physician assistants, lacked a focus on the main reasons why Pt. B was seeking care from Dr. Ogoke. Dr. Satwicz was aware that Pt. B had complained to the BORM about not having detailed physical examinations, and yet the visit reports contained write-ups of such detailed physical examinations. Dr. Satwicz testified that this lack of focus within the visit reports did not mean that the detailed physical examinations did not occur. (Ex. 83. Testimony of Dr. Satwicz, Vol. X, 1843-1844.)

7. By a decision of the Social Security Administration of September 23, 2000, Pt. B received supplemental security income (SSI) disability benefits starting May 15, 1999. (Ex. 43, 271-281/394-404.)

8. On January 30, 2001, Pt. B had a psychiatric evaluation. She was found to have depression and anxiety. On September 6, 2001, Pt. B had another psychiatric evaluation. She was assessed for depression, anxiety, insomnia, and post-traumatic stress disorder ("PTSD") symptoms. She claimed she never abused her medications, was not using illicit drugs, acknowledged a family history of alcoholism, but denied ever having a substance abuse problem. She reported a childhood physical abuse history and an abusive history with her employer causing her PTSD symptoms. She was seeing a therapist and having psychotherapy that was helping her. Dr. Ogoke received the reports from both psychiatric evaluations that included the psychiatric medications she was being prescribed. (Ex. 43; 40-41/163-164 & 292-295/415-418.)

9. On September 21, 2001, Pt. B was seen at Dr. Ogoke's office. She had not come back for her follow-up care because she had difficulties getting her costs for continuing care with Dr. Ogoke covered by her workers compensation carrier. Her primary complaint was pain in her left shoulder and left upper extremity, rating the pain at a 10/10 level. She reported her back pain

had resolved, but the neck pain continued when sitting or lying down for too long. She was given a physical examination. The impression reached was of sympathetic maintained pain in the left upper extremity and a left acromioclavicular joint strain. The treatment plan was a series of three cervical ESIs, one every four weeks, once she received approval to have them from her workers compensation carrier. Also under consideration was a left acromioclavicular joint injection. She was prescribed Nortriptyline 25 mg. (60), Ccelebrex 200 mg. (60), Skelaxin 400 mg. (90), and Zonegran 100 mg. (60). On October 2, 2001, Dr. Ogoke's office sought insurance approval to do a cervical ESI. On November 12, 2001, Dr. Ogoke's office sought approval from the workers compensation carrier to do Neurometer testing. On November 12, 2001, Dr. Ogoke gave Pt. B a cervical ESI with fluoroscopy at levels C3-4, C4-5, C5-6 and C6-7. Pt. B was seen at Dr. Ogoke's office on November 16, 2001. She reported a pain level of 8/10 involving her left arm, lower back and left lower extremity, and no pain relief from the cervical ESI. She was given a physical examination. The impressions reached were: multi-level cervical disc herniations at C3-4, C4-5, C5-6 and C6-7 with possible nerve root compression at C4-5 and C5-6 and possible root compression at C3-4; cervical radiculitis; sympathetic maintained pain of the left upper extremity; left acromioclavicular joint strain (severe); lumbar radiculopathy; disc bulges at L4-5 and L5-S1; lumbar degenerative disc disease at L4-5 and L5-S1; and, sacroiliitis. The treatment plan was to do a repeat cervical MRI as soon as possible; have nerve conduction threshold studies using Neurometer CPT for the L4-5 and L5-S1 nerve roots as soon as possible; consider doing nerve conduction studies for the cervical nerve roots; schedule another cervical ESI to be done in another two weeks; and, consider lumbar discography and an IDET procedure. (Ex. 43: 207-215/330-338; 314-315/437-438; 322-325/445-448; 327/450 & 330/453.)

10. On December 13, 2001, Dr. Ogoke gave Pt. B a cervical ESI with fluoroscopy at the

C7-T1 level. On December 18, 2001 and December 31, 2001, Pt. B had nerve conduction studies done revealing mild right sided radiculopathy at L4, L5 and S1. (Ex. 43: 204-206/327-329; 181-183/304-306; 193-195/316-318 & 201-206/324-328.)

11. Pt. B was seen at Dr. Ogoke's office on December 31, 2001. She complained of: upper left extremity pain at an 8/10 level with burning pain in the left axillary area; coldness and numbness complaints in her left hand and wrist; a 10/10 pain level in her low back radiating into her left lower extremity with foot numbness; and, left side neck stiffness with a reduced range of motion, but having had pain relief from last cervical ESI. She had a physical examination. The results from the nerve conduction studies involving the lumbar spine were discussed with her. The impressions reached were unchanged from the November 16, 2001 evaluation. The treatment plan was to schedule another cervical ESI as soon as possible. She was prescribed Skelaxin 400 mg. (90) and Pamelor 25 mg. (60). To consider in the future was prescribing different NSAID medications like Mobic, and having nerve conduction studies done for Pt. B's cervical nerve roots. (Ex. 43; 196-200/319-323 & 296/419.)

12. After this last visit, Dr. Ogoke's office sought approval from Pt. B's workers compensation carrier to do the cervical ESI scheduled for January 17, 2002. The approval did not come until January 18, 2002. On February 10, 2002, Dr. Ogoke's office sought approval from the carrier to do a thoracic ESI. On March 28, 2002, Dr. Ogoke completed a work capacity form on Pt. B. He answered that her sympathetic maintained pain in the left upper extremity and her AC joint strain limited her work capacity. He found her able to do sitting, walking and standing for four hours, and to do pushing, pulling and lifting of no more than five pounds over four hours. He found her able to do these activities with a fifteen minute break after two hours. He found her unable to reach above the shoulder, twist, squat, kneel or climb. Dr. Ogoke noted

that Pt. B had a low back condition of bulging discs that impacted her ability to lift, bend and stand for long time periods. (Ex. 43: 29/152; 177/300; 189/312 & 290-291/413-414.)

13. Dr. Ogoke saw Pt. B on August 28, 2002. She complained of: pain at levels of 10/10 in her left arm and left side of her neck; a burning sensation at her left armpit; and, coldness and numbness in her left wrist and fingers with heat providing pain relief. She reported that the injection procedures and exercising had not helped. She reported “a grapefruit-sized swelling on the left side from her thoracic symphysectomy.” She told Dr. Ogoke she did not want narcotic medications. Dr. Ogoke gave her a physical examination. He reached the following impressions: sympathetic maintained pain of the left upper extremity; multilevel cervical disk herniations at C3-C4, C4-C5, C5-C6 and C6-C7 with root compression at C4-C5 and C5-C6, possible root compression at C3-C4; cervical radiculopathy; lumbar disc bulge at L4-L5, L5-S-1; lumbar degenerative disc disease at L4-L5, L5-S-1; and, sacroiliitis. Dr. Ogoke’s treatment plan was to give Pt. B a thoracic ESI, consider use of a Duregesic (Fentanyl) Patch for better pain control, and do a follow-up on Pt. B’s condition at her next visit. Pt. B received prescriptions for Skelaxin 400 mg. (90), Doxepin 25 mg. (60), Zonegran 100 mg. (45), and Lidoderm Patch 5% samples. (Ex. 43: 178-180/301-303; 190-192/313-315 & 289/412.)

14. Pt. B was seen by Dr. Ogoke, the next day, August 29, 2002. She reported pain symptoms in her neck that radiated at times into her shoulders, and pain in her low back area that radiated into her buttocks and both legs, including into her left knee. She reported shooting pain on her left side with numbness when she sat or drove. She took hot baths for pain relief. Pt. B reported taking the Zonegran, but had an allergic reaction to it with swelling due to its sulphur component. She reported that the Doxepin helped her sleep. She reported her pain level as 5/10 in the neck and 8/10 in the low back. Dr. Ogoke gave a physical examination. He reached the

following assessments: lumbar disc bulge at L4-L5, L5-S1; lumbar degenerative disc disease at L4-L5, L5-S1; lumbar radiculopathy; cervical degenerative disc disease; lumbar strain; cervical radiculitis, rule out herniated nucleus pulposus; cervical strain; and, sacroiliitis. Dr. Ogoke's treatment plan was to continue Pt. B on her current medications other than to stop the Zonegran, and to consider prescribing Oxcarbozepine in the near future. He was considering a discogram for Pt. B in the near future. He wanted to do a follow-up visit with Pt. B in two weeks. (Ex. 43: 8-10/131-133; 176/299 & 188/311.)

15. Pt. B did not have another evaluation at Dr. Ogoke's office until November 11, 2002. She reported having suffered from Giardia with daily diarrhea for two months that kept her from having her follow-up appointment at Dr. Ogoke's office. Dr. Paul Bothner, her PCP, had prescribed medications of Levaquin, Flagyl and Alveza. Pt. B reported a pain level of 8/10 in her lower back with pain radiating into her buttocks, legs and toes, mostly on the left side. She was given a physical examination. The assessments reached were unchanged from August 29, 2002. The treatment plan was to do a series of lumbar ESIs, then provide a sacroiliac joint (SI) injection, and have physical therapy treatments and Matrix proElec DT2 therapy. Pt. B was to keep her follow-up appointment with Dr. Ogoke's office following her next injection procedure. She was prescribed Mobic 7.5 mg. (30) and Ativan 2 mg. (2) for the next interventional procedure. (Ex. 43; 5-7/128-130 & 28/151.)

16. On March 27, 2003, Pt. B had x-rays of her hips, pelvis, coccyx, and sacrum that were read as "unremarkable." (Ex. 43, 147/270.)

17. On April 14, 2003, Dr. Ogoke gave Pt. B a thoracic ESI with fluoroscopy at the T3-4 level. She had signed the information sheet describing the procedure and the consent form to have this procedure. Her insurer had approved this procedure on December 12, 2002, but she

had not returned to Dr. Ogoke's office to have it around that time. This procedure was again approved on March 10 2003. Pt. B was prescribed various medications that day of Elavil 25 mg. (50), Naprosyn EC 375 mg. (60), Lidoderm Patch 5% (90), Robaxin (Percocet) 500 mg. (60), and Topamax 25 mg. (60). (Ex. 43: 147/270; 172-175/295-298: 184-187/307-310 & 261-268/384-391.)

18. On March 20, 2003, Dr. Ogoke's office sought approval from Pt. B's insurer to cover another thoracic ESI. On May 29, 2003, Pt. B had a thoracic ESI with fluoroscopy at level T4-T5. She received a prescription for Elavil 50 mg. (30). (Ex. 43; 256-258/379-381 & 260/383.)

19. On May 30, 2003, Pt. B underwent another comprehensive evaluation with Dr. Ogoke. Pt. B had been in another motor vehicle accident on May 21, 2003. She was the driver and was rear ended. Her car was pushed forward and hit head on by another motor vehicle. She had worn her seat belt. She did not lose consciousness. She was transported from the scene to a hospital emergency room. She had a series of cervical spine x-rays that showed degenerative changes, no fractures, and no acute malalignment. At this visit, Pt. B completed the initial evaluation questionnaire containing pages of questions about her medical, social and work history, and about her pain complaints, including shading-in a diagram of the body to show where the pain was being felt. Pt. B again completed various new patient forms about consenting to treatment, the narcotics agreement, and agreements to cover the costs of care. At this visit, Pt. B rated her pain level at a 10/10 level in her neck and low back. Dr. Ogoke had the results from her recent cervical spine x-rays, and was aware of the medication she took since the accident of Naprosyn, Flexeril, Hydrocodone, and Zyrtec. He gave a comprehensive physical examination and a review of systems with the details contained in the report of this evaluation. Pt. B's diagnoses and treatment plan were included in the report. He diagnosed: cervical and

lumbar strains rule out further injuries; cervical herniated nucleus pulposus at C3-C7; lumbar spine degenerative disc disease and disc bulges at L4-5 and L5-S1; cervical radiculopathy; lumbar radiculopathy; intercostal neuritis at T4-T9; cervicogenic headaches; moderate post-concussion syndrome; sacroiliitis; and, myofascial pain syndrome involving the trapezius on the left side. His treatment plan was: start Pt. B on NSAID medications, muscle relaxants, and tricyclic anti-depressants; have a physical therapy evaluation and treatments, and Bioelectric treatments; have repeat cervical and lumbar MRIs; do cervical and lumbar ESIs upon review of the MRI results; and, have intercostal nerve blocks. Dr. Bothner was sent a copy of this report. (Ex. 43: 78/201; 79-88/203-210 & 111-119/234-242.)

20. On June 12, 2003, Pt. B had a cervical spine MRI showing: cervical disc herniations at C3-4-C4-5 with impingement; generalized disc bulging; spondylosis at C5-6-C6-7; suggestion of a disc herniation at C5-6; and, degenerative joint disease with discogenic changes at C4-5-C6-7. Also on June 12th, Pt. B had a lumbar spine MRI showing; generalized bulging at L4-L5, L5-S1 with localized discogenic degenerative changes, and mild eccentric spondylosis. On June 20, 2003, Pt. B signed forms for a release of medical records from two other physicians to Dr. Ogoke. On July 24, 2003, Pt. B's insurer approved a thoracic ESI in connection with her November 12, 1991 injury. (Ex. 43; 120-124/243-247 & 253-254/376-377.)

21. Pt. B stopped keeping her appointments with Dr. Ogoke and went off the pain medications he prescribed. She understood her treatment plan included interventional procedures. She did not want to have further injections because she felt they were not helping her enough. When the pain did not diminish, she returned to Dr. Ogoke's office on September 15, 2003. At this visit, she reported a pain level of 10/10. She was given a physical examination. The impressions reached were: sympathetic maintained pain in the upper left

extremity; multi-level disc herniation in the cervical spine at C3 through C7 with nerve root compression at C4 through C6; cervical radiculitis; an improved left acromioclavicular joint strain; improved lumbar radiculopathy; lumbar spine disc bulges; degenerative disc disease at L4-5, L5-S1; and, sacroiliitis. The treatment plan was to prescribe medications and do trigger point injections. Pt. B was prescribed Pamelor 10 mg. (30), Mobic 7.5 mg. (15), and Topamaz 25 mg. (21). She had a urine drug screen (UDS) test done on September 17, 2003²⁹. On October 17, 2003, Dr. Ogoke's office received approval from Pt. B's insurer to do the trigger point injection. Pt. B was seen at Dr. Ogoke's office on October 20, 2003. She was given a physical examination. No changes to the prior impressions were made. The treatment plan included scheduling a cervical ESI series as soon as possible. This was in connection with her workers compensation injury, and Dr. Ogoke's office made a request to the insurer for approval to perform an ESI that had been part of Pt. B's treatment plan. Pt. B was prescribed Mobic 75 mg. (30), Topomax 25 mg. (21), and Elavil 50 mg. (30). Pt. B had stopped the Pamelor prescription. Pt. B received an order for physical therapy treatments. On December 30, 2003, Pt. B had an emergency CT scan to the abdomen and pelvis that showed a possible fracture at the right transverse process of L1 of an uncertain age. (Ex. 43; 154/276; 155/278; 168/291; 170-171/293-294; 243-246/367-369 & 248-252/371-375 & 253/378.)

22. Pt. B was seen at Dr. Ogoke's office on January 12, 2004. She reported low back pain and sought pain medication. The emergency CT scan was discussed and she was given a referral to see Dr. Thomas Kaye. She had a physical examination. She was prescribed Topamax 25 mg. (60), Oxy IR (60)³⁰, and Mobic 7.5 mg. (samples). Pt. B was seen at Dr.

²⁹ I could not locate or decipher the results from this UDS test within Pt. B's medical records (Exhibit 43).

³⁰ I could not decipher the strength of the Oxy IR on Ex. 43, 156/279.

Ogoke's office on January 22, 2004. She reported constant and severe low back pain but with relief from her pain medications. She had an appointment with Dr. Kaye concerning the possible L1 fracture. She was given a physical examination, and was prescribed "Oxy IR 5mg. 2 p.o.q. 8h," and Mobic samples. Pt. B was evaluated on January 28, 2004 by Dr. Kaye and Dr. Amado Munson of the Noble Hospital neurosurgery services, who recommended continued physical therapy treatments for her back and neck. After having this physical therapy, Pt. B was to return for follow-up with the surgeons. Dr. Ogoke was sent a copy of this visit report. (Ex. 43: 107-110/230-233; 142-143/265-266 & 156/279.)

23. On February 5, 2004, Pt. B was seen at Dr. Ogoke's office seeking medication refills. She reported a 3/10 pain level. She was given a physical examination and prescribed Oxycontin 10 mg. (30), Mobic 7.5 mg. and Oxy IR 5 mg.³¹ On February 20, 2004, Pt. B was seen at Dr. Ogoke's office. She complained of a pain level of 6-7/10 in her low back that was "intermittent, heavy and [with a] deep ache" with the pain sometimes radiating into her lower extremities. She described having foot numbness at times. Pt. B described the pain in her neck as a "constant stiffness ache." She rated the pain at an 8/10 level. She was given a physical examination. The following assessments were made: cervical strain; cervical radiculopathy; cervical herniated discs at C3-C7; cervicogenic headaches (improved); post-concussion syndrome (improved); intercoastal neuritis (improved); lumbar sprain; lumbar radiculopathy; lumbar degenerative disc disease; lumbar disc bulge L4-L5, L5-S1; and, lumbar fracture L1 transverse process. The treatment plan was to continue with the traction and pool therapy treatments she was having at Noble Hospital, and schedule a series of lumbar ESIs as soon as possible followed by a series of cervical ESIs. She was to have sNCT testing for her upper

³¹ I could not decipher the amounts prescribed for the Mobic and Oxy IR on Ex. 43, 146/269.

extremity radiculopathy. She was to do follow-up with Dr. Kaye. Pt. B was prescribed Oxycontin 10 mg. (60). Pt. B was seen on March 1, 2004 at Dr. Ogoke's office with pain complaints in her neck and back at an 8.5/10 level. She was seeking pain medication.³² On March 10, 2004, Pt. B was evaluated for physical therapy treatments. She was seen by Dr. Kaye who found her to be walking better and to have an improved range of motion in her neck and back. On March 18, 2004, Pt. B was seen at Dr. Ogoke's office. She was seeking pain medication that she reported was improving her quality of life, as was physical therapy. A physical examination was given. She was prescribed Mobic 7.5 mg. (14), Ativan 1 mg. (2) for an interventional procedure, Oxycontin 10 mg. (60), Oxy IR 5 mg. (90) to fill March 22, 2004, and Topamax 25 mg. (30). (Ex. 43: 99-106/222-229; 130-132/253-255; 135-136/258-259; 138-141/261-264 & 146/269. Ex. 105.)

24. Pt. B was seen at Dr. Ogoke's office on April 15, 2004. She reported a pain level of 10/10. She described constant and achy low back pain, intermittent right hip pain with activity, achy neck pain, and numbness in the mornings with pins and needles in both arms. She reported left upper back scapula area pain where she had the 1993 thoracic sympathectomy. She had bumped this area recently. Pt. B reported that she did not believe her insurer would cover the costs for the interventional procedures or for the prescribed physical therapy. Dr. Ogoke's office explained to her that both treatments were covered by her insurer. At this visit, Pt. B explained that she had missed taking her prescribed medication due to being away at a funeral. She also asked to stop the Topamax because she blamed that medication for a recent kidney stone she had passed. Dr. Ogoke's office instructed her to address this issue of the kidney stone with her PCP. Pt. B also asked to stop all her narcotics medication. She was given a physical examination. No

³² I could not find copies of the prescriptions with the date of March 1, 2004 within Pt. B's medical records (Exhibit 43), although some scripts were copied with illegible dates on them.

new assessments were made. The revised treatment plan was to have her undergo the prescribed physical therapy as soon as possible, and the interventional procedures would be put off for one month. She was to start tapering off the Topamax by taking 25 mg. p.o.q. hrs. for one week and then stop taking it. She was to discontinue taking the Oxycontin and use Oxy IR one to two tablets a day for three days and then one tablet for three days. She was given samples of Mobic 7.5 mg. (14). Pt. B was told to return to the office if she had concerns of problems associated with the tapering. She agreed to do this tapering. A urine specimen was taken for a urine drug screen (UDS). On April 16, 2004, Pt. B had another UDS done. The results of this UDS were received by Dr. Ogoke's office on April 16, 2004, and were negative for illicit drugs and for opiates. The results of the first urine specimen were received by Dr. Ogoke's office on April 19, 2004 and were negative for illicit drugs and for opiates.³³ (Ex. 43: 95-98/218-221; 126-127/249-250; 128/251 & 242/365. Ex. 99.)

25. Dr. Satwicz opined that the UDS tests done on Pt. B's April 15 or 16, 2004 urine specimens had not tested for the presence of Oxycontin or Oxy IR. Since Pt. B had been prescribed these two opioids, Dr. Satwicz found this was avoiding addressing a potential red flag if she was not taking those medications or not taking them as prescribed. Dr. Satwicz would also have expected to see further UDS testing done over the years of care with Dr. Ogoke when Pt. B was taking opioids as a way to monitor her proper use of these medications. (Testimony of Dr. Satwicz, Vol. X, 1852-1862.)

26. Dr. Trescot opined that in 2004, many laboratories doing UDS testing did not have the capacity to do testing of synthetic opioids of the kind Pt. B had been prescribed in March 2004. Dr. Trescot also opined that UDS testing in 2004 was done primarily to find the presence

³³ I could not locate or decipher in Pt. B's medical records (Exhibit 43) any UDS test results from the April 2004 urine specimens that showed the separate testing for detecting the presence of Oxycodone had been done. Pt. B had been prescribed Oxycontin and Oxy IR.

of illicit drugs and not so much used to determine if a patient was taking prescribed synthetic opioids such as Oxycontin and Oxy IR. By April 15, 2004, Dr. Trescot did not view Pt. B as someone with drug seeking behavior or who was diverting her opioid medication. She had not been taking it due to being away for a funeral. In addition, Dr. Trescot noted that she wanted to taper off narcotics with that process started with the April 15, 2004 prescriptions. (Testimony of Dr. Trescot, Vol. XIV, 2744-2745; Vol. XVI, 3127-3129.)

27. By October 4, 2004, Pt. B had returned for care with Dr. Ogoke. She received a Stellate Ganglion nerve block procedure after signing her consent to have the procedure. Pt. B was also prescribed Mobic 7.5 mg. (30) and Topamax 25 mg. (120). (Ex. 43; 169/292; 234-237/357-360.)³⁴

28. Pt. B did not return to fulfill her treatment plan with Dr. Ogoke. Her medical records with Dr. Ogoke contained a record from Baystate Medical Center with entries made on April 28, 2005 and October 27, 2005, and containing the stamp of Grace Makari-Judson on it.³⁵ (Ex. 43, 230/353.)

29. Pt. B received prescriptions from Dr. Ogoke's office on October 6, 2005 for Lyrica 50 mg. (90) and 50 mg. (21), Lidoderm Patch 5% (60), Mobic 7.5 mg. (30), and Gabitril 2 mg. (28). October 28, 2005 Pt. B received prescriptions from Dr. Ogoke's office for Gabitril 2 mg. (60), Percocet 5/325 mg. (90), Lidoderm patch 5% (60), and Lyrica 75 mg. (42). (Ex. 43, 231-233/354-356.)³⁶

30. When Pt. B stopped treating with Dr. Ogoke, she did not want to undergo more

³⁴ I could not locate in Pt. B's medical records (Exhibit 43) any explanation for this time gap from April 2004.

³⁵ This record appears not to be connected to Pt. B's conditions for which she treated with Dr. Ogoke.

³⁶ No reports were found in Pt. B's medical records (Exhibit 43) to explain why she received these October 2005 prescriptions.

injection treatments, a part of Dr. Ogoke's treatment plan for her. She filed a complaint with the BORM against Dr. Ogoke and his staff in July 2006. She complained about delays in receiving her medical records from Dr. Ogoke's office. She complained about a lack of privacy when receiving treatments in Dr. Ogoke's office, including being able to view other patients even when they were not fully clothed and while she was on a gurney. She described a situation on October 6, 2005 in Dr. Ogoke's office reception area with about eight other patients waiting for their appointments. She was expecting to see Dr. Ogoke's physician's assistant who was very late. Dr. Ogoke was not expected to be in the office for a few weeks. She felt she was left without any explanation for the delay and suffered a long waiting period while she was in pain as were the other patients waiting for their appointments. She complained that when she saw the physician assistant she was "rude and abusive" to her. Because the physician assistant was insisting on the need for injection treatments, Pt. B would not cooperate. Pt. B claimed that she had been led to believe by the physician assistant and Dr. Ogoke's staff that the physician assistant was going to give Pt. B an injection treatment because Dr. Ogoke was not available for a few weeks. Pt. B concluded that Dr. Ogoke's practice was not professionally run. She also complained that Dr. Ogoke would not clearly answer the questions she asked him about certain parts of her body and why she felt the way she did. She concluded that Dr. Ogoke never sought "the root of the overall problem," and just gave "repeated injections" while milking the system making money. Her complaint did not contend that Dr. Ogoke never performed the detailed physical examinations that were within the reports of her visits. (See Ex. 83.)

31. Dr. Ogoke would never authorize a physician assistant to perform an interventional treatment other than a very simple injection and not a treatment requiring use of the fluoroscopy. Pt. B did not receive any such interventional treatments from any of Dr. Ogoke's physician

assistants. Pt. B, like all Dr. Ogoke's patients, received physical examinations at their visits which were described within the visit reports. Dr. Ogoke did not allow his patients to determine their treatment plan and that was true for Pt. B. Injection procedures were a key component of his treatment plan for Pt. B. (Ex. 84.)

Conclusion and Recommendation

The BORM failed to prove that the UDS testing done in April 2004 that showed opiate tests were negative for Pt. B, led to improper prescribing of further opioid medication in violation of the standard of care, because the tests showed Pt. B had not been taking her prescribed opiate medication. The BORM failed to prove that when Pt. B's visit reports showed physical examinations were performed that they were never performed. These are the two charges regarding Pt. B made against Dr. Ogoke in the Statement of Allegations. The facts alleged in the Statement of Allegations to support these charges are not all accurate, and some are inconsistent with the course of care Pt. B received with Dr. Ogoke.

Pt. B did not testify, and her written complaint to the BORM does not help to determine whether there were violations of the required standard of care in how Dr. Ogoke treated her. Her written complaint addressed long waits at Dr. Ogoke's office to receive treatments, and a messy office. These are charges contained in Statement of Allegations, #s 2-8. Her written complaint was not given any weight in determining these charges. The long wait she described dealt with seeing Dr. Ogoke's physician assistant and involved one occasion. She also did not explain in any detail what about the office was always messy. In her written complaint to the BORM, Pt. B claimed that she had not received soon enough her requested medical records from Dr. Ogoke once she stopped care with him. She did not testify, and no other evidence collaborated this claim. This was not in the Statement of Allegations for Pt. B as a violation of standard of care.

The BORM contends that Pt. B was not given the physical examinations that Pt. B's medical records show occurred at her office visits. Dr. Satwicz opined that if this charge is true, then Dr. Ogoke violated the standard of care. He did not testify that his review of the medical records for Pt. B showed false details of physical examinations.

Pt. B did not testify to support the charge that she did not receive the physical examinations listed in her visit reports. No other evidence supported this charge. Dr. Ogoke's testimony and his interview with the BORM (Exhibit 84) was persuasive that he lists in his visit reports the results of physical examinations performed by him or by his physician assistants. As I reviewed the course of events in Pt. B's care with Dr. Ogoke, I did not find verbatim copied physical examination texts in the visit reports. And, I found impressions listed in the visit reports following the physical examinations to be understandable and to support the treatment plans listed in these visit reports. The BORM failed to prove this charge.

The BORM contended that Dr. Ogoke violated the standard of care when he failed to adequately test for the Oxycodone medications Pt. B had been taking when he did UDS testing of her April 15 and 16, 2004 urine specimens. The testing done did test for illicit drugs and none were detected. But, to test for the Oxycontin and the Oxy IR opioid medications Pt. B was taking, a separate screen had to be done. No evidence was found in Pt. B's medical records that this separate test was performed. Pt. B came to her visit on April 15, 2004 explaining that she had not been taking her pain medication while she had been away attending a funeral. She also asked at this visit to stop taking narcotic medications. For Dr. Satwicz, this was red flag conduct to investigate, including doing UDS testing to help to uncover whether Pt. B was diverting her opioid medications. This required doing the separate Oxycodone screen test that was not done. Dr. Satwicz opined that this was avoiding addressing a red flag situation and a violation of

standard of care to be using a negative opiates screen result to show no diversion or improper use of prescribed opioids by Pt. B.

On the other hand, there were no indicators at this time or prior to this time period that Pt. B was diverting or improperly taking her Oxycodone medications. No red flag conduct was found in the course of care the findings show Pt. B received with Dr. Ogoke. If any red flag conduct ever emerged, it was Pt. B explaining at the April 15, 2004 visit that she had not been taking her medications while she was away attending a funeral. At this visit, she also asked to stop her narcotic medication. I found the opinion of Dr. Trescot persuasive, that such a set of circumstances does not show a patient who was drug seeking or diverting her opioid medication given that she sought to stop taking narcotic medication. And, addressing a red flag for diversion or for Pt. B abusing her Oxycodone medications would not have helped her continue such conduct with the tapering plan that was put in place on April 15, 2004. She began the process at that time for tapering-off her narcotic medication, including off the Oxycontin and Oxy IR medications. The visit report for April 15, 2004 had Pt. B agreeing to this tapering plan. In addition, Dr. Trescot testified to the kind of UDS testing available in 2004. She convincingly explained that most laboratories did not do the separate test for synthetic opioids and that the UDS testing was primarily testing for the presence of illicit drugs. All these circumstances do not support the BORM claim that Dr. Ogoke violated the standard of care by not doing the further testing with the Oxycodone screen on the April 15 and 16, 2004 urine specimens. He was not violating the standard of care when on April 15, 2004, Pt. B received a prescription for opioids as part of her tapering off process. The BORM did not prove this charge.

Patient C

Summary

Patient (Pt.) C did not testify.

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Inappropriately prescribed high doses of opioids;
- Terminated care without properly tapering Pt. C off her opioid medications; and
- Failed to describe the doses of opioids in Pt. C's progress reports.

The facts the BORM alleged to support its allegations include the following:

- Pt. C was treated by Dr. Ogoke between 2005 and November 2006 for low back and lower extremities pain with diagnoses he made of sacroiliitis, post-laminectomy syndrome of the lumbar level; lumbar herniation at L4-5; lumbar radiculopathy; lumbar degenerative disc disease at T12-L1; and, cervical herniation at multiple levels.
- Dr. Ogoke treated Pt. C with opioid pain medications that included Methadone, Morphine (MS Contin), and Oxycodone.
- Dr. Ogoke also treated Pt. C with multiple injections including cervical and lumbar spine epidural steroid injections, sacroiliac joint injections, and lumbar transforaminal injections. The injection treatments were painful. Pt. C needed a towel to bite into to prevent her from screaming during injection procedures Dr. Ogoke gave her.
- Dr. Ogoke failed to detail the doses of opioids that were being refilled or adjusted in Pt. C's visit reports.
- On November 17, 2006, Dr. Ogoke terminated Pt. C from his care without first tapering Pt. C off her high doses of opioids.

Findings of Fact

1. Pt. C, born in 1977, was first evaluated by Dr. Ogoke on June 20, 2001 upon referral from Dr. Michael Jawitz for management of low back pain that was radiating into her legs. She had been hurt in a fall and had undergone lumbar spine fusion surgery, anterior and posterior, in April 2001 with Dr. Scott Cowan. By the time she was first seen by Dr. Ogoke, she was already having physical therapy treatments and taking Oxycontin 10 mg., three times a day, as well as

taking Oxycodone for break-through pain. Nevertheless, she was ranking her pain at an 8/10 level that would reach a 10/10 at times, and was not lower than 5/10. She complained of pain that was constant, “sharp, achy and shooting.” Pt. C reported that the pain had affected her work in and outside the home, her social activities were “curtailed,” and her relationships with family were strained. Prior to the back surgery, Pt. C had tried chiropractic treatments “with limited benefits,” and had “received epidural steroid injections x3 per Dr. Paasch without improvement, as well as a discogram per Dr. Paasch.” Pt. C had undergone a lumbar MRI on February 25, 2000 that had shown “a small midline and right paramedian protrusion of the L5-S1 disc beginning to make contact with the right S1 root without displacing the root. Also shown was “prominent S1, S2 disc indicating partial lumbarization at the first sacral segment.” Dr. Ogoke gave Pt. C a review of systems and a detailed physical examination with the results set-forth in the report of this visit. The diagnoses made were; failed back surgery syndrome status-post back surgery, severe sacroiliitis, and lumbar radiculopathy. The treatment plan developed for Pt. C included another lumbar MRI. She was prescribed high-dose non-steroidal anti-inflammatory drugs (NSAID), muscle relaxants, and tricyclic anti-depressant medications. Her progress on those medication was to be reviewed and titrated. She was also prescribed Oxycontin 20 mg. (40) to take “one p.o.q. [every] 12 hours.” She was to continue physical therapy treatments. Under consideration was to give Pt. C an epidurogram and a lumbar epidural steroid injection (ESI) series. She was to return for follow-up in one week. This report was sent to Dr. Jawitz. (Ex. 100.)

2. On December 9, 2004,³⁷ Pt. C was given a urine drug screen (UDS) at Dr. Ogoke’s office with results on December 21 and 23, 2004 from an outside laboratory that were negative

³⁷ There is an unexplained gap in the Pt. C’s medical records (Exhibit 43) between 2001 through 2004. In the Statement of Allegations, the BORM has Pt. C treating with Dr. Ogoke between 2005 and 2006. I did not locate within Pt. C’s medical records copies of the prescriptions written on June 21, 2001.

for illicit drugs and positive for Methadone and for opiates (morphine). (Ex. 43, 130-131/624-625.)

3. On February 9, 2005, Dr. Ogoke gave Pt. C her first in a series of lumbar transforminal ESIs with fluoroscopy. This procedure was at levels L4, L5 and S1 on the left side. At this time, Dr. Ogoke suspected nerve pain was causing her complaint of bilateral leg pain; and he was attempting to locate the source of the pain. At this visit, Pt. C was prescribed Zonegran (an anti-seizure medication used for nerve pain) 100 mg. (60), Dexedrine 10 mg. (30), MSIR (short acting form of morphine) 30 mg. (120), IBU (Ibuprofen) 800 mg. (90), and Methadone 10 mg. (180). (Ex. 43; 62-63/556-557 & 135-136/629-630. Testimony of Dr. Ogoke, Vol. VI, 1159 & Dr. Trescot, Vol. XIV, 2761.)

4. Pt. C was seen at Dr. Ogoke's office on March 11, 2005. She reported pain at an 8/10 level in her back and legs, although she reported the injection procedure decreased the intensity and achiness in her left leg for about a week. She described her low back pain as "constant and achy," radiating "constantly" into her legs. She complained of intermittent numbness in her toes. She had a review of systems and a physical examination performed. An assessment was made that included: lumbar sprain; lumbar radiculopathy; lumbar degenerative disc disease at T12-L1; lumbar disc herniation at L4-5; discogenic pain at L5-S1; post-laminectomy syndrome at L5; sacroiliitis; and, headache syndrome. Her treatment plan was to undergo the next lumbar ESI in the series. Pt. C had a UDS done on March 11, 2005 testing for Oxycodone, opiates, and illicit drugs. She was prescribed Actiq 600 mg. (6) for pain during her interventional procedures, and Valium 10 mg. (2) in connection with having sedation for the next procedure. In addition, she was prescribed Methadone 10 mg. (180), MSIR 30 mg. (120), and Ritalin 20 mg. (60). Her Dexedrine prescription was discontinued. On March 21, 2005, Pt. C

had a lumbar foraminal ESI on the left side with fluoroscopy at levels L4, L5 and S1. (Ex. 43: 56-61/550-555; 128-129/622-623 & 132-134/626-628.)

5. Multi-level injections were performed at and around this time period by pain management specialist physicians as a useful tool to try to get medication into the nerve roots to reach the source of pain to provide pain relief. Pt. C's condition in 2005 meant that she was potentially getting a decrease in blood flow to her spinal cord leading to pain, numbness and potential nerve damage. When there has been fusion surgery in the spinal cord, it is harder to target effectively the nerve roots causing the pain. (Testimony of Dr. Trescot, Vol. XIV, 2751.)

6. On April 8, 2005, Pt. C was seen at Dr. Ogoke's office. She reported a 5/10 pain level in her legs and a 6/10 level in her back. She also complained of cervical pain. A review of systems and a physical examination were done. A left lumbar ESI with fluoroscopy was planned. The treatment plan was to do a cervical MRI. A cervical ESI injection series was considered. Pt. C was prescribed Methadone 10 mg. (42), MSIR 30 mg. (60), Ritalin 40 mg. (60), and two prescriptions for Valium 10 mg. (2) for use before the next planned injection procedure and for the MRI. (Ex. 43: 55/549; 115/609 & 121-126/615-620. Testimony of Dr. Ogoke, Vol. VI, 1154.)

7. Pt. C was seen at Dr. Ogoke's office on May 16, 2005. She reported low back pain at an 8/10 level and right leg pain at an 8.5/10 level. She sought medication refills and received prescriptions for Ritalin 20 mg. (120) and Methadone 10 mg. (42). Her treatment plan was to have a left-sided lumbar ESI and to start on a series of right-sided lumbar ESIs after that. On May 23, 2005 Dr. Ogoke gave Pt. C a left-sided lumbar ESI with fluoroscopy at levels L4, L5 and S1. She was again seeking medication refills and was prescribed Methadone 10 mg. (180), MSIR 30 mg. (120), and Zonegran 100 mg. (60). Pt. C called Dr. Ogoke's office on May 25,

2005 due to pain experienced following the recent lumbar ESI. She wanted stronger pain medication.³⁸ (Ex. 43: 50-54/544-548; 116/610 & 118-120/612-614.)

8. On June 10, 2005, Pt. C had a cervical MRI that showed:

1. Right paramedian extruded disc herniation with mild cephalad migration and right sided cord impingement at C4-5.
2. Central extruded disc herniation at C5-6 with moderate ventral cord impingement uncovertebral spurring on the left with mild left sided neural foraminal stenosis at this level.
3. Very small central to right paramedian disc protrusion at C6-7 and a tiny central disc protrusion at C7-T1.
4. Lordotic loss.

(Ex. 43, 109-112/603-606.)

9. On June 13, 2005, Pt. C was seen at Dr. Ogoke's office. She reported pain levels of 8.5/10 in her low back and 7.5/10 in her legs. She reported having a 50% decrease in her pain level in her leg from the baseline level that lasted about one week following the last lumbar ESI. Pt. C reported the low back pain was as "constant [and] achy." She reported that physical activity aggravated her pain symptoms. Although her legs were not weak, Pt. C reported having radiating pain through the legs with numbness in her toes. She was given a physical examination. Her assessments were not changed. The treatment plan was to stop Methadone, and start MS Contin with a temporary increase in the MSIR medication, and an increase the Ritalin, prescribed for her somnolence. Pt. B was to continue taking her other medications as prescribed. At this visit, Pt. C was prescribed Ritalin 20 mg. (90), MSIR 30 mg. (120), MS Contin 100 mg. (60), and Zonegran 100 mg. (60). She was to have a follow-up evaluation in two weeks or sooner if needed. Under consideration was having her undergo a cervical ESI series following a review of her cervical MRI. Pt. C returned to Dr. Ogoke's office on June 27, 2005

³⁸ I could not locate prescriptions written for Pt. C on May 25, 2005. Also, by this time, I could not locate the results from the March 12, 2005 UDS testing and did not find any discussion about the results in any of the visit reports through May 2005.

with continuing complaints of low back pain at an 8.5/10 level and at a 7.5/10 level in her legs. She reported that the pain medication helped her feel better, and that the Ritalin was helping the somnolence. She was given a physical examination. She was prescribed MS Contin 30 mg. (30). (Ex. 43: 46-49/540-543; 108/602 & 113-114/607-608. Testimony of Dr. Ogoke, Vol. VI, 1158-1159.)

10. Pt. C was seen at Dr. Ogoke's office on July 7, 2005. She reported a pain level of 8/10 in her back and 9/10 in her legs. She reported that the pain medication was not effective enough. She was given a physical examination. She was scheduled to start a cervical ESI series on July 15, 2005. She received prescriptions for Ritalin LA 20 mg. (90), Oxycodone 30 mg. (90) and MS Contin 100 mg. (30). The next day, Pt. C received prescriptions for MS Contin 100 mg. (60) and MS Contin 60 mg. (60). Another prescription for MS Contin 30 mg. (60) was written on July 11, 2005.³⁹ The increase in pain medication was to help her obtain more pain relief. (Ex. 43; 105-107/599-601 & 45/539. Testimony of Dr. Ogoke, Vol. VI, 1159-1161.)

11. Pt. C signed information and consent forms before Dr. Ogoke performed a cervical ESI with fluoroscopy at the C5-C6 level, on August 2, 2005. This was to address her cervical radiculopathy. She received prescriptions that day for Oxycodone 30 mg. (90), MS Contin 30 mg. (60), and MS Contin 100 mg. (60). (Ex. 43: 42-44/536-538; 99/593, 101-104/595-598.)

12. On August 29, 2005, Pt. C was seen at Dr. Ogoke's office complaining of "unbearable" pain. Dr. Ogoke gave her a cervical ESI with fluoroscopy at the C5-C6 level. A UDS was done. She was given prescriptions for MS Contin 100 mg. (60), MS Contin 30 mg. (60), and Oxycodone 30 mg. (90). During the August 29, 2005 injection procedure, Pt. C reported some difficulty. She was having paresthesias in her upper extremity, an uncomfortable, electric

³⁹ I could not locate or decipher within Pt. C's medical records (Exhibit 43) visit reports for July 8 & 11, 2005.

sensation that can feel like hitting the funny bone. With waiting, the paresthesias diminished and the procedure was successfully accomplished. (Ex. 43; 39-41/533-535, 98/592 & 183/677.

Testimony of Dr. Ogoke, Vol. VI, 1162-1169 & Dr. Trescot, Vol. XIV, 2752.)

13. Pt. C saw Dr. Ogoke on September 1, 2005. She reported a pain level of 9/10 in her low back and legs. She claimed that she was compliant in taking her medications “including MS Contin and Oxycodone,” but her medications were not helping her pain. The physical examination detected,

an area of hyperpathia and some paresthesia in her left upper extremity from the elbow down to the fingers. During the procedure on August 29, 2005 ... she had an episode of paresthesia in the left upper extremity during her injection. She was quite agitated at that time. The episode was single and lasted briefly. The patient’s needle was repositioned and she successfully had the injection.⁴⁰

Dr. Ogoke explained to Pt. C that her symptoms could “last between one and two weeks on the average and she should continue her current oral medication in the interim.” He assessed her with: “sympathetic maintained pain of the left upper extremity status-post epidural steroid injection #2 at the cervical spine level (possibly transient);” lumbar radiculopathy and radiculitis; herniation at L4-5 and disc protrusion at L5-S1; post lumbar laminectomy syndrome; sacroiliitis; degenerative disease at T12-L1; and, cervical spine herniations at C4-5, C5-6 and C6-7. The treatment plan was to: add Elavil 50 mg. (60), taking one or two tablets at bedtime; add a NSAID medication; have Mobic 7.5 mg. (30) available as needed for a few days; and, see Pt. C in about one to two weeks. She received these new prescriptions at this visit. (Ex. 43; 36-38/530-532 & 182/676.)

14. Having an episode of paresthesia during an injection procedure is not unusual. When the sensation was felt by Pt. C in her left forearm, Dr. Ogoke gave time for the effect of the

⁴⁰ The August 29, 2005 injection procedure may have been when Pt. C used a towel to bite down on during the procedure as she claimed in her complaint to the BORM (Ex. 83). But, there was a lack of sufficient proof that this actually occurred during that or during any injection procedure she was given.

injection to numb the area around the nerve that was inflamed. Pt. C was asked if the sensation had subsided and it had so that the injection procedure was completed. An anti-inflammatory medication like Elavil may be prescribed for a mild trauma to a nerve. Pt. C received an Elavil prescription at her September 1, 2005 visit. (Ex. 43, 36-38/530-532. Testimony of Dr. Ogoke, Vol. VI, 1163-1169; Dr. Trescot, Vol. XIV, 2752-2753, 2756-2757 & Ms. Dawes, Vol. XI, 2136-2138.)

15. At a September 21, 2005 visit to Dr. Ogoke's office, Pt. C reported her medications were not helping to control her pain sufficiently. She reported a pain level of 7-8/10 in her low back and legs. She was given a physical examination. She received prescriptions for Zonegran 100 mg. (60), Oxycodone 30 mg. (90), Actiq. 600 mg. (2) for the next procedure, and Methadone 10 mg. (270) to take 3 tablets, 3 times a day. The Methadone prescription was instead of the MS Contin (Morphine) which was not working as well as expected to control her nerve pain. When MS Contin is not working as well as expected, it is appropriate to start Methadone for addressing nerve pain. The dose of Methadone prescribed for Pt. C of 10 mg. (270) and taking 30 mg. per day was a high dose, but was prescribed in light of Pt. C's high pain level and because it was effective for nerve pain. Pt. C had taken Methadone in the past under Dr. Ogoke's care. The treatment plan included a referral to orthopedic surgeon, Dr. Linson, regarding her lumbar spine conditions. Dr. Trescot opined from her practice with the use of Methadone for non-cancer chronic pain at a high level, that Dr. Ogoke was within the standard of care in prescribing Pt. C to take 90 mg. of Methadone a day. Dr. Trescot had prescribed for a patient 300 mg. of Methadone per day. (Ex. 43; 35/529 & 180-181/674-675. Ex. 107. Testimony of Dr. Ogoke, Vol. VI, 1187-1191 & Dr. Trescot, Vol. XIV, 2757-2762, 2769-2770, Vol. XV, 2865-2866.)

16. Dr. Satwicz opined that a prescription for a month of Methadone at 10 mg. per tablet,

3 tablets per dose with 90 mg. taken daily, was too high a dose for Pt. C to have been prescribed for the kind of musculoskeletal pain she was having of “aches and pains.” When this level of Methadone was combined with the Oxycodone 30 mg. taken four to six times a day, Pt. C was taking too much opioid medication. Dr. Satwicz opined that the combination of these two high doses was “very unusual doses of opioids to be chronically used,” and was a violation of the standard of care. Dr. Satwicz also did not find in the visit reports adequate information whether with such high doses of opioids if they were working to make Pt. C better, and if Pt. C was showing signs of diversion of her opioid medications. (Testimony of Dr. Satwicz, Vol. X, 1870-1873, 1876-1877.)

17. On October 19, 2005, Pt. C received prescriptions for Oxycodone 30 mg. (90), Methadone 10 mg. (270), and Zonegran 100 mg. (60). On November 4, 2005, Pt. C received another prescription for Actiq 600 mg. (2) to be used for her next ESI procedure.⁴¹ Pt. C was seen at Dr. Ogoke’s office on December 6, 2005. She reported a pain level of 6/10, and sought medication refills. She was prescribed Oxycodone 30 mg. (90), Zonegran 100 mg. (60), and Methadone 10 mg. (270). She refused referral to a surgeon concerning the conditions in her spine. She reported that the Methadone was helping her. A UDS was done. On December 15, 2005, the results of Pt. C’s UDS showed she was positive for Amphetamines, Methadone, and negative for Opiates.⁴² (Ex. 43; 34/528 & 176-179/670-673. Testimony of Dr. Ogoke, Vol. VI, 1182, 1184-1186.)

⁴¹ I could not locate or decipher within Pt. C’s medical records (Exhibit 43), visit reports for October 19 and November 4, 2005. I could also not locate or decipher a medical record showing an injection procedure done before October 19, 2005 to explain a need for another prescription for Actiq for a next injection procedure. Pt. C had been prescribed Actiq on September 21, 2005.

⁴² I could not locate or decipher with Pt. C’s medical records (Exhibit 43) a UDS test done for Oxycodone, the synthetic opioid Pt. C was taking, or the UDS results from the UDS done on August 29, 2005.

18. Dr. Ogoke's prescriptions for Actiq were to be taken only during an interventional procedure for associated pain and discomfort, and were not prescribed as ongoing pain control medication. For Dr. Satwicz, despite this limited use of Actiq, it is a powerful cancer pain medication providing very fast pain relief. He opined that Actiq should be reserved for cancer pain, and not prescribed to a patient with the kind of underlying conditions that Pt. C had. He opined that to prescribe Actiq to Pt. C was giving Pt. C an excessive amount of an opioid and was a violation of the standard of care. Dr. Trescot opined that when Dr. Ogoke used Actiq to help a patient receiving an interventional procedure, this was within the standard of care. For Dr. Trescot, many of the medications that were effective for pain management and had been used by pain management specialists at and around this time in the mid-2000's, had not been approved specifically for pain management use by the FDA (Federal Drug Administration). Dr. Trescot opined that this lack of FDA approval of an effective pain medication for limited use was not prescribing in violation of the standard of care. Dr. Trescot testified why providing Actiq (Fentanyl) to Pt. C to use for pain experienced during an injection procedure was not outside the standard of care:

[B]ecause the procedures are actually uncomfortable, it's appropriate to add a pain medicine that's for the procedure. These procedures are short, so a very short pain medicine is appropriate. You have to be able to give the medicine quickly and you can either give it by vein or now at this point the transmucosal Fentanyl is available, Actiq.

(Testimony of Dr. Satwicz, Vol. X, 1875-1876 & Dr. Trescot, Vol. XV, 2924-2927.)

19. Pt. C was seen by Dr. Ogoke on January 11, 2006: She reported a pain level of 7/10 in the back and a pain level of 5/10 in her left lower extremity. She reported being compliant in taking her prescribed medications, and reported that they helped with pain control. The results from her December UDS were discussed in terms of being positive for Amphetamines,

medications Dr. Ogoke's office had never prescribed. As a result, Dr. Ogoke's office had her do another UDS to determine whether or not the positive Amphetamine result was true or due to contamination. An Oxycodone UDS test was also done using the laboratory at Baystate Medical Center. At this visit, Pt. C had a review of systems was done as well as a physical examination. Pt. C was assessed with: severe sacroiliitis; improved sympathetic maintained pain in the left upper extremity; lumbar radiculopathy; lumbar herniation at L4-5; degenerative disc disease at T12-L1; and, multiple cervical disc herniations. Pt. C had prescriptions renewed for Zonegran 100 mg. (60), Methadone 10 mg. (270), and Oxycodone 30 mg. (90). She was to return in four weeks. Under consideration was giving Pt. C a sacroiliac joint (SI) injection to help with her leg pain if that pain persisted. The results of the UDS from January 24, 2006 showed Pt. C was again positive for Amphetamines as well as positive for the prescribed Methadone. The results of the UDS from Baystate were positive for Oxycodone. (Ex. 43; 30-33/524-527 & 171-175/665-669.)

20. Pt. C was seen at Dr. Ogoke's office on February 8, 2006. She reported a pain level of 6-7/10. She reported that she had been taking Adderall, an Amphetamine, for her somnolence, as prescribed by her treating psychiatrist. She reported that it was effective. This was found to explain her positive UDSs for Amphetamines. Otherwise, the UDSs showed Pt. C was compliant in taking her prescribed medications. Most of Pt. B's pain was in the sacroiliac notch area and joint mediated flare. She had another UDS done at this visit. She was given prescriptions for Methadone 10 mg. (270) and Oxycodone 30 mg. (90). The results of the February 8, 2006 UDS showed the same results as the prior UDS had showed. She was compliant with taking the prescribed medications, as well as positive for Amphetamines. The therapeutic trial use of a spinal cord stimulator was discussed with Pt. B at this visit. The spinal

cord stimulator would have been implanted through a hospital procedure under anesthesia. The stimulator would be “laid above the spinal cord.” The stimulator would not be buried into the patient’s body, but would be attached “to an external device” to “stimulate the spinal cord” during a “seven to ten day test period when ... [Pt. B] can move around with it and report back.” Dr. Ogoke would have controlled what stimulation Pt. B would have received of anywhere from a “continuous stimulation” to “a burst” at one time. (Ex. 43; 28-29/522-523⁴³ & 165-170/659-664. Testimony of Dr. Ogoke, Vol. VI, 1197-1204.)

21. Pt. C was seen on March 6, 2006 at Dr. Ogoke’s office. She reported a pain level of 6/10 in her lower back. Dr. Ogoke gave her a bilateral SI injection with fluoroscopy after she signed consent and information forms about the procedure. She also received prescriptions for Methadone 10 mg. (270), IBU 800 mg. (90), Zonegran 100 mg. (90), and Oxycodone 30 mg. (90). A UDS was done, and the results showed the same results as the prior UDSs; that Pt. C was compliant in taking her prescribed medications. (Ex. 43: 26-27/520-521; 152-153/646-647; 155-158/649-652 & 161-162/655-656.)

22. On April 7, 2006, Dr. Ogoke gave Pt. C the first in a series of left-sided lumbar transforaminal ESI injections with fluoroscopy at L3, L4, L5 and S1. According to Dr. Trescot, this was a standard of care procedure for Dr. Ogoke to provide to Pt. C.

In 2006 it was very common when you had someone who had multiple levels of pathology like this patient [C] ... and ... multiple diagnoses and nerve impingements at multiple levels ... to try and deliver medicine to multiple levels.

[I]t’s sometimes hard to tell where the actual pathology is occurring, and so trying to put medicine in multiple levels is a shotgun approach for a patient who doesn’t have a clear target.

[G]iven that the more general procedure which would have been a lumbar epidural couldn’t be done because of her prior surgery, this was an appropriate technique to use instead.

⁴³ I could not locate the full February 8, 2006 visit report in Pt. C’s medical records (Exhibit 43).

She received prescriptions for Methadone 10 mg. (270), Oxycodone 30 mg. (90), and Zonegran 100 mg. (90). Pt. C also had a UDS done. The results of the UDS showed Pt. C was compliant in taking her prescribed medications. (Ex. 43:23-25/517-519; 146/640 & 150-151/644-645. Testimony of Dr. Trescot, Vol. XIV, 2764-2765.)

23. On May 11, 2006, Dr. Ogoke gave Pt. C her a left-sided lumbar transforaminal ESI injection with fluoroscopy at the L3, L4, L5 and S1 levels. At this visit, she reported a lower back pain level of 8/10 and a left upper extremity pain level of 4/10. She received prescriptions for Actiq 600 mg. (2) for pain during procedures, Oxycodone 30 mg. (90), Methadone 10 mg. (270), and Zonegran 100 mg. (90). (Ex. 43: 20-22/514-516; 138-142/632-636 & 144-145/638-639.)

24. On June 10, 2006, Dr. Ogoke gave Pt. C a bilateral SI injection with fluoroscopy. At this visit, she received prescriptions for Methadone 10 mg. (270), Oxycodone 30 mg. (90), Actiq. 600 mg. (2) for pain during procedures, and Zonegran 100 mg. (90). On July 3, 2006, Dr. Ogoke gave Pt. C a left-sided lumbar transforaminal ESI with fluoroscopy at the L2, L3, L4 and L5 levels. she received prescriptions for Methadone 10 mg. (270), Zonegran 100 mg. (90), Oxycodone 10 mg. (90), and Actiq 600 mg. (2) for pain during procedures. She had a UDS done. The results of this UDS showed Pt. C continued to be compliant in taking her prescribed medications. (Ex. 43: 14-19/508-513; 86-96/580-590 & 137/631.)

25. Pt. C was seen at Dr. Ogoke's office on August 4, 2006. She reported a decrease in pain after the third lumbar ESI, but the pain level had slowly returned with a pain level of 7/10 in her back and 6/10 in her legs. She reported having experienced redness and swelling in her legs for about a year and "mild dizziness intermittently over several weeks to months," conditions she had reported to her PCP. She was given a physical examination was given. A UDS was done.

She was assessed with: sacroiliitis; post lumbar laminectomy syndrome; lumbar disc herniation; lumbar degenerative disease; lumbar radiculopathy; sympathetic maintained pain of the left upper extremity; and, cervical disc herniations. The treatment plan was to do a facet joint injection and a diagnostic lumbar block, as recommended previously by Dr. Ogoke. Pt. C was to address her leg conditions with her PCP for dizziness, erythema, trace pedal edema, and to rule out deep venous thrombosis. She declined further evaluation and management of a possible vascular condition by Dr. Ogoke's office. The treatment plan also included renewing her medications, and she received prescriptions for Actiq 600 mg. (2) for pain during procedures, Zonegran 100 mg. (90), Methadone 10 mg. (270), and Oxycodone 30 mg. (120). The results of the UDS showed Pt. C was compliant in taking her prescribed medications. (Ex. 43; 11-13/505-507 & 80-85/574-579.)

26. Pt. C was seen at Dr. Ogoke's office on September 14, 2006. She reported a pain level of 8/10 in her legs and 6/10 in her back. She continued to have the symptoms of pedal edema. She had seen her PCP who started her on Lasix medication for this condition but without success. A physical examination was given. The treatment plan was for Pt. C to do follow-up with her PCP concerning the pedal edema, the Lasix medication, and her occasional dizziness. She agreed to have a venous Doppler test through Dr. Ogoke's office to rule out deep venous thrombosis in her legs, a condition that might have explained her leg pain. Another UDS was done.⁴⁴ Prescriptions were renewed for Zonegran 100 mg. (90), Oxycodone 30 mg. (120), and Methadone 10 mg. (270). She was to have a lumbar facet diagnostic block as soon as possible. The Doppler test was done on September 15, 2006 and showed bilateral pedal edema, but no evidence of deep venous thrombosis in either leg and no definite clot in either leg. Having this

⁴⁴ I could not locate or decipher within Pt. C's medical records (Exhibit 43) any UDS results from the September 14, 2006 urine specimen.

Doppler test done was “prudent” to rule out the deep venous thrombosis as a reason for the leg pain to make the radicular pain from the lumbar spine condition more likely the cause of the pain. The test was very safe to do. Up until now, Pt. C’s leg pain was thought to have been generated from her back condition. (Ex. 43; 7-10/501-504 & 76-78/570-572. Testimony of Dr. Trescott, Vol. XIV, 2766-2768.)

27. Pt. C was seen at Dr. Ogoke’s office on October 20, 2006. She reported a pain level of 6/10 in her legs and back. She continued to have the pedal edema condition, but had stopped taking the Lasix medication. She had not seen her PCP for awhile, and was “strongly advised” to see her PCP. Pt. C expressed her concerns over doing more injections because of this condition. She was given a physical examination. She reported having no shortness of breath or neurologic symptoms. The treatment plan continued to include doing a lumbar facet joint injection. A UDS was done. The UDS results showed Pt. C was compliant in taking her prescribed medications. Due to continuing concerns about deep venous thrombosis, Pt. C had another Doppler test and it was again negative for this condition. (Ex. 43; 4-6/498-500 & 72-75/566-569.)

28. By this time, Pt. C had a pedal edema condition in her legs with its cause undetermined. She was also not gaining much lasting relief from the injection treatments. She was refusing to consider any further low back surgery, and was refusing a trial use of a spinal cord stimulator. Dr. Ogoke did not have more to offer her other than to continue prescribing the high doses of opioids. He was also concerned that Pt. C had not returned to her PCP to explore the cause of the pedal edema in her legs. He opined that Pt. C had to work with her PCP to determine whether she had any other health concerns not connected to the reasons she was treating with Dr. Ogoke. (Testimony of Ogoke, Vol. VI, 1201, 1210-1213.)

29. On November 17, 2006, Pt. C came to Dr. Ogoke's office about 12:10 PM for her 11:45 AM appointment. Because she was late, Pt. C was told by the receptionist that the appointment would need to be rescheduled. Having a patient re-schedule her appointment when she is about twenty minutes late is not unusual and is within standard of care practicing. Pt. C's boyfriend was with her and this information caused him to become very upset and insistent that Pt. C get to see Dr. Ogoke. He began to yell and became belligerent to the office staff while his behavior was also experienced by those in the office waiting area. Dr. Ogoke was in a treatment room and did not hear the commotion. Pt. C's boyfriend was told by the office staff that the police would be called unless he left. He and Pt. C did not leave. The police came, Pt. C's boyfriend left the office, but Pt. C stayed. She continued to insist that Dr. Ogoke see her or she would sue the practice. She was not able to see Dr. Ogoke and she eventually left. An office note was made of this event and put into Pt. C's medical records. On or about November 19, 2006, Pt. C was mailed a termination letter from Dr. Ogoke by certified mail; that she was ceasing "immediately" to be his patient. The letter instructed her to seek care at an area pain management facility or with another physician. She was provided with the names of two pain management facilities in the area for continued care of the kind she had been receiving at Dr. Ogoke's office. She was also instructed that she could secure emergency care from Dr. Ogoke's office within the next thirty days. To provide a thirty day time period following termination of care for emergencies is a common practice, including at times providing even more time than thirty days. It is within standard of care to terminate care with a patient who is harassing and disrupting the medical practice in the office such as Pt. C had done. On November 28, 2006, Pt. C requested and received renewals of her prescriptions at the same levels that she had been taking them. The prescriptions were written as not renewable and were for Methadone 10 mg.

(270), Oxycodone 30 mg. (120), and Zonegran 100 mg. (90). The prescriptions covered about a week more than the date of her termination of care with Dr. Ogoke. No discussion was put into Pt. C's medical record on November 28, 2006 that indicated she had or was going to secure a particular new pain management facility, or that she was transferring her care to a new physician, or to her PCP. By November 28, 2006, Pt. C understood she would not receive continued care with Dr. Ogoke. On February 17, 2007, Dr. Ogoke's office responded to Pt. C's request for her medical records. (Ex. 43; 65/559 & 67-71/561-565. Testimony of Dr. Satwicz, Vol. XVI, 3145-3147 & Dr. Trescot, Vol. XIV, 2772-2775.)

30. If no actual transfer of pain management care occurred and Dr. Ogoke's prescriptions ended, Pt. C would expect to experience withdrawal symptoms due to the high opioid doses she had been taking. Withdrawal symptoms from opioids are very uncomfortable and are a dramatic medical event. No tapering-off from the high dose opioid medications was done by Dr. Ogoke before he ended his care of Pt. C, and Pt. C did not ask him to taper her off her opioid pain medications. (Ex. 83. Testimony of Dr. Ogoke, Vol. VI, 1212 & Dr. Satwicz, Vol. X, 1885; Vol. XVI, 3148.)

31. For Dr. Trescot, the course of events surrounding Pt. C receiving November 28, 2006 following her termination of care, her on-going pain medications that included the high doses of Methadone and Oxycodone, was within the standard of care for pain management practicing. Pt. C had on-going high pain levels in her legs that might or might not be due just to her back condition, or might be contributed to by her pedal edema condition, although that had not yet been resolved. If Dr. Ogoke had stopped or tapered down his opioid prescriptions, Pt. C's pain would have been increased from the already high level she had. Pt. C was aware of her need to continue to seek pain management care and to resolve the cause of her pedal edema condition

through her PCP. Dr. Ogoke provided her with area pain management facilities she could go to. (Testimony of Dr. Trescot, Vol. 2775-2779.)

32. Dr. Satwicz opined that there should have been some indication in Pt. C's medical records that either a transfer of care occurred, or that a tapering down from high doses of opioids was done in connection with her termination of care. Without one or the other of these events occurring, there would in his opinion, be a failure of the standard of care in treating Pt. C. He found no evidence in Pt. C's medical records that a transfer of care had occurred. He also found no tapering down process was done or even a discussion of doing that within Pt. C's medical records. (Testimony of Dr. Satwicz, Vol. X, 1886-1888.)

33. In her February 2007 complaint to the BORM, Pt. C contended that the injections she received were painful, and that she would be given a towel to bite into during them so that she would not be heard screaming by patients in the wait area. She complained that she had to wait up to six hours to see Dr. Ogoke. She contended that he would leave the office to do personal errands while patients waited. In terms of the incident at Dr. Ogoke's office when she arrived late, refused to reschedule her appointment, and insisted upon seeing Dr. Ogoke, Pt. C contended that she was not very late and should not have been forced to reschedule her appointment as her only option. She described her boyfriend as only questioning why she could not wait to see Dr. Ogoke. She complained that Dr. Ogoke terminated her care, because her boyfriend questioned the office staff why she could not wait to see Dr. Ogoke, and because she refused further injection treatments that were not helping her pain. She complained that Dr. Ogoke did not wean her off her opioid medications when he terminated her care, leaving her without another pain management program and causing her to go through difficult withdrawal symptoms. (Ex. 83.)

Conclusion and Recommendation

The Statement of Allegations charged Dr. Ogoke with violations of standard of care by: improperly prescribing and then maintaining Pt. C on high doses of opioids; failing to set forth the details of the opioid prescriptions he wrote for Pt. C within her visit reports; and, failing to taper her off her high doses of opioids in connection with ending her care with him. The BORM did not prove these charges against Dr. Ogoke.

Pt. C did not testify, and her written complaint to the BORM (Exhibit 83) did not help to determine whether there were violations of the required standard of care in how Dr. Ogoke treated her. I did not give her complaint much weight to support the charges against Dr. Ogoke. Pt. C complained that Dr. Ogoke was wrong to end his care of her and not to continue to prescribe her pain medication, when she would not continue to have injection procedures. She opined that telling Dr. Ogoke that the injection procedures were not providing sufficient pain relief, should have been enough to justify her staying on her pain medication without a termination of care. She complained that upon ending her care, Dr. Ogoke never helped her wean off her high doses of opioids, did not get her new pain management care with another physician or clinic, and that he was responsible for her subsequent difficult withdrawal symptoms.

Pt. C complained that she had to bite into a towel during injection procedures so that her screams would not be heard by people in the office waiting area. She complained that she would have long waits to see Dr. Ogoke and that he left the office instead of fulfilling his patient appointments in order to do personal errands. She complained that the one time she was about ten minutes late for an appointment and was told to reschedule her appointment, that she had every right to be upset as did her boyfriend who accompanied her to the office. She complained

that she and her boyfriend were treated poorly because she got angry and wanted to wait to see Dr. Ogoke. She opined this justifiable conduct on her part was wrongfully used as another reason why Dr. Ogoke ended his care with her.

Pt. C's complaints about the long waits to see Dr. Ogoke because he would leave the office to do personal errands instead of keeping patient appointments, and biting into a towel to muffle screams, were charges in the Statement of Allegations at #s 2-8. Without her testimony, her written complaints were not given any weight to prove these claims. The long wait she described in her complaint to see Dr. Ogoke after she was no more than ten minutes late, was refuted by her medical record information that had her late about double that time. Having to reschedule an appointment when a patient was late was an office protocol. Her account left out the very disruptive conduct of her boyfriend in the office that day that led to the police being called to make him leave. It was not long after this event that Dr. Ogoke ended his care of Pt. C, due to her uncooperative conduct to explore with her PCP the cause of her pedal edema, her disruptive conduct in his office, and her refusal to have further interventional treatments. The BORM has charged that Dr. Ogoke had no sound reasons to end his care of Pt. C the way he did, because he was forcing her to have interventional procedures if she wanted to stay on her pain medications that she was dependent upon for pain relief. The charge is expressed as a kind of blackmail or a tool to compel Pt. C to continue interventional procedures due to her dependency on the high opioid doses. This is an inaccurate view of the course of events. The reason Pt. C was having care with Dr. Ogoke was to receive interventional procedures and not just to receive long-term opioid pain medications at high doses. Pt. C knew this as shown from the medical records that contained mostly monthly visits at Dr. Ogoke's office. She was well aware that her treatment plan always included having interventional procedures and not just high

dose opioid prescriptions. She had come to care with Dr. Ogoke already having taken high doses of opioids and having had some interventional procedures. Dr. Ogoke ending her care because she was refusing injection procedures was appropriate.

When Pt. C was terminated from Dr. Ogoke's care, he provided her with the names of two area pain management clinics and provided her with about five weeks of her ongoing prescriptions, including the Oxycodone and Methadone, her high dose opioid medications. There was no proof that she tried to set up continuing care for pain management through either of these clinics, or through some other physician, or even through her PCP where she had initially been prescribed opioid pain medications. The weight of the evidence points to Pt. C having been aware that she would not be continuing care with Dr. Ogoke following her receipt of the termination letter, or after her receipt of further pain medication on November 28, 2006 at Dr. Ogoke's office. She had received additional pain medication on November 28th within the emergency care time period Dr. Ogoke gave his patients following the termination of their care. There was no proof that Pt. C returned to Dr. Ogoke upon her termination of care to ask him to taper her off her opioid medications, and the record contains more of an indication through her complaint to the BORM that she did not want to be tapered-off her opioid medications. There was no proof that Pt. C was rejected from receiving pain management care with an alternative pain management clinic, or with another pain management physician, or with her PCP. There was no proof, that if Pt. C began to experience withdrawal symptoms, she did not receive or was refused medical attention to address the symptoms. No evidence showed upon her termination of care with Dr. Ogoke, that he knew she could never line-up continuing pain management care anywhere else. Around the time of the termination, Dr. Ogoke had been administering routine UDS tests to Pt. C that showed she was being compliant in taking her

prescribed opioid medication. There was no UDS or other information Dr. Ogoke had that Pt. C had been taking illicit drugs to require her to undergo detox treatment.

Dr. Satwicz would have required Dr. Ogoke to have included in his medical record information that Pt. C in fact was receiving pain management care elsewhere before he could terminate his care of her, or that she was in a tapering-off process with him in advance of being terminated from his care. Dr. Satwicz's opinion was not persuasive given the course of care that Pt. C received from Dr. Ogoke, in light of her high pain levels, and in light of her insistence upon continuing to receive her pain medication.

Dr. Ogoke had clear refusals by Pt. C at the time he ended his care of her that she would not cooperate toward using alternatives to her high pain medications for securing pain control. Her PCP had prescribed Lasix medication for her pedal edema but she refused to take it. She refused to resolve with her PCP why she had the pedal edema. Without that resolution, tapering Pt. C off the opioid medications would have likely caused Pt. C even more pain than the high levels she was already reporting. Nothing in the record showed Dr. Ogoke was practicing pain management care improperly or recklessly or negligently by wanting to address adequately the pedal edema before he would do another injection procedure. When Pt. C informed Dr. Ogoke that she was not taking the Lasix and was not doing follow-up about the pedal edema with her PCP, Dr. Ogoke was left with only being able to keep Pt. C on high doses of opioids and not being able to fulfill his treatment plan that depended on Pt. C receiving interventional procedures. Dr. Ogoke had also recommended to Pt. C that she see a surgeon to determine if surgery would help her pain control. She refused. He wanted to explore trial use of a spinal stimulator to see if that would help her pain control toward decreasing her dependence on pain medications. She refused. By the time of the termination of care, she was an uncooperative

patient with the patient-pain management specialist physician relationship not working. The charge that Dr. Ogoke violated the standard of care by not tapering Pt. C off her opioid prescription levels before terminating her care was not proven.

Pt. C's medical records showed that Pt. C had significant cervical and lumbar spinal conditions that it was reasonable to understand were capable of causing her to experience ongoing high pain levels. No evidence showed that Pt. C was exaggerating her pain complaints at any time, or that they were not as harsh as she claimed. Pt. C came initially to Dr. Ogoke in 2001 following back fusion surgery and when she was already on opioid pain medication. Dr. Satwicz initially opined when he lacked knowledge of Pt. C's back fusion anterior and posterior surgery, that Pt. C was having aches and pain that many people experience with their back. Upon learning of this medical background by viewing Exhibit 100, her initial evaluation with Dr. Ogoke, he acknowledged that her pain could have been at high levels when she came to see Dr. Ogoke for the first time in June 2001, two months after her back fusion surgery. When she returned to Dr. Ogoke's practice in 2005, Pt. C was still experiencing high levels of chronic pain. MRIs of her cervical and lumbar spines revealed conditions that supported her reported high pain levels. I concluded that during the time in 2005-2006 that Dr. Ogoke treated Pt. C, she had difficulty to control intractable chronic pain. As a result, Dr. Ogoke tried to give her injection treatments to target her sources of pain so that she would require less opioid pain medication. Locating where in her lumbar spine to target the injections was made more difficult due to the 2001 fusion surgery.

Dr. Satwicz opined that no matter what, the high doses of opioids that Pt. C was being maintained on were excessive for the kind of painful physical ailments she had. But, I was persuaded by Dr. Trescot's contrary opinion in her evaluation of not only Pt. C's condition, but

of Dr. Ogoke's treatment responses to her chronic pain. No evidence showed Pt. C's pain complaints were in the nature of only intermittent high pain or discomfort complaints that could have been adequately treated with life-style changes, physical therapies, and low dose pain medications. I was persuaded by Dr. Ogoke's testimony about how he treated patients like Pt. C, with physical therapy orders, as well as with the periodic re-evaluations of Pt. C's conditions, and that he used UDS testing to check on proper use of the prescribed pain medications.

The BORM's charge of medical mistreatment of Pt. C or misconduct by Dr. Ogoke by having prescribed high opioid doses of medications over a long time period, was not proven. No evidence showed that Pt. C was obviously exaggerating her pain complaints given her underlying conditions, or that she was diverting her opioid medication, or that she was using illicit drugs. Her UDS results revealed that she was taking her opioid medication as prescribed. Dr. Ogoke was trying to help Pt. C reach an improved quality of life through securing adequate pain relief through thoughtful treatment plans for her.

Pt. C found her injection treatments could be painful when she was undergoing them. This was not unusual for some of Dr. Ogoke's chronic pain patients who received interventional treatments. For such patients, he would prescribe a sedative such as Ativan for his patients to take in preparation for the procedure. For some patients, like Pt. C, he also prescribed Actiq if it was covered by their insurance carrier. The Actiq would be taken during the procedure to stop a pain reaction. All three physicians, Dr. Ogoke, Dr. Trescot and Dr. Satwicz agreed that Actiq is a strong fast-acting cancer drug would stop any pain sensation quite quickly. Since an injection would not be a long-time event, the pain relief would have to be delivered quickly to make a difference. Dr. Satwicz opined that this drug should never have been prescribed for Pt. C to add to the already high doses of opioids she was taking even if just for use during an injection

procedure. For him, this was just too strong an opioid drug for her. Dr. Trescot disagreed on this limited use of Actiq, and I was persuaded by her expert opinion that this limited use of Actiq was not a violation of standard of care for Pt. C. This issue was not singled out for Pt. C in the Statement of Allegations as a violation of standard of care by Dr. Ogoke, but Dr. Satwicz's opinion on Pt. C taking this was viewed as part of why he opined that Pt. C was on too high doses of opioids for too long.

On one occasion Pt. C experienced paresthesias during the cervical injection procedure at the C5-6 level. I concluded that Dr. Ogoke properly addressed this reaction. He waited to proceed and was able to because the injection began to work to numb the area around the targeted nerve. I was persuaded by the testimony of Dr. Ogoke and Dr. Trescot that experiencing paresthesias is not uncommon during a lumbar ESI when the injection reaches the area causing the pain. Dr. Satwicz's opinion was insufficient proof of a violation of the standard of care in the way Dr. Ogoke carried out that particular procedure in August 2005. It was insufficient proof that Pt. C was taking too much opioid medication. Dr. Ogoke gave Pt. C multiple level lumbar spine injections during one procedure. Pt. C had pain at multiple levels on her spine as shown from her physical examination results and from MRI findings. Dr. Trescot agreed with Dr. Ogoke about the complications due to Pt. C's spinal fusion surgery of locating the sources of pain in the lumbar spine. Dr. Ogoke was not overprescribing for Pt. C when he prescribed Elavil after she experienced the paresthesias during the injection procedure to calm any irritation to any nerve root that might have occurred during the procedure. Paresthesias was not reported by Pt. C after this post-injection care to be an ongoing symptom. Dr. Trescot's expert opinion was persuasive that Dr. Ogoke properly addressed this symptom experienced during the procedure.

Within the medical records on the disc, Exhibit 43, none of the hundreds of pages covering a particular patient were in any chronological order. Also complicating an ability to set-up a course of events of Dr. Ogoke's treatment of each patient, were the often difficult to read or not properly copied medical records. This was a problem with Pt. C's medical records requiring a time consuming and tedious task to assemble her care with Dr. Ogoke in chronological order. I found this a necessary task to do in order to address the charges regarding Pt. C. In the course of this task, I was able to line-up pretty routinely, the prescriptions that Dr. Ogoke or his physician assistants wrote at each office visit. In this regard, I take issue with Dr. Satwicz's opinion that the task I accomplished could not be reasonably done to make leaving out the details about each prescription written within each visit report a failure to meet a standard of care. Perhaps if the BORM had presented a witness to explain how Dr. Ogoke's records were received, assembled, and copied, etc., I might have appreciated Dr. Satwicz's assessment more, but that did not happen. And, I also found discussions within the visit reports that addressed why particular treatment plans and medication regimens were being pursued. The mostly monthly visit reports included Pt. C explaining her pain complaints, whether she had suffered any new injuries or had new health issues, what her physical examination at the visits revealed, the on-going diagnoses she carried, and the treatment plan that would be followed.

Patient E

Summary

Patient (Pt.) E did not testify.

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Injected Pt. E with multiple needles of medication at one time during an injection procedure;
- Failed to properly manage Pt. E's adverse reaction to an injection treatment on November 29, 2006;
- Wrote a note on December 1, 2006 in Pt. E's medical record contradicting the November 29, 2006 note decreasing the amount of Depo-Medrol medication dose Pt. E actually received during his injection treatment; and,
- Terminated Pt. E from his care because Pt. E did not want to have further injection treatments.

The facts the BORM alleged to support its allegations include the following:

- Pt. E, a male born in 1958, was treated by Dr. Ogoke from 1997 to 2006 for: low back and leg pain with diagnoses of lumbar disc herniation at L5-S1; lumbar disc bulge at L4-L5; lumbar facet arthropathy at L4-L5 and L5-S1; failed back surgery syndrome; and, sacroiliitis.
- Among the medications Pt. E was prescribed by Dr. Ogoke were Percocet and Vioxx.
- Dr. Ogoke gave Pt. E "multiple injections ... including facet injections, sacroiliac joint injections, and epidural [steroid] injections."
- On November 29, 2006, Dr. Ogoke gave Pt. E "a bilateral 4-level facet block injection with the use of multiple needles at one time." In his note on this procedure, Dr. Ogoke wrote that Pt. E "received 2 vials of 80 mg. of Depo-Medrol during the injection." After the November 29, 2006 procedure, Pt. E experienced "dizziness, chest pain, and shortness of breath." Pt. E went home after having the injection, but returned to Dr. Ogoke's office on December 1, 2006 because of this continuing symptomatology.
- Pt. E was referred to a hospital emergency room by Dr. Ogoke's physician assistant due to his symptoms, but Dr. Ogoke's staff "refused to give Pt. E his medical records from the previous visit to take with him to the emergency room." Within Pt. E's medical records is a handwritten note

dated December 1, 2006 stating that Pt. E “received 20 mg. of Depo-Medrol on November 29, 2006.”

- When Pt. E next saw Dr. Ogoke, he told Dr. Ogoke that “he did not want to receive any more injections.” As a result, Dr. Ogoke told Pt. E “he would no longer treat him.”
- Within Pt. E’s medical records “is a note from an independent medical exam (IME) in which that physician documents that he suspects Patient E is exaggerating his pain symptoms.” Dr. Ogoke continued to treat Pt. E anyway “with multiple injections and pain medication.”

Findings of Fact

1. Pt. E, a male born in 1958, began care with Dr. Ogoke in 1997 for low back pain radiating into both legs. He was referred to Dr. Ogoke by Dr. Andrew Gregory, a chiropractor. Pt. E had been in a car accident on October 10, 1997 and had lumbar spine and cervical spine x-rays taken. He had minimal cervical osteoarthritis. On October 20, 1997, he had a lumbar spine CT scan that showed diffuse bulges at L3-4 and L4-5 with no herniations. Pt. E had undergone lumbar spine surgery in April 1991 due to injuries from a fall at work in 1990. Pt. E’s 1997 pain was different from the pain he had in 1990-1991. He had a comprehensive evaluation with Dr. Ogoke on November 6, 1997. Dr. Ogoke’s office had received from Dr. Gregory’s office the results of the October 20, 1997 lumbar spine CT scan, and the cervical and lumbar spine x-ray results. Pt. E reported a pain level of 10/10 and that he was taking Hydrocodone, Toradol, and Duract. He signed various forms to become a new patient of Dr. Ogoke. Dr. Ogoke took a medical and social history, had Pt. E complete a questionnaire about his conditions, did a review of systems, and gave a detailed physical examination. He concluded Pt. E had a poor response to conservative management of his pain. He diagnosed: lumbar radiculopathy consistent with L1, L2, L3 radicular symptoms; sacroiliitis; and, failed back surgery syndrome. Pt. E’s treatment plan included prescriptions for non-steroidal anti-inflammatory (NSAID) medication, muscle relaxants, and tricyclic anti-depressant medication. Pt. E received prescriptions for Robaxin 500

mg. (60), Relafen 500 mg. (30), and Elavil 25 mg. (30). If these measures did not help, then further x-rays and a lumbar spine CT scan would be ordered. (Ex. 43: 25-29/705-709; 74/754 & 77-88/758-768.)

2. At a follow-up visit on November 18, 1997, Pt. E, who had been compliant in taking the prescribed pain medication, reported a pain level of 8-9/10. Dr. Ogoke discussed the worth of injection treatments. Pt. E agreed to the injection treatments to be spaced four weeks apart. He gave him a caudal epidural steroid injection (ESI) at this visit; "20 cc of 0.125% bupivacaine mixed with 100 mg. of Depo-Medrol was injected aseptically. A good block was achieved." (Ex. 43: 21-24/701-704; 68/748; 71-73/751-753; 75-76/755-756 & 89/769.)

3. Pt. E had a follow-up visit at Dr. Ogoke's office on December 2, 1997. He reported feeling better with a pain level of 6-7/10. A sacroiliac joint (SI) injection was planned. Pt. E was seen at Dr. Ogoke's office on December 16, 1997. Pt. E reported a pain level of 8-9/10. Dr. Ogoke gave a physical examination and assessed him with severe sacroiliitis and a failed back surgery syndrome. He gave Pt. E a bilateral SI injection. During the procedure, Pt. E received "6 cc of 0.20% bupivacaine mixed with 40 mg. of Depo-Medrol." The plan was to schedule the caudal ESI #2. (Ex. 43: 18-20/698-700; 51/731 & 60-70/740-750.)

4. Dr. Ogoke gave Pt. E the ESI #2 with caudal approach on January 6, 1998. "200 cc of 0.125% bupivacaine mixed with 100 mg. of Depo-Medrol was injected aseptically ... a good block was achieved." At this visit, Pt. E reported that the injections were not providing lasting pain relief because the pain had returned a week after the last injection. He was scheduled for the ESI #3 in four weeks. Pt. E was seen at Dr. Ogoke's office on January 20, 1998. He felt better, and no change was made in the plan to do the ESI #3. On February 4, 1998, Dr. Ogoke gave Pt. E the ESI #3 injection. He received "20 cc of 0.125% bupivacaine mixed with 80 mg.

Depo-Medrol ... A good block was achieved.” In January 1998, Dr. Ogoke had sought an evaluation for Pt. E by Dr. Ronald P. Cantanese, a urologist. Dr. Cantanese saw Pt. E on February 2, 1998 and reported to Dr. Ogoke in a February 6, 1998 report that Pt. E’s “urinary stream is improving markedly ... I expect follow-up ... on a prn basis if this does not spontaneously remit. Discharge diagnosis was reversible neurogenic bladder secondary to trauma.” Pt. E was seen at Dr. Ogoke’s office on February 18, 1998. He reported feeling markedly improved with better ambulation and overall reduced back pain. He reported neck pain at a 3/10 level with no radiating pain. He had a physical examination. The assessment of cervical strain was added to his lumbar spine condition assessments. The treatment plan was to take NSAID medication and to do a follow-up in a week for a possible discharge from care. (Ex. 43: 10-17/690-697; 45-50/725-730; 52-57/732-737 & 58-60/738-740.)

5. On March 6, 1998, Pt. E was evaluated by Dr. Ogoke. Pt. E reported back pain at a 3/10 level, relieved with NSAIDs medications. Dr. Ogoke gave Pt. E a physical examination, assessed him with a failed back surgery syndrome and a cervical strain. Dr. Ogoke discharged Pt. E from his care prescribing high dose NSAID medications for the neck pain, and he included Daypro 600 mg. (30). He was to return if his back or neck conditions worsened. On March 16, 1998, Dr. Ogoke produced a report on his care of Pt. E. He provided a history of treatments and progress, assessments, results from x-rays and CT scan, a prognosis, a past medical history of the April 1991 back surgery, and an opinion on the degree of disability Pt. E had at the time of his discharge from Dr. Ogoke’s care of “an 8% whole person impairment as the result of two disc bulges at the L3-4 and L4-5 levels.” The final diagnoses included aggravated failed back surgery syndrome, cervical strain, and sacroiliitis. Dr. Ogoke found a cause and effect relationship between the car accident of October 10, 1997 and the conditions he treated Pt. E for. He opined

Pt. E had a good short-term prognosis and a guarded long-term prognosis because of “pre-existing structural problems, lower back pain, status post-surgery, and aggravation of ... problems” from the car accident. (Ex. 43; 4-10/684-690 & 43-44/723-724.)

6. Pt. E returned for care with Dr. Ogoke on May 10, 2001. He was referred by Dr. Paul Filippini. He had another comprehensive evaluation. He reported a pain level of 7/10 of the same kind in his low back and legs that he had when Dr. Ogoke had previously treated him. He reported that the pain varied in intensity. He reported no new injuries to account for the pain returning, but the pain had worsened since his discharge from Dr. Ogoke’s care in 1998 as well as over the prior two weeks. He had taken Indocet and Hydrocodone medication without much relief, but hot packs and a TENS unit had helped to relieve the pain. The pain was interfering with his ability to bend and lift, and with his abilities to work in the house and at work. Dr. Ogoke took a medical and family history. He did a review of systems. Pt. E had not had any recent radiographic studies, but he had undergone a recent work-up at the Holyoke Hospital for right hip pain. Dr. Ogoke sought this hospital record. Dr. Ogoke gave a physical examination. His diagnoses included: lumbar radiculopathy with a need to rule out herniation versus facet arthropathy; severe sacroiliitis; and, failed back surgery syndrome. The treatment plan was to have Pt. E have a physical therapy evaluation and to do therapy with “bioelectric with Matrix ProElec DT2 starting at the lumbar level.” Pt. E was to have a lumbar CT scan as soon as possible. For pain control, Dr. Ogoke prescribed high dose NSAID medications, muscle relaxant, and tricyclic anti-depressant medications (Celebrex 200 mg. (60), Elavil 50 mg. (30), and Skelaxin 400 mg. (40)). Also planned were three spaced out in time lumbar ESI injections, and after the first ESI was done, having a bilateral SI injection. The report of this evaluation was sent to Dr. Filippini. (Ex. 43: 202-210/882-890; 436-445/1116-1125 & 447/1127.)

7. Pt. E had a lumbar CT scan done on May 24, 2001 that showed, “[m]ild disc bulge and degenerative change at L4-5”, and “[m]ild broad-based central disc herniation at L5-S1”. On May 29, 2001, Pt. E was seen at Dr. Ogoke’s office and reported a pain level of 9/10. Dr. Ogoke gave Pt. E a lumbar ESI #1 with fluoroscopy covering L5-S1. (Ex. 43: 306/986, 199-201/879-881 & 431-435/1111-1115.)

8. Pt. E was seen at Dr. Ogoke’s office on June 15, 2001. He reported a pain level of 5-7/10. He reported a good response to the ESI #1 including improvement in his radicular leg pain. The results of the May 24, 2001 lumbar CT scan were discussed with him. He was given a physical examination. The assessments reached were: ongoing lumbar spine conditions of radiculopathy; disc herniation at L5-S1 and a disc bulge at L4-L5 along with facet arthropathy at these two levels; failed back surgery syndrome; and, sacroiliitis. Pt. E found the Celebrex he had been prescribed produced a rash. He was instructed to discontinue using it and was prescribed Vioxx 25 mg. (30). His other medications were renewed. A bilateral SI injection was to be scheduled as soon as possible. The lumbar ESI #2 was to be scheduled after the SI injection. (Ex. 43: 196-198/876-878; 398-399/1078-1079 & 425-430/1105-1110.)

9. On July 12, 2001, Dr. Ogoke gave Pt. E a bilateral SI injection with fluoroscopy. On July 20, 2001, Pt. E had a follow-up visit at Dr. Ogoke’s office. He reported his back pain was better at a 3-4/10 level. Pt. E reported being compliant in taking his medications. He reported the pain that radiated into his lower extremities had “resolved” following the injection procedures. A physical examination was given. The assessments remained the same. The treatment plan was to continue his medications including Celebrex 200 mg. (60) and Skelaxin 400 mg. (90). He was scheduled for the ESI #2 injection. On July 24, 2001, with a pain level in his back of 5-6/10, Dr. Ogoke gave Pt. E the lumbar ESI #2 injection with fluoroscopy at the L5-

S1 level. (Ex. 43: 192-195/872-875 (incomplete record of July 20, 2001 report); 407-409/1087-1089 & 419-422/1099-1102.)

10. On August 7, 2001, Pt. E had a follow-up visit at Dr. Ogoke's office. He reported a pain level in his back of 2-3/10. He reported a "50 percent improvement" in low back pain after the lumbar ESI #2. He reported that the SI injection had helped the sacroiliitis symptoms. He reported a flare-up of pain that was helped by taking the Skelaxin and Celebrex. A physical examination was given. The assessments remained the same. The treatment plan was to do physical therapy for four weeks to include "Bioelectric treatment with Matrix pro Elec DT2" to the lumbar area, continue taking the prescribed medications, and schedule a lumbar ESI #3 injection. (Ex. 43; 189-191/869-871 & 405-406/1085-1086.)

11. On August 27, 2001, Pt. E had an independent medical evaluation (IME) connected to workers compensation benefits with Dr. DeWitt Brown, an orthopedic surgeon. Dr. Brown understood Pt. E was a machine operator who stopped working after two years on July 27, 1990 when he was hurt pulling a hand truck that became stuck on the floor causing him low back pain. Dr. Brown understood Pt. E sought care with a chiropractor and then with James Reiss, MD. Dr. Brown understood Pt. E had a lumbar laminectomy at L4-5 right, but did poorly after surgery. Dr. Brown understood Pt. E had physical therapy and chiropractic treatments, and saw Dr. Ogoke for pain management which involved seven ESIs with no lasting improvement. Dr. Brown understood Pt. E had ongoing pain in the low back and left leg, had trouble sleeping, and was taking Skelaxin, Celebrex, Hydrocodone, Naprosyn, and Indocin. Dr. Brown had knowledge of the results of the May 2001 CT scan, and examined medical records of treatments Pt. E had received, including records from Dr. Ogoke's office. Dr. Brown gave a physical examination. He concluded that the treatments Pt. E had undergone had been reasonable and

necessary. He opined that Pt. E was a “symptom magnifier” with “subjective” pain complaints that were much greater than objective findings supported. Dr. Brown concluded that Pt. E had reached a medical end point with a “ten percent whole person impairment,” and was capable of doing sedentary work with no lifting over twenty pounds. Dr. Ogoke saw this report and had a copy of it put into Pt. E’s medical records. (Ex. 43; 402-404/1082-1084 & 424/1104.)

12. At a follow-up visit with Dr. Ogoke’s office on September 4, 2001, Pt. E had an improved pain level in his back of 3/10 following his lumbar ESI #3⁴⁵ when his pain level was 8/10. He reported what was likely an anxiety attack. He was given a physical examination. The assessments reached were the same; lumbar disc herniation at L5-S1, lumbar disc bulge at L4-L5, lumbar facet arthropathy at these two levels, failed back surgery syndrome, and improved sacroiliitis. The treatment plan was to have a multi-level lumbar facet joint injection as soon as possible, consider another multi-level lumbar facet joint injection (double block), and then possibly have a facet denervation procedure. He was to continue taking his medications and to start physical therapy treatments. Pt. E received a copy of Dr. Brown’s report through his attorney on or about September 19, 2001. (Ex. 43; 186-188/866-868 & 401/1081.)

13. Pt. E did not return to Dr. Ogoke’s office again until January 15, 2003 when he reported a pain level of 6-7/10 in his low back and ongoing symptoms since September 2001. He had not continued in Dr. Ogoke’s care due to workers compensation not covering his expenses with Dr. Ogoke. He reported having been prescribed medications by Dr. Filippini in the interim. A physical examination was given. The assessments reached were: lumbar strain; lumbar herniation at L5-S1 and bulge at L4-5; lumbar facet arthropathy at L4-5 and L5-S1;

⁴⁵ I could not locate or decipher in Pt. E’s medical records (Exhibit 43) a write-up specifically about the ESI #3 procedure.

sacroiliitis; and, failed back surgery syndrome. Pt. E was prescribed medications.⁴⁶ The treatment plan was: obtain a new lumbar CT scan; do a repeat series of three lumbar ESIs; consider a lumbar facet injection if the ESIs were not effective; and, do an SI injection after the first lumbar ESI. Pt. E signed Dr. Ogoke's Narcotic Prescription Policy & Agreement form (narcotics agreement). (Ex. 43; 183-185/863-865 & 393/1073.)

14. On January 21, 2003, Pt. E underwent a lumbar CT scan that showed a slight reduction in the L5-S1 disc herniation "with persistent disc bulge and moderate mass effect on the anterior thecal sac," and the minimal bulge at the L4-L5 disc unchanged from prior films. Dr. Ogoke wanted this CT scan to provide more information on the status of the different parts of Pt. E's lumbar spine. The CT scan revealed: the status of the discs at different levels; the facet joints; the neuroforamina itself; where the nerve roots are exiting; whether the nerve roots are compressed or irritated or whether they have problems; the general contour of the lumbar axial spine as there should be a lordotic curvature; and, the integrity of the bones of the lumbar spine such as the traverse process, and spinous processes. This information could help to locate the potential sources of the Pt. E's pain to allow focusing on these specific locations to deliver effective pain relief using interventional procedures. (Ex. 43, 307/987. Testimony of Dr. Ogoke, Vol. VI, 1295-1296.)

15. On January 22, 2003, Dr. Ogoke gave Pt. E the lumbar ESI #1 with fluoroscopy at the L5-S1 level. At this visit Pt. E reported a pain level of 7/10. On February 3, 2003, Dr. Ogoke gave Pt. E the bilateral SI injection with fluoroscopy. (Ex. 43: 177-182/857-862; 391-392/1070-1072 & 384-386/1064-1066.)

16. Pt. E was seen at Dr. Ogoke's office on February 21, 2003. He had a pain level of 2-

⁴⁶ I could not locate or decipher in Pt. E's medical records (Exhibit 43) what Pt. E was prescribed on January 15, 2003.

6/10 in the low back, and felt the SI injection had helped. He had a physical examination. The assessments reached remained unchanged. The treatment plan was to return for the lumbar ESI #2 as soon as possible, stop taking Celebrex due to stomach upset, and consider a lysis of adhesion procedure in the future. He was prescribed Ultram (Tremadol) 50 mg. (90). (Ex. 43; 175-176/855-856 & 381/1061.)

17. On February 25, 2003, Pt. E had the lumbar ESI #2 with fluoroscopy at level L5-S1. (Ex. 43, 172-174/852-854.)

18. On March 11, 2003, Pt. E was seen by Dr. Ogoke. He reported a pain level of 8-9/10 in the low back and a pain level of 8-9/10 in his neck. He reported pain relief for awhile after the lumbar ESI #2. Consideration was given to having Pt. E have a lysis adhesion procedure to address his pain. A physical examination was given, and the same assessments were reached with the addition of "failed back surgery syndrome, possible epidural scarring and radiculopathy." The plan was to continue his current medications, do the lumbar ESI #3, and to possibly do a lysis of adhesion procedure once Pt. E was back from a trip. At this visit, he was prescribed Vicodin (30), Vioxx 25 mg. (30), Ultram 50 mg. (90), Skelaxin 400 mg. (90), and Elavil 50 mg. (30). (Ex. 43; 170-171/850-851 & 376-377/1056-1057.)

19. Pt. E was seen by Dr. Ogoke on May 16, 2003. He reported a pain level of 9-10/10 that was worse in the left lower back. He was having trouble walking and standing for long periods of time. He felt his current treatments were not helping enough to control his pain. Pt. E had not been compliant with his treatment plan concerning the timing of his office visits. The importance of maintaining compliance with his treatment plan was discussed with Pt. E. There was no change in his review of systems, he had a physical examination, and his assessments remained unchanged. Dr. Ogoke did the lumbar ESI #3 with fluoroscopy at the L5-S1 level.

The treatment plan was for Pt. E to have a lysis of adhesion procedure if he did not experience much help from today's procedure, or he was to have a lumbar ESI #4 done. His current medications were renewed.⁴⁷ (Ex. 43, 165-169/845-849.)

20. Pt. E was seen by Dr. Ogoke on May 30, 2003. He reported a pain level of 7-8/10 with some relief from the last lumbar ESI procedure. Dr. Ogoke found Pt. E to be disabled by low back radiating pain down his legs with only marginal pain relief from the interventional procedures. He was given a physical examination, and the assessments reached were unchanged. The treatment plan was to schedule an epidurogram study and to consider a lysis of adhesion procedure. Pt. E was continued on his current medications,⁴⁸ and a bilateral SI injection was to be done as soon as possible. (Ex. 43, 163-164/843-844.)

21. On June 10, 2003, with a reported pain level of 7/10, Dr. Ogoke gave Pt. E an epidurogram with fluoroscopy to assess his post-lumbar laminectomy syndrome with lumbar radiculopathy. He tolerated the procedure well. As a result of this procedure he was found to be a candidate for a lysis of adhesion procedure. (Ex. 43; 160-162/840-842 & 363-365/1043-1045.)

22. Pt. E was seen at Dr. Ogoke's office on August 13, 2003. He reported a pain level of 6-7/10 in the low back and left leg. He had a physical examination. The same assessments were made. The treatment plan was to schedule him for a lysis of adhesion procedure as soon as possible in light of his positive epidurogram. He was also to start physical therapy as soon as possible, and to start taking anti-inflammatory, muscle relaxant, and Elavil medications. He was prescribed Skelaxin 400 mg. (20), EC Naprosyn 500 mg. (60), and Elavil 25 mg. (60). (Ex. 43; 158-159/838-839 & 360/1040.)

⁴⁷ I could not locate or decipher in Pt. E's medical records (Exhibit 43) the copies of the prescriptions written at this August 16, 2003 visit.

⁴⁸ I could not locate or decipher in Pt. E's medical records (Exhibit 43) the copies of the prescriptions written at this May 30, 2003 visit.

23. On September 22, 2003, Dr. Ogoke performed a lysis of adhesion procedure with fluoroscopy on Pt. E. (Ex. 43; 154-155/834-835 & 353-358/1033-1038.)

24. Pt. E was seen at Dr. Ogoke's office on October 6, 2003. He reported a pain level of 4-5/10 and felt better overall. He had a physical examination and the assessments were unchanged. He was to continue his home physical therapy treatments, including use of a TENS unit. (Ex. 43, 156/836.)

25. Pt. E was seen on November 6, 2003, at Dr. Ogoke's office. He had a pain level of 6-7/10 in his back, but 8/10 in his legs. The lysis of adhesion procedure had lowered his pain by about 50%. He was given a physical examination and the assessments were unchanged. The treatment plan was to schedule a lumbar transforaminal ESI as soon as possible due to the recurrence of the radiculopathy symptoms. He was to stop Celebrex and Skelaxin because of stomach upset. He was to continue physical therapy treatments, and was prescribed Vioxx 25 mg. (30) and Lidocaine patches (60). (Ex. 43; 151-153/831-833 & 347-350/1027-1030.)

26. On January 29, 2004, Pt. E had a follow-up visit at Dr. Ogoke's office. He needed refills of his prescriptions. He received prescriptions for Vioxx 25 mg. (30), Ultram 50 mg. (120), and Lidocaine patches (60). (Ex. 43; 150/830 & 344/1024.)

27. Pt. E was seen at Dr. Ogoke's office on March 17, 2004. He reported a pain level of 9/10 in his low back that was "constant, deep and achy" despite doing home physical therapy and taking walks, stretching, and using heat. He had no radicular pain. He was having trouble sleeping. His review of systems remained unchanged. He had a physical examination. The assessments were unchanged. The treatment plan was to stop taking Vioxx due his history of ulcers, stop the use of the Lidocaine patches because he reported no help from them, but continue the Ultram medication, and schedule a lumbar ESI series as soon as possible. (Ex. 43, 147-

149/827-829.)

28. Pt. E was seen at Dr. Ogoke's office on April 29, 2004. He reported back pain of 8-9/10. He was having trouble walking and sleeping. He reported that workers compensation insurance was not covering the planned lumbar ESI series. Because Pt. E had a very good response to the SI injections, the decision was made to seek coverage for this procedure. Pt. E reported that the Ultram medication was not being covered by the workers compensation insurance. He was given samples of Ultracet and warned not to take this new medication with Ultram and acetaminophen. He had a physical examination and the assessments were unchanged. The treatment plan was to get coverage for the SI procedure, to continue home physical therapy treatments, and to do follow-up visits as needed. (Ex. 43; 144-146/824-826 & 333-336/1013-1016.)

29. Pt. E was seen at Dr. Ogoke's office on June 15, 2004. He was seeking medication refills. He was prescribed Ultracet (120) and Lidoderm patches (90). (Ex. 43; 143/823 & 325/1005.)

30. Pt. E was seen at Dr. Ogoke's office on July 15, 2004. He reported a pain level of 8-9/10 in the back that was constant, achy, and moderate to severe. He complained of difficulty walking and sleeping. A review of systems was done. He had a physical examination. The assessments were unchanged. The plan remained to schedule an SI injection as soon as possible, and to continue his current medications. On August 7, 2004, Dr. Ogoke gave Pt. E a bilateral SI injection with fluoroscopy. Pt. E had a pain level at this visit of 8/10. (Ex. 43; 137-142/817-822.)

31. Pt. E was seen at Dr. Ogoke's office on August 23, 2004. He reported a pain level of 5/10 due to pain relief from the SI procedure. Both the SI injection and the lysis of adhesion

procedure produced pain relief. The lysis of adhesion in the lumbar region led to “improved capacity” functioning as it relieved his radiculopathy symptoms in the legs. A physical examination was done. The assessments were unchanged. Pt. E was to continue his current medications. The treatment plan was to do a repeat lysis of adhesion procedure and another SI injection. Doing diagnostic lumbar facet joint injections before a repeat lysis of adhesion procedure was considered. (Ex. 43, 134-136/814-816.)

32. Pt. E was seen by Dr. Ogoke on January 5, 2005. By then, Dr. Ogoke had not been able to get Pt. E’s insurance to cover the planned SI procedure, or the lumbar facet joint injections, or the repeat lysis of adhesion procedure. This had been an ongoing problem for Dr. Ogoke in seeking to provide Pt. E with interventional injection treatments according to Pt. E’s treatment plan. At this visit, Pt. E reported a pain level of 6/10 in his back. Dr. Ogoke produced a comprehensive report on the history of his treatments from May 2001, including setting forth the particular procedures that brought the most pain relief to Pt. E, and why Dr. Ogoke proposed providing these procedures to Pt. E.

Pt. E ... states that he has had about 50 to 60% reduction in his baseline pain since he came to see me in May of 2001. He has had multiple procedures and treatments, including oral medication, physical therapy, epidural steroid injections, sacroiliac joint injections, and lysis of adhesion at the lumbar level. The lysis of adhesion appeared to be what had made the most significant benefit for the patient, ... done in September of 2003. Ever since then the pain level has come down substantially but the pain is persistent in the sacroiliac notch area and in the lumbar spine area. I have reviewed the patient subsequently and considered other possibilities and reasons for recurrent flare of the sacroiliitis and persistent low back area pain that he has had. [T]he patient has a need for diagnostic lumbar facet joint injections, as well as a repeat lysis of adhesion in the future, in conjunction with intermittent treatment with sacroiliac joint injection as needed ... His overall condition has not changed. He claims that he has had a recent worsening of pain and comes in today with a cane, ambulating with an antalgic gait, for support.

At this visit, Dr. Ogoke gave a physical examination. The same assessments were made. The

treatment plan was to renew his existing medications and to try to get approval from Pt. E's insurer to do the SI injection, the lumbar facet joint injection, and the repeat lysis of adhesion procedure. Pt. E was prescribed Ultracet. (Ex. 43; 131-133/811-813 & 303-304/983-984.

Testimony of Dr. Ogoke.)

33. On February 21, 2005, Dr. Ogoke gave Pt. E a bilateral SI injection with fluoroscopy. Pt. E had a follow-up visit with Dr. Ogoke on March 10, 2005. He reported having bladder issues and he "asked to see a urologist." He reported a pain level of 7-8/10. He had leg pain and was using a cane. The February 21, 2005 SI injection had helped his pain.

Most of the pain is still located now in the coccyx with sacrococcygeal ligament area ... sharp ... about 7-8/10 ... The patient stated that the lysis of adhesion ... slightly improved his low back pain and related lower extremity radicular pain and he ... made marked progress with that though his low back area pain still persists and he requires a cane to ambulate for support. He ... claims compliance with his medications.

Dr. Ogoke performed a physical examination. The assessments were unchanged. The treatment plan was to schedule a sacrococcygeal ligament injection and facet joint injections. The lysis of adhesion procedure and the SI injection were on hold until these other injections were done. Pt. C was prescribed Mobic 7.5 mg. (30), Skelaxin 800 mg. (90), and Ultracet (90). (Ex. 43: 124-131/805-811; 299/979 & 301-302/981-982.)

34. On May 24, 2005, Pt. E had a lumbar spine MRI revealing:

1. Status post surgery at the L4-5 level with enhancing scar tissue noted in the epidural space. There is a recurrent broad-based disk herniation, slightly eccentric to the right causing moderate mass-effect in the ventral thecal sac, eccentric to the right. There is moderate mass-effect on the right neural foramen with mild mass-effect on the left neural foramen.
2. The remaining disk spaces and heights are well-maintained. There is no significant bulge or herniation noted at the other levels ... The conus is normal with morphology and signal intensity.

On June 1, 2005, Pt. E was seen at Dr. Ogoke's office. He was seeking prescription refills. Pt. E

was prescribed Kadian 20 mg. (60), MSIR 15 mg. (90), Mobic 7.5 mg. (30), and Skelaxin 800 mg. (120). Pt. E was seen on July 14, 2005 at Dr. Ogoke's office. He reported a pain level of 8-10/10 in the low back and neck that was moderate to severe that radiated into his upper and lower extremities, especially on his left side. He was given a physical examination and a review of systems. The assessments made were: lumbar conditions from sprain; lumbar facet arthropathy; post lumbar laminectomy syndrome; lumbar disc herniation at L5-S1 and disk bulge at L4-L5; severe sacroiliitis; and, a cervical strain and radiculitis with a need to rule out herniations. The treatment plan was to include consideration of cervical ESIs in addition to the lumbar injections. Efforts were made to secure insurance coverage for these interventional treatments. (Ex. 43: 120-123/800-803; 251-252/931-932; 254-256/934-936 & 290/970.)

35. On October 26, 2005, Pt. E had a right shoulder x-ray that was normal. On December 8, 2005, Pt. E had a cervical MRI that showed:

Disk/osteophyte complexes at the C4-5 and C6-7 levels with central disk herniations causing effacement of the anterior thecal sac at both levels and bilateral neuroforaminal narrowing at C5-6 level secondary to osteophyte formations. No significant central stenosis.

(Ex. 43; 249-250/929-930 & 253/933.)

36. Pt. E did not return to Dr. Ogoke's care again until May 9, 2006 when he was re-evaluated. At this time he was having neck pain and low back pain radiating into his legs. He was seeking changes in the medications he had been taking of Kadian, MSIR and Skelaxin because of nausea and rashes. He did not want to take Morphine or Methadone. He was seeking a prescription for Percocet. He had been treating with his PCP, who had been prescribing Ultram, and had done three months of physical therapy which had provided some pain relief. He wanted the injection treatments with Dr. Ogoke he had undergone in the past that had helped relieve his pain level, but workers compensation would not cover them. He was given a physical

examination. He was again assessed with the same lumbar conditions and with cervical strain and history of cervical radiculopathy. Pt. E was prescribed Percocet 7.5 mg. (90), along with Mobic 7.5 mg. (30) and Norflex 100 mg. (60). He was given a urine drug screen (UDS).

Approval was to be sought for a lumbar facet joint injection. (Ex. 43; 116-118/796-798 & 243-244/923-924.)

37. Pt. E did not return to Dr. Ogoke's office until September 20, 2006. The treatment plan that included the interventional pain management injections that had helped Pt. E with pain relief in the past was denied coverage by the workers compensation insurer. Pt. E presented with a pain level of 10/10 with worsening pain mostly in his low back radiating into his left leg. He had run out of medication. He was given a physical examination. The same assessments were made as at the May 9, 2006 evaluation. The plan was to renew his medications without changes to them and to again seek approvals for the kinds of interventional pain management procedures that had helped relieve his pain in the past; "lumbar transforaminal ESI, lumbar facet joint injection, diagnostic block and SI injections." (Ex. 43; 113-115/793-795 & 240-241/920-921.)

38. Dr. Ogoke wrote to Pt. E's insurer explaining how he had provided care to Pt. E over many years for recurrent low back and left leg pain that followed from a workers compensation injury in July 1990. In an October 6, 2006 letter, Dr. Ogoke explained his current treatment of Pt. E had begun in May 2001. Dr. Ogoke provided the assessments/diagnoses he made including noting the objective information concerning Pt. E's back and neck from the x-rays and CT scans. Dr. Ogoke set forth in the letter the interventional pain management treatments he had given Pt. E, noting why his choice of treatments were reasonable and appropriate. He set forth his proposed further interventional treatments based on the success Pt. E had in the past in relieving his pain level. Specifically, Dr. Ogoke explained that he wanted to have Pt. E undergo:

1. A diagnostic lumbar facet joint block.
2. Sacroiliac joint injection for pain control.
3. A lumbar transforminal epidural steroid injection at the selected nerve roots, both as a diagnostic and therapeutic block as well.

Dr. Ogoke further explained:

[If Pt. E did] well with the facet block injections ... the most likely culprit in conjunction with sacroiliitis of the patient's persistent pain, then a facet denervation procedure will be an appropriate next step. Facet joint pain is not confirmed through radiographic imaging and a diagnostic block is the standard of care in reaching that diagnosis.

(Ex. 43: 242/922; 257-258/937-938; 264/944 & 266-271/946-951.)

39. Insurance coverage was obtained. On November 6, 2006, Dr. Ogoke gave Pt. E a bilateral SI injection with fluoroscopy. Pt. E came to the appointment with a pain level of 9/10. This injection was to help his low back and leg pain. On November 29, 2006, Dr. Ogoke gave Pt. E a bilateral multi-level lumbar ESI#1 procedure with fluoroscopy at levels L2-3, L3-4, L4-5 and L5-S1. He was prescribed Percocet 7.5 mg. (90) and Norflex 100 mg. (60) at this visit. (Ex. 43: 107-108/787-788, 110-112/790-792, 236/916 & 238-239/918-919.)

40. The November 29, 2006 procedure involved "an injection either into the joint or next to the joint ... Facets are the little joints in the back between each vertebrae ... one on each side. So this ... [was] a four-level bilateral facet block." The area of coverage was L2-3 through L5-S1, with 20 mgs. of Depo-Medrol, the typical dose to inject in each level of a facet joint, and 1 cc of Lidocaine injected at each of the eight locations for a total Depo-Medrol injected during the procedure of 160 mg. To Dr. Satwicz, this was too much Depo-Medrol to inject within one procedure, although 160 mg. was not in and of itself an "extraordinary dose." Doing bilateral and two or three levels during one procedure is more commonly done than doing four levels. (Testimony of Dr. Satwicz, Vol. X, pg. 1895-1986.)

41. Dr. Trescot opined that 160 mg. of Depo-Medrol injected during the one bilateral

lumbar multi-level ESI procedure is a high dose of Depo-Medrol, but not an excessive dose to administer at one time. (Testimony of Dr. Trescot, Vol. XIV, 2788-2789.)

42. Pt. E was seen at Dr. Ogoke's office on December 1, 2006. He had a pain level of 7/10. He complained of shortness of breath and chest tightness over the last two days following the November 29, 2006 multi-level ESI procedure. Dr. Ogoke's physician assistant saw Pt. E. Pt. E was given a physical examination. The site of the injection was healing well with no signs of an infection and with no signs of an allergic reaction. His blood pressure was elevated at 193/120. Pt. E was instructed to seek emergency care as soon as possible for evaluation of tachycardia, the high blood pressure reading, and for his symptoms of shortness of breath and chest tightness lasting about two days from the day of the injection. He wanted to go to the Holyoke Medical Center. Dr. Ogoke's physician assistant handwrote a note for him to take with him to alert the Emergency Room that Pt. E had a recent interventional pain management injection with Lidocaine and Depo-Medrol. The physician assistant entered into the report of this visit: "A narrative was written for patient describing his injection on 11/29/06 and the medications used. He is to present this to the Emergency Department ... The symptoms do not appear related to the procedure on 11/29/06." This note was dated December 1, 2006. It listed Pt. E's symptoms of shortness of breath, chest tightness, and a blood pressure reading of 198/107. The note explained that Pt. E was status-post a November 29, 2006 lumbar facet joint diagnostic block for his lumbar facet arthropathy. The note included that during the procedure, he had received 1% Lidocaine and 20 mg. Depo-Medrol. The total injected during the procedure of 160 mg. of Depo-Medrol was not listed. The note contained the letterhead information for Dr. Ogoke's office that included contact information. Pt. E was told to have a follow-up visit in a few days at Dr. Ogoke's office. (Ex. 43; 104-106/784-786 & 235/915. Testimony of Dr. Ogoke,

Vol. VI, 1268-1270, 1273.)

43. Pt. E was seen on December 1, 2006 at the Holyoke Medical Center Emergency Department. He was not hospitalized. He received instructions upon his discharge. He was instructed to see Dr. Michael Zmurko and was given a referral to see Dr. Lawrence Bernstein. He was given a prescription for Ativan to take one pill three times a day as needed to address anxiety and the stress reaction that was found to have been the likely cause of his shortness of breath and his elevated blood pressure. The instructions were given to him, typed in English and Spanish. (Ex. 43; 226-232/906-912. Testimony of Dr. Ogoke, Vol. VI, 1274-1275.)⁴⁹

44. Dr. Ogoke did not know whether Pt. E was given, in addition to this note from the physician assistant, the medical record detailing the November 29, 2006 injection treatment to show that Pt. E received a total of 160 mg. of Depo-Medrol. Dr. Ogoke thought it important that if the emergency room physicians wanted further information if all they saw was the note, that the note contained his office's telephone number and contact information. Dr. Ogoke had approved of his physician assistant's decision to have Pt. E evaluated at an emergency room. He had not seen the physician assistant's note before it was given to Pt. E. (Testimony of Dr. Ogoke, Vol. VI, 1270-1275.)

45. To Dr. Satwicz it would have mattered to the emergency room physician to learn from the note given to Pt. E that his symptoms emerged near the time he received not 20 mg., but 160 mg., of Depo-Medrol. Dr. Satwicz saw nothing in the medical records to indicate Pt. E was given the record of the November 29, 2006 procedure to take with him to the emergency room.

⁴⁹ The BORM did not offer the full Emergency Room visit records and I did not locate them within Pt. E's medical records (Exhibit 43). The physician assistant who dealt with Pt. E when he came to Dr. Ogoke's office on December 1, 2006 and produced the note for him to take to the emergency room, did not testify.

Steroids can cause fluid retention, and it's a dose related phenomenon. So if an emergency room physician were to see 20 milligrams, they would say that is a trivial dose. If they were to see 160 milligrams, they would have a different opinion as to what is going on with the patient. Treating for fluid retention from steroids, very easy to treat. If the proper information was transmitted ... they would probably more quickly come to a diagnosis of fluid retention from steroids, very easy to treat, versus evaluating somebody for another unrelated problem because that is what the 20 milligrams would suggest. So it's a huge difference and would greatly affect the care ... I view this as a major problem.

(Testimony of Dr. Satwicz, Vol. X, pg. 1900-1901.)

46. Pt. E returned to Dr. Ogoke's office on December 12, 2006, stating that he wanted to stop the injection treatments, but wanted to keep taking pain medications except for Percocet and Norflex. Pt. E explained that he thought these medications had caused anxiety symptoms. Pt. E felt too anxious and too depressed to continue to take the injection treatments right now, although he would consider resuming them when his anxiety and depression came under control. He produced a note with this information, written in English and Spanish, presented to Dr. Ogoke's physician assistant. Pt. E was questioned by Dr. Ogoke's physician assistant who found his history presented in a "very unclear" way. He explained that he had been treating with a psychiatrist for depression and anxiety until about three months ago when he stopped this treatment and stopped taking the medications the psychiatrist had prescribed that included "Fluoxetine for depression and Doxepin for sleep." Dr. Ogoke's physician assistant wrote in the medical record of this visit that on November 29, 2006 at the Holyoke Medical Center Pt. E had been given medication for dyspnea, hypertension, and anxiety, and told to follow-up with his PCP. Pt. E was prescribed Ativan at the Holyoke Medical Center Emergency Department and Klonopin by his PCP. Pt. E explained that when he submitted the November 29, 2006 prescriptions written for him by Dr. Ogoke's office for Norflex and Percocet, that they were refused because his workers compensation insurer would not cover their costs. At this visit, Pt.

E completed a pain inventory form and was given a physical examination. He had elevated blood pressure and was told to follow-up with his PCP. A UDS was done. The assessments reached were: sacroiliitis; lumbar facet arthropathy; lumbar disc bulge; lumbar strain; and, lumbar post laminectomy syndrome. Pt. E was instructed to stop taking Percocet and Norflex, and that the outstanding November 29, 2006 prescriptions for them had to be cancelled before any different medications could be prescribed. The treatment plan was for Pt. E to have a follow-up visit with Dr. Ogoke. The plan developed from this visit was extensive. (Ex. 43; 39-40/719-720, 98-100/778-780 & 233-234/913-914.)

47. Pt. E was seen at Dr. Ogoke's office on January 10, 2007. He reported a pain level of 5/10 in his low back with pain worse with activity. He was not taking any medications prescribed by Dr. Ogoke's office. He was taking Clonazepam for anxiety and Lisinopril for hypertension prescribed by his PCP. At this visit, Pt. E continued to refuse to have injection treatments due to his concern about them increasing his anxiety level that he thought had occurred on November 29, 2006. Pt. E reported an area on his back that was itchy. Upon examination the area of his lumbar spine where he had received the injections on November 29, 2006, covering L2-3 to L5-S1, showed no rash and appeared unaffected by any itching done by Pt. E. Rather, the area of the low thoracic spine showed a "pruritic rash" area. Pt. E was seeking a Lidocaine patch and Naprosyn for his low back pain because he had used them in the past. He did not want to be given opioids. He was given a physical examination. A UDS was done. The assessments made were: sacroiliitis; post lumbar laminectomy syndrome; lumbar disc bulge; and, lumbar facet arthropathy. The Norflex and Percocet medications had been discontinued, and Pt. E received prescriptions for Lidocaine patches (60) and for EC Naprosyn 500 mg. (60). Pt. E was to do follow-up with his PCP about conditions found and lab results from his December 1,

2006 emergency department visit, about his thoracic spine area rash, and about his long-standing anxiety condition. He was to return in a month to discuss with Dr. Ogoke the implications of refusing any injection therapies and his future pain management treatments. Dr. Ogoke's staff was able to help him translate questions he had and the answers to them. (Ex. 43: 95-97/775-777; 217/897 & 223/903.)

48. Pt. E had a follow-up visit on February 8, 2007 with Dr. Ogoke. Pt. E reported his same issues with the pattern of his pain symptoms. He continued to assert that he would not agree to more injection treatments. Dr. Ogoke reviewed his record. Pt. E had been scheduled for an SI injection on December 12, 2006, but he refused it. Part of his treatment plan was, after the SI injection, to have a lumbar transforminal ESI injection, and that did not occur. Dr. Ogoke was aware that the November 29, 2006 prescriptions for Percocet and Norflex could not be filled according to Pt. E because payment for them was not covered by the workers compensation insurer. He was given a physical examination during which Dr. Ogoke found Pt. E to be anxious and uncooperative. Pt. E had not returned for care with a psychiatrist for his anxiety. Dr. Ogoke's assessments remained the same. Given Pt. E's rejection of his treatment plan that included injection treatments over several visits, Dr. Ogoke decided to discontinue his care of Pt. E "in the next 30 days, giving him a 30-day notice" so he could locate alternative pain management care. Dr. Ogoke concluded he was not going to continue to treat a patient not compliant with the treatment plan developed for his pain condition. Dr. Ogoke renewed his prescriptions for Naprosyn 500 mg. (60) and for Lidocaine patches (60). Pt. E had a UDS done to determine if he had been compliant with his medication regimen and with the narcotic contract he signed.⁵⁰ (Ex. 43; 93-94/773-774, 213-214/893-894 & 216/896.)

⁵⁰ There may be within Pt. E's medical records (Exhibit 43) the results from Pt. E's UDS tests done, but none of the results was legible or may not have been included in Exhibit 43. This includes the results of

49. When a patient refuses further injection treatments that he had been undergoing as part of his treatment plan but still wants pain medications, to do a random UDS is proper caregiving, and if a problematic UDS result occurs, that information is important to a future physician undertaking the patient's care. Dr. Trescot, Dr. Ogoke and Dr. Satwicz all agree that a problematic UDS result needs to be addressed with the patient. (Testimony of Drs. Trescot, Ogoke & Satwicz.)

50. To Dr. Trescot, Dr. Ogoke acted appropriately in ending his care with Pt. E who was refusing to comply with his treatment plan that included having interventional injection procedures. Dr. Trescot opined that there was no reason for Dr. Ogoke to continue to treat Pt. E with only pain medications; that patients engage interventional pain management specialists to use their specialty of practice, if appropriate, to do more than what pain medications can do.

Pain medicines will never ever get someone better ... and the only possibility of improving the cause of their pain is with interventions ... [Pain medications] will not fix the cause of the problem, medications manage it just like insulin manages diabetes.

(Testimony of Dr. Trescot, Vol. XIV, 2798.)

51. Pt. E began treating at the Baystate Medical Center's Pain Management Center on referral from Dr. Ogoke. Pt. E was evaluated on June 8, 2007 by Dr. Ajay Rudraraju and Dr. Maher El-Khatib. (Ex. 43, 35-36/715-716.)

52. In or around July 2007, Pt. E filed a complaint with the BORM about his care with Dr. Ogoke. The complaint Pt. E completed is in Spanish with portions translated in English. Pt. E believed that Dr. Ogoke had abandoned him by not agreeing to continue to treat him even if he was not going to have injections anymore. Pt. E's complaint describes what he experienced

the UDS tests done on December 12, 2006 and on January 10, 2007. I also could not locate or decipher the results of the May 9, 2006 UDS test. I could not locate a termination of care letter to Pt. E in his medical records.

when he received the injection treatment on November 29, 2006. He reported feeling an unsettling sensation when the needle was used that was followed by a feeling of pain when the liquid was released. He reported that he felt dizzy, confused and anxious. He recalled being a long time in the recovery area after the injection treatment. He reported that when he got home, the symptoms he experienced in Dr. Ogoke's office continued for days, and worsened. He reported that when he was seen on December 1, 2006 at Dr. Ogoke's office by the physician assistant, that he remembered the physician assistant telling him he might be having a heart attack and to go to an emergency room. He recalled asking the physician assistant for a copy of the November 29, 2006 procedure note so that he could show the emergency room doctors, but instead received only a "worthless" note without the information he wanted the emergency room doctors to learn. When he eventually saw Dr. Ogoke again, he felt Dr. Ogoke was rude to him and dismissed him from care without answering his questions. (Ex. 83.)

Conclusion and Recommendation

The Statement of Allegations charged Dr. Ogoke with improper conduct in connection with the November 29, 2006 interventional procedure he gave Pt. E. Dr. Ogoke was charged with: having injected Pt. E with many needles of medication at one time during the procedure; failing to properly address Pt. E's adverse reaction to the injection procedure; his physician assistant having producing a misleading note for Pt. E to show an emergency room physician concerning this injection procedure when Pt. E received 160 mg. of Depo-Medrol and not just 20 mg. Depo-Medrol as contained in this note; and, ending his care of Pt. E without cause based only on Pt. E not wanting to have further injection treatments. The BORM did not prove these charges.

The course of care that Dr. Ogoke provided to Pt. E, initially in 1997, then in 2001, and

then in 2003-2007, with gaps of time away from care, was not adequately or fairly described in the Statement of Allegations to support the contentions made by the BORM that Dr. Ogoke failed to meet the required standard of care at times in his treatments of Pt. E as charged.

During the course of his care of Pt. E, Dr. Ogoke arrived at treatment plans that integrated a number of interventional injection treatments. After receiving these treatments, Pt. E would return for follow-up visits reporting pain relief from them. During 2003-2006, Dr. Ogoke experienced times when Pt. E's workers compensation insurer would not cover these injection treatments so that the timing of receiving them in a planned series could not always be done. Nevertheless, Pt. E was able to receive some of these injection treatments with subsequent pain relief over the course of this time period. His ongoing assessments and diagnoses were primarily sacroiliitis and lumbar spine conditions that included a failed back surgery (1991) syndrome and facet arthropathy. These conditions were not shown by any expert evidence to be conditions that interventional injection treatments, done by a specialist like Dr. Ogoke, would never be expected to help.

Within Pt. E's medical records Dr. Ogoke had a report from August 27, 2001 from Dr. DeWitt Brown, an orthopedic surgeon who had done an IME assessment of Pt. E, and concluded that Pt. E had a 10% overall body impairment and had reached a medical end point. Dr. Brown also reported that he found during his physical examination of Pt. E that Pt. E was a symptom magnifier. The BORM questioned Dr. Ogoke about Dr. Brown's conclusion and also about the workers compensation insurer not agreeing to cover a number of Dr. Ogoke's proposed injection treatments. I found Dr. Ogoke's responses to these inquiries to be persuasive. He explained that the workers compensation insurer may have wanted more clinical trial results to support doing more injection treatments for Pt. E and those did not exist at the time. Dr. Brown was not a

treating physician, and was paid by the insurance company to do his evaluation. By Dr. Brown indicating Pt. E had reached a medical end point, Dr. Ogoke explained that this could signal no need to cover the costs of further interventional treatments with their goal to improve Pt. E's pain symptoms. Dr. Ogoke explained how these IME and insurer decisions regarding policy determinations on what the insurer will pay for should not be equated with the kind of decision-making Dr. Ogoke was engaging in with Pt. E as his pain management specialist. There is no evidence that Dr. Ogoke wanted to do injection treatments on Pt. E for no significant treatment reason. Rather, Dr. Ogoke explained well in Pt. E's medical records and in his testimony bolstered by Dr. Trescot's testimony, that injections can often provide pain relief to the area on the spine that is the source of the pain, and that this can result in more long-lasting pain improvement than just taking pain medications.

The BORM's Statement of Allegations contends that Dr. Ogoke violated a standard of care in using on Pt. E's back, "multiple needles of medication at one time during an injection procedure." The only time the medical records show Dr. Ogoke did a lumbar bilateral ESI injection with fluoroscopy covering L2-3 through L5-S1. There were eight injection sites on the lumbar spine. This procedure was done on November 29, 2006 after Pt. E had undergone many prior lumbar ESI procedures with successful pain relief. He wanted to have these injection procedures continue while his insurance carrier was refusing to cover their costs. On November 6, 2006, Pt. E had undergone with Dr. Ogoke the SI injection that also had been awaiting approval from Pt. E's workers compensation insurer to cover. Pt. E did not report any issues about what he experienced within that procedure.

The BORM contends that doing these eight injections during one procedure and injecting an overall total of 160 mg. of Depo-Medrol, 20 mg. at each injection site, was misconduct in the

practice of medicine. This charge was supported by Dr. Satwicz in a general objection to it being appropriate for Pt. E. Dr. Satwicz opined that doing all those levels of the spine with injections was a lot to do, but he did not dispute that in 2006 it was not outside the standard of care. Dr. Satwicz did not find it was a commonly performed injection procedure; that one or two bilateral injections was more commonly performed with doing three bilateral injections was on the high end. Dr. Trescot opined that in 2006 to inject 160 mg. of Depo-Medrol during one procedure was within standard of care and was shown to fit within an acceptable range of receiving that much Depo-Medrol at one procedure even if at the high end of the range. This was far from being Pt. E's first injection procedure with Dr. Ogoke. Pt. E was familiar with how Dr. Ogoke provided these injection procedures. It was from his medical records the first time he had eight injection sites during one procedure; the first time he received 160 mg. of Depo-Medrol during one procedure. Nevertheless, there is insufficient proof that Dr. Ogoke knew or should have known that this procedure was too much for Pt. E to undergo. There is insufficient proof that by injecting Pt. E bilaterally at multiple spine levels with Depo-Medrol during one procedure was in violation of the standard of care.

Pt. E cooperated and complied with Dr. Ogoke's treatment plans for his pain complaints and spinal conditions in 1997, 2001, and 2003-2006 until a few days after the November 29, 2006 procedure. By this time, Pt. E had been under the care of a psychiatrist treating his long-standing anxiety condition for which he was prescribed medication for control over it. The first time it appears in the medical record that Pt. E stopped his care with the psychiatrist, including stopping the medications the psychiatrist prescribed, was in the December 1, 2006 medical record of Pt. E's visit with Dr. Ogoke's physician assistant. Pt. E reported that he had stopped this care about three months prior. There is also no information in Pt. E's medical record of Pt. E

having anything like an anxiety attack in connection with undergoing all the numerous injection procedures he had leading up to the November 29, 2006 injection procedure. This includes having no symptoms reported when he had the SI injection on November 6, 2006. He had waited a long time for that November 6, 2006 injection procedure because of insurance coverage delays. Pt. E left for home after the November 29, 2006 procedure with no information in the medical record that he suffered shortness of breath or chest tightness in connection with that procedure. He seems, based only on the complaint he filed with the BORM (Ex. 83) to be claiming he did have such symptoms at the time of the injections on November 29th. It is just as possible that the symptoms of high blood pressure, shortness of breath, and feelings of chest tightness first emerged only after he was home.

Pt. E did show up on December 1, 2006 at Dr. Ogoke's office and was seen to have those symptoms by the physician assistant. This properly prompted Dr. Ogoke's physician assistant to send Pt. E for an emergency room evaluation, because these symptoms might involve a significant medical condition requiring immediate care that was completely unrelated to that November 29th procedure and the 160 mg. of Depo-Medrol he had received. The physician assistant had already determined that the situs of the November 29, 2006 injections showed healing, no rash, no swelling, and no other worrisome conditions.

The physician assistant jotted down a note to inform the emergency room physicians that Pt. E had a November 29, 2006 injection procedure to his lumbar spine as part of his pain management care, listing the medications that were injected. The physician assistant at least listed the 1 cc of Lidocaine and the 20 mg. of Depo-Medrol, despite not totaling in the note the full amount of Depo-Medrol received of 160 mg. over eight injection sites. There was insufficient proof that the actual medical record of the procedure was copied and provided to Pt.

E to take with him to the emergency room. There was no evidence that such a record was easily available to the physician assistant, or that it was otherwise available so soon after the procedure had occurred. There was no evidence that Pt. E understood, as he should have, that he received four lumbar bilateral injections that he could report to the emergency room physicians even if that note lacked that specific information. He may have had Spanish as his primary language, but given the Spanish translation of his hospital visit summary, it is not likely a language barrier was involved in his emergency room care. No evidence was presented whether or not the site of the eight injections on his back would have been visible to an examining emergency room physician to have helped that physician determine the number of injections. Since 1 cc of Lidocaine and 20 mg. of Depo-Medrol was the commonly used dose for an injection site of this kind of injection treatment (as testified to by Dr. Ogoke, Dr. Trescot and Dr. Satwicz), it is possible that the emergency room physician figured out that Pt. E had more than one injection site even if Pt. E said nothing about multiple injections received. The note with the wrong amount of Depo-Medrol given was on the letterhead of Dr. Ogoke with contact information on it if the emergency room physicians needed clarifications concerning the November 29th procedure.

The assessment reached by the emergency room physician was that Pt. E mostly likely was suffering from an anxiety state. He was not hospitalized and he was given a prescription for Ativan for treating his anxiety state. For this to be the assessment reached is consistent with the information Pt. E provided at his subsequent visits to Dr. Ogoke's office leading up to his last visit on February 8, 2007. He reported ending his care with the psychiatrist, including stopping the medication he had been prescribed for his anxiety condition. To stop such medications could produce the symptoms he had at the emergency room visit. He reported that it was his anxiety

condition that was the reason he was refusing any further injection treatments. He reported this refusal to have such further treatments on each of his visits following his hospital evaluation. If there was more to the hospital emergency room visit that would have supported a medical mistreatment by Dr. Ogoke in doing the eight injections during the November 29, 2006 procedure due to too much Depo-Medrol medication administered, then the BORM could have introduced more of that hospital medical record. And, Pt. E could have testified, subject to cross-examination to refute what is in his medical records that he experienced anxiety symptoms from that injection procedure.

Dr. Satwicz opined, had the information in the note been accurate and noted that Pt. E had received during one injection, a total of 160 mg. of Depo-Medrol steroid, then the possibility of fluid retention might have been addressed. There is insufficient proof that the emergency room evaluators got it wrong and that Pt. E's symptoms were not due to the anxiety state Pt. E had, but to fluid retention that should have been treated.

In terms of Pt. E's refusal to comply with Dr. Ogoke's established treatment plan for him to undergo injection procedures and Dr. Ogoke concluding he would need to terminate his care with Pt. E, the evidence does not show Dr. Ogoke violated a standard of care in making this decision. He was not abandoning Pt. E. Dr. Ogoke's specialty of interventional pain management was what he had to offer Pt. E. This was especially the case based on Dr. Ogoke's prior care of Pt. E when Pt. E was having interventional treatments with success. Because Pt. E was having anxiety attacks when facing interventional procedures after stopping his care of his anxiety condition, did not mean Dr. Ogoke had to continue to just prescribe pain medications to Pt. E on an ongoing basis. Certainly the testimony of Dr. Ogoke and Dr. Trescot supported the propriety of a pain management specialist not continuing to treat a patient who does not intend to

agree to the interventional pain specialist's treatment plan. This is the reason for the termination of care and it has not been shown to have caused Dr. Ogoke to engage in a violation of a standard of care.

At times, the Pt. E medical records were hard to assemble to determine what happened in chronological order at Pt. E's visits with Dr. Ogoke's office. This was true for all of the patients listed in the Statement of Allegations. Sometimes I did not locate what I would have expected to find of legible copies of prescriptions or UDS test results. Sometimes I would have benefitted from more detail about why a particular course of prescribing was being pursued. But, I did not find sufficient proof was presented that Dr. Ogoke violated a standard of care with Pt. E due to poor recordkeeping or insufficient visit reports to be able to follow adequately why a particular the course of care was followed for Pt. E.

Patient F

Summary

Patient (Pt.) F testified.

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Dr. Ogoke prescribed excessive doses of opioids for Pt. F's clinical conditions.
- Dr. Ogoke gave Pt. F painful injections and lumbar spine multi-level bilateral injections.
- Dr. Ogoke yelled at Pt. F when she brought a billing discrepancy to his attention that triggered him terminating her care.
- Dr. Ogoke failed to taper Pt. F off her opioid medications upon her termination of care and she experienced painful withdrawal symptoms.

The facts the BORM alleged to support its allegations include the following:

- Pt. F had neck and back pain with diagnoses of: trochanteric bursitis; lumbar radiculopathy; lumbar degenerative disc disease; lumbar disc herniation at L3-4 and L4-5; sacroiliitis; cervical strain; cervical radiculitis; and, cervicogenic headaches.
- Dr. Ogoke prescribed opioid medications for Pt. F's pain complaints, including excessive on-going high doses of Methadone and Oxycodone for the kind of clinical condition Pt. F had.
- There were several times between 2002 and 2007 when Pt. F treated with Dr. Ogoke when he performed multi-level bilateral facet injection procedures resulting in large doses of medication being injected during one procedure.
- Pt. F found some injection procedures to be painful. To prevent her from screaming in pain, she was held down and given a towel to bite on during injection procedures.
- On May 3, 2007, Pt. F brought a billing discrepancy to Dr. Ogoke's attention and he yelled at her. As a result, Dr. Ogoke terminated her from his care.
- Dr. Ogoke did not engage in any tapering off process for Pt. F from her high opioid medication doses upon her termination from care. As a result, she suffered painful withdrawal symptoms.

Findings of Fact

1. Pt. F; born in 1965, treated with Dr. Ogoke between 2002 and 2007. At age eight, Pt. F sustained a shock from a home electrical outlet, and at age twenty-one, she was struck by lightening that entered through her right hand and exited through her left foot. After the lightening strike she treated at the Bay State Medical Center Burn Clinic. She had pain management treatments with Dr. Duane Dixon at the burn clinic, and then with Dr. Michael Daley at the Mercy Hospital Pain Clinic. By June 2000, Pt. F was often falling with symptoms of numbness in her legs and feet, and she was fired from her long-held job in sales work due to her falling. She had undergone pain management treatments for neck pain and lumbar spine pain with radiating symptoms, including as many as 56 ganglia blocks in her neck and 53 epidural steroid injections. By 2002, she was taking Roxicodone 5 mg., Lorazepam, and Amitriptyline 75 mg. In 2002, Pt. F saw an advertisement on television about Dr. Ogoke's pain management practice. She thought he might have some different treatments to offer to try to finally gain control of her long-term pain symptoms. She received a referral from her primary care physician (PCP), Dr. Warren Thau, to be evaluated by Dr. Ogoke. At that time, Pt. F and her fiancé were hoping that she might be able to stop taking narcotic medications so she could have children. Under Dr. Thau's care, on March 22, 2002, Pt. F had a thoracic spine MRI that was negative, and a lumbar spine MRI that showed "a [t]iny central disc herniation at L4-L5," and [d]iscogenic degenerative disc of L4-L5." (Ex. 43: 211-219/1340-1348; 723/1852 & 731-740/1860-1869. Exs. 45-46. Testimony of Pt. F, Vol. III, 546-550, 568-569, 647-662.)

2. Someone who has been electrocuted and struck by lightening may have internal burning and scarring with some nerve destruction. This causes intense contracting of muscles that can be so harsh that it causes bones to break and muscles to partially rip off bones. There

can also be some memory loss, personal behavior changes, severe pain, and confusing pain episodes. (Testimony of Dr. Trescot, Vol. XIV, 2810.)

3. Pt. F's first visit with Dr. Ogoke was on April 10, 2002 when he gave her a full evaluation. Pt. F complained of primarily neck, back and bilateral lower extremity pain. Pt. F reported her family relations were "strained," and her socializing was "curtailed" due to her persistent pain symptoms. She rated her pain at this evaluation at a 10/10 level with the least pain within the prior 48 hours at a 7/10 level. Dr. Ogoke learned of her previous "26 stellate ganglion blocks" and "53 epidural steroid injections." Dr. Ogoke did a review of systems and gave a comprehensive physical examination. Pt. F completed a questionnaire about her current pain complaints, the medications she had been taking, and a medical, work, and social history. Dr. Ogoke reached the following impressions:

1. Lumbar herniated disc, L4-5.
2. Radiculopathy.
3. Possible discogenic low back pain.
4. Sacroiliitis.
5. Cervical radiculitis, rule out herniated nucleus pulposus vs. facet arthropathy.
6. Cervicogenic headaches, right side.
7. Cervical strain, rule out facet arthropathy.

The treatment plan for Pt. F was to: continue to evaluate her neck pain and order a cervical spine MRI; consider a lumbar discogram for Pt. F's possible discogenic low back pain; schedule a series of bilateral sacroiliac joint (SI) injections with reviews of her sacroiliitis condition in-between the injections; schedule a sensory nerve conduction threshold study; and, keep Pt. F on her current medications of "Lorazepam 1mg. b.i.d, Roxicodone 5 mg. q.i.d., and Amitriptyline 75 mg. q.h.s." Dr. Ogoke also prescribed Elavil 25 mg. (60), Skelaxin 400 mg. (120), and Celebrex 200 mg. (60). Pt. F agreed to come under the care of Dr. Ogoke. She completed various new patient forms. Pt. F had an appointment set up to see a neurologist, Dr. Emelio

Melchionna, in June 2002. Pt. F came to Dr. Ogoke in great pain and agreed to follow his treatment recommendations, including to undergo tests to try to locate the sources of her pain. She knew the treatment plan would include injection treatments. She was prescribed Valium 10 mg. (2) for injection procedures. Dr. Ogoke did not give her a timeframe for when her pain would come under control. (Ex. 43; 1340-1348/211-219 & 721-723/1850-1852. Exs. 45-46. Testimony of Pt. F, Vol. III, 663-664 and Dr. Ogoke, Vol. VI, 1346-1347.)

4. Dr. Ogoke concluded that Pt. F had,

a very complex problem situation that required a lot of expert management of her besides his care. She required multiple providers including “spine surgeons, neurologists ... also ... including facet diagnostic blocks following guidelines of American Society of Interventional Pain Physicians regarding interventional techniques ... required different adjustments of pain relievers, including opioids ... and medication for neuropathic pain.

(Testimony of Dr. Ogoke, Vol. VI, pgs. 1346-1347.)

5. Dr. Trescot opined that Pt. F came to Dr. Ogoke’s care having significant chronic pain despite years of prior treatments that included a “very large number of stellate ganglion blocks and epidural steroid injections.” (Testimony of Dr. Trescot, Vol. XIV, 2811-2812, 3164-3170.)

6. Pt. F had a cervical spine MRI on April 15, 2002 that was unremarkable. (Ex. 43; 208/1337 & 456/1585.)

7. Pt. F was seen on April 25, 2002 by Dr. Ogoke. Her evaluation included a review of systems and a physical examination. She reported persistent neck and low back pain, and a pain level of 10/10 throughout her “entire body.” She reported headache issues and right sided jaw, face and head pain. She was using crutches for walking. She was anxious but cooperative during her physical examination. She reported having had multiple falls, and Dr. Ogoke observed bruising on her arms, knees and legs. During her physical examination, she was

“anxious but cooperative.” She reported having had about two falls since her prior visit. The assessments made were: cervicogenic right-sided headaches, rule out cluster headaches; cervical radiculopathy and cervical strain, rule out facet arthropathy; sacroiliitis; and, possible discogenic low back pain, lumbar radiculopathy and herniated disc at L4-5. Pt. F had a nerve conduction study done on April 29, 2002 confirming lumbar radiculopathy. The treatment plan was to have a series of SI injections as soon as possible, a discogram, and a series of cervical spine epidural steroid injections (ESI). By April 29, 2002, Dr. Ogoke had prescribed Pt. F with Percocet 5 mg. (60), Elavil 25 mg. (60), Skelaxin 400 mg. (120), Celebrex 200 mg. (60), Tylenol (90), and Valium 10 mg. (2) for a procedure. Tylenol (90) but it was discontinued on April 29, 2002 due to adverse symptoms of stomach ache and dizziness. (Ex. 43: 718-720/1847-1849; 205-210/1334-1339; 403-405/1532-1534 & 696/1825.)

8. On May 7, 2002, Dr. Ogoke gave Pt. F a bilateral SI injection with fluoroscopy. She came to this visit with a pain level of 9/10. She reported that the Celebrex, Skelaxin and Percocet were not helping her, and that she had stopped taking them. She still had some of these medications left. She was prescribed Elavil 100 mg. (30) and Robaxin 500 mg. (90). (Ex. 43: 400-402/1529-1531; 712/1841 & 714-717/1843-1846. Ex. 47.)

9. On June 3, 2002, Dr. Ogoke gave Pt. F a cervical bilateral ESI with fluoroscopy at C6-7. This was the first in a planned series of cervical ESI procedures. At this visit, she complained of neck pain at a 10/10 level. She was prescribed Robaxin 500 mg. (90), Elavil 150 mg. (30), and Percocet 5mg. (90). (Ex. 43: 706-707/1835- 1836; 709-711/1838-1840; 397-399/1526-1528 & 522/1651. Ex. 48.)

10. On July 1, 2002, Pt. F had an MRI of the brain that was normal. On July 3, 2002, Pt. F had a cervical bilateral ESI #2 with fluoroscopy at the C4-5 level. At this visit, she reported

whole body pain at a 9/10 level. She was prescribed Percocet 5 mg. (90), Elavil 150 mg. (30), and Zanaflex 2mg. (90). (Ex. 43: 394-396/1523-1525; 588/1717 & 702-704/1831-1833. Ex. 49.)

11. On July 29, 2002, Pt. F signed Dr. Ogoke's Narcotics Prescription Policy and Agreement (narcotics agreement).⁵¹ She understood that signing this agreement meant that she agreed to stay in compliance with taking the narcotic medications as prescribed. On July 29, 2002, Dr. Ogoke gave Pt. F had a lumbar ESI #1 procedure with fluoroscopy at the L5-S1 level. She had been complaining of a pain level of 10/10 in her low back. At this visit, she was prescribed Percocet 5 mg. (90) to fill on August 3, 2002, Elavil 100 mg. (30), and Zanaflex 4mg. (90). Pt. F had requested a higher dose of Zanaflex. (Ex. 43: 204/1333; 392-393/1521-1522; 690-692/1819-1821; 694-695/1823-1824 & 697-701/1826-1830. Ex. 51.)

12. On August 12, 2002, Dr. Ogoke gave Pt. F had a lumbar ESI #2 procedure with fluoroscopy at the L4-5 level. Pt. F was seen on August 31, 2002 at Dr. Ogoke's office. She reported that the August 12, 2002 injection had not helped her pain and that she had a full body pain level of 10/10, including pain radiating from her low back into her lower extremities. She complained of trouble sitting and standing for long. Pt. F asked for a lower dosage of Elavil because she was trying to wean herself off of it. She reported that she wanted to get pregnant next year. Pt. F was given a physical examination. The treatment plan was for Pt. F to have a physical therapy evaluation,⁵² consider a lumbar ESI #3 procedure, and do a discogram covering the L2-3 to L5-S1 levels to check for discogenic pain. She was prescribed Elavil 150 mg. (30)

⁵¹ Pt. F testified that she recalled the narcotics agreement language and that she signed it. She is not sure if she signed the narcotics agreement at her April 10, 2002 visit. I could not locate other than the July 29, 2002 signed narcotics agreement in Pt. F's medical records (Exhibit 43). (Testimony of Pt. F, Vol. III, 751.)

⁵² It is not clear in Pt. F's Exhibit 43 medical records whether she had physical therapy under Dr. Ogoke's care following a physical therapy evaluation. Pt. F testified that she did not have the evaluation or physical therapy treatments. (Testimony of Pt. F, Vol. III, 691.)

because her requested dose of 125 mg. could not be written and the 100 mg. was not helping her sleep, Percocet 5 mg. (90) not to be filled until September 3, 2002, and Zanaflex 4mg. (90). (Ex. 43: 386-391/1515-1520; 685-686/1814-1815 & 688-689/1817-1818. Exs. 50 & 56.)

13. On September 12, 2002, Pt. F had lumbar spine x-rays showing “[m]ild degenerative changes ... mainly at L5-S1 level. No evidence of spinal instability.” (Ex. 43; 455/1584 & 587/1716.)

14. Neurologist, Dr. Emilio M. Melchionna, reported on his evaluation of Pt. F in a September 12, 2002 report. Dr. Melchionna noted how Pt. F’s MRI of the brain was normal, her EEG testing was normal, and the Lyme titer was negative as was other blood work. Dr. Melchionna opined:

The patient’s symptoms and signs are difficult to put together into one uniform diagnosis, but I suspect there is a significant component of depression associated with musculoskeletal pain and possibly radicular pain as well. The electrocution could theoretically have resulted in a sub-clinical myelopathy, but patient is being treated with Zanaflex at this time, and I have no further medication recommendations.

(Ex. 43, 684/1813. Ex. 52. Testimony of Pt. F, Vol. III, 681.)

15. Pt. F was seen at Dr. Ogoke’s office on October 2, 2002. She reported a pain level of 9/10 in her neck and 10/10 in her back. She had a physical examination was given. She was “anxious,” “uncomfortable,” but “cooperative.” To rule out discogenic pain, a discogram was ordered for the L3 through S1 levels. Her medications were renewed; Percocet 5 mg. (90), Zanaflex 4 mg. (90), and Elavil 150 mg. (30). Added due to trouble sleeping, was a prescription for Oxcarbazepine 150 mg. to take twice a day. For the next injection procedure she was prescribed Ativan 2 mg. (2). Dr. Ogoke gave Pt. F the discogram on October 16, 2002. At this visit, she was prescribed Oxcarbazepine 300 mg. (60), Elavil 150 mg. (30), and Levaquin 500 mg. (4). Pt. F was seen by Dr. Ogoke on October 30, 2002. She reported ongoing high levels of

pain. The discogram results were positive at the L3-L4 and L4-S5 levels and negative at the L5-S1 level. Lumbar x-rays showed mild degenerative changes at the facet joints with some narrowing. Pt. F was given a physical examination. The assessments reached were: discogenic low back pain at L3-4 and L4-5 with herniation at L4-5 and lumbar radiculopathy; sacroiliitis; cervical strain and radiculitis; and, cervicogenic headache on the right side, rule out cluster headaches. The treatment plan was to have Pt. F see Dr. Thomas Kaye, a neurosurgeon, for consideration of any surgical options, and to continue on her same medications. At this visit, she was prescribed Zanaflex 4 mg. (60) and Percocet 5 mg. (90). (Ex. 43; 377-385/1506-1514 & 677-683/1806-1812. Testimony of Pt. F, Vol. III, 579, 681.)

16. Pt. F was seen at Dr. Ogoke's office on November 20, 2002. She complained of a 10/10 level of pain in her low back, including her coccyx area, and pain that radiated into both hips and legs. She had not yet seen Dr. Kaye for consideration of lumbar fusion surgery. She was given a physical examination. The assessments remained the same. She was prescribed a support pillow for the coccyx area. Consideration was given to having a IDET procedure, if she could secure insurance coverage for it. She was prescribed;

Zanaflex 4 mg. [(120)] and Elavil 150 mg. [(30)], as well as a change in medications from Percocet to Oxycodone 5 mg. [(90)] due to her increase in Tylenol intake, as well as Zonegran 100 mg. [(45)] versus the Oxcarbazepine for back pain ... Will discontinue the Trileptal and begin the Zonegran in replacement, as well as for migraine prophylaxis, in that the Trileptal was not improving her symptoms ... In addition, Oxycodone 5 mg. will replace the Percocet 5/325 mg. for pain relief.

(Ex. 43; 374-376/1503-1505 & 675-676/1804-1806.)

17. Right hip x-rays from November 26, 2002, ordered by Dr. Kaye, showed minimal osteoarthritis of the hip joints bilaterally and the remainder of the findings were normal. Pt. F was seen by Dr. Kaye who produced a November 26, 2002 report of his evaluation and

recommendations. Dr. Kaye noted that the October 16, 2002 discogram showed “the presence of a concordant pain response at the L3-4 and L4-5 regions, worse apparently at the L3-4 region.” Pt. F complained of being in “constant pain.” Dr. Kaye gave a physical examination. He recommended that Pt. F have a right hip x-ray, and consider care for “a trochanteric bursitis of the right hip.” He discussed treatment options with Pt. F including his recommendation that a IDET procedure was the best option for her and that he would support her insurance covering the procedure. (Ex. 43; 586/1715 & 624-625/1753-1754. Ex. 53.)

18. An IDET procedure is an intradiscal electrotherapy. A needle is placed in the disc and a catheter is thread into the inside of the disc. The catheter is heated-up inside the disc to try to seal leaks from its center that go out to the annulus or outside portion of the disc, or to stop leaks from outside the annulus of the disc. By this time in 2002, the procedure’s efficacy had been shown to help patients who had been unable to get relief from other treatments. (Testimony of Dr. Trescot, Vol. XIV, 2813.)

19. Pt. F was seen at Dr. Ogoke’s office on December 6, 2002. She reported a pain level of 10/10 in both her lower and upper back areas, as well as all over her body. She reported that the Zonegran medication had upset her stomach. The November 26, 2002 right hip x-rays were reviewed with her. They revealed, “osteophyte formation and osteoarthritis of the right hip as well as middle osteoarthritis of the hip joints bilaterally.” She was given a physical examination. The assessments remained the same. The treatment plan was to do a right hip trochanteric trigger point injection (TPI), to wait for her insurer to approve the IDET procedure, and to prescribe in addition to her other medications, Protonix 40 mg. (30) and use of a Duragesic Patch 25 mcg. (10). (Ex. 43; 571-573/1500-1502 & 613/1742.)

20. By letter of December 10, 2002, Pt. F’s insurer denied coverage for the IDET

procedure for her low back pain. The insurer had the benefit of the discogram results and follow-up reports from Dr. Ogoke from October and November 2002. No reference was made in the letter to Dr. Kaye's evaluation in favor of Pt. F having this procedure. The letter was written to Dr. Ogoke and copied to Dr. Thau. The procedure was refused because it was found to be an experimental procedure. The procedures involved to appeal this refusal to cover payment of a IDET procedure were provided. Pt. F had wanted this procedure and not to have back surgery. (Ex. 43, 670-673/1799-1802. Testimony of Pt. F, Vol. III, 682-685.)

21. Pt. F was seen at Dr. Ogoke's office on December 19, 2002. She reported; a pain level of 10/10; that the Duragesic patch made her vomit after use of it so she had stopped using it; and, that she wanted medication refills of Elavil and Protonix. She was given a physical examination. There was tenderness and guarding upon palpation of the back and sacroiliac knotches as well as at the right hip. Added to the assessments was trochanteric hip bursitis of the right hip. The treatment plan was to await approval to do the IDET procedure and to have a right hip injection. She was prescribed Elavil 150 mg. (30), Protonix 40 mg. (30), and Percocet 7.5/325 mg. (90). (Ex. 43; 368-370/1497-1499 & 612/1741.)

22. Pt. F was seen at Dr. Ogoke's office on January 7, 2003. She reported a popping sensation pain in her back that was shooting down into her buttocks and legs with a pain level of 8/10. She complained that her pain medication was inadequate. She was given a physical examination. The treatment plan was still to wait for insurance approval for the IDET procedure. She received prescriptions of Doxepin 50 mg. (60), Norflex 100 mg. (60), and Percocet 10/325 mg. (180). Pt. F filed an appeal with her insurer on January 10, 2003 for failing to cover the costs of an IDET procedure. Pt. F received a right hip tranchanteric bursa injection on January 13, 2003 at Dr. Ogoke's office. By letter of January 31, 2003, the IDET procedure was again

denied by Pt. F's insurer as experimental and investigative even after receiving Dr. Kaye's approval for Pt. F undergoing the procedure. A further right to appeal this denial was explained in the letter. Pt. F was seen at Dr. Ogoke's office on February 3, 2003. She reported a pain level of 10/10 in her low back, legs and buttocks, with a burning sensation and at times severe pain. She felt the right hip injection had provided only minimal pain relief. She reported pain with sitting or standing for long, and trouble getting out of her bed. She was given a physical examination. She had tenderness and guarding on her mid-spine area and sacroiliac joints bilaterally upon palpation. The treatment plan was to give her the third in a series of lumbar bilateral ESIs as soon as possible, to consider a percutaneous discectomy if the IDET continued not to be approved by her insurer, and to consider having SI injections. At this visit, she was prescribed Percocet 10/325 mg. (180), Doxepin 75 mg. (30), and Flexeril 10 mg. (90). On February 4, 2003, Pt. F sought a copy of her medical records from Dr. Ogoke's office. Pt. F was seen at Dr. Ogoke's office on February 27, 2003 and reported the same 10/10 pain level in the low back into her legs. She reported a recent emergency room visit due to her pain. Pt. F was given a physical examination. The treatment plan remained to get approval for an IDET procedure with hopes that her new insurer would approve her for the procedure. She received prescriptions for Percocet 10/325 mg. (180), Zanaflex 4 mg. (90), and Elavil 50 mg. (60). (Ex. 43: 359-367/1488-1496; 604-607/1733-1736; 610-611/1739-1740; 614-618/1743-1747 & 663/1792.)

23. Pt. F was seen by Dr. Ogoke on March 27, 2003. He reviewed her entire record. She reported a pain level of 10/10 in her low back and a 6/10 pain level in her cervical spine. She was given a physical examination. Lumbar spine flexion and extension x-rays were ordered

to address her lumbar spine stability. Her current medications were renewed.⁵³ At an April 2, 2003 follow-up visit, Pt. F complained of neck pain at a 6/10 level, and mid to low back pain at a 10/10 level. She was encouraged to do physical therapy for the lumbar spine and to include Bioelectric treatments. She was prescribed a firm back brace. She was prescribed Elavil 150 mg. (30), Percocet 10/325 mg. (180), and Zanaflex 4 mg. (120). Pt. F was seen on April 29, 2003 at Dr. Ogoke's office. Pt. F continued to have pain complaints at a 10/10 level in the low back and 7/10 in the neck and shoulders. She had fallen twice in the prior week sustaining a right shin abrasion. She wanted to stop Zanaflex because she believed it was not helping her. Pt. F had a physical examination. The assessments remained the same. The treatment plan was to explore having the IDET procedure done by a different doctor who would be covered by her insurance, because she continued to be denied coverage for the procedure from her insurer. She was prescribed Percocet 10/235 mg. (180), Elavil 150 mg. (30), Lidoderm patch (60), and Trileptal 300 mg. (90). (Ex. 43: 354-358/1483-1487; 597/1726; 600-603/1729-1732; 659-663/1788-1792. Ex. 54.)

24. Pt. F had a follow-up visit at Dr. Ogoke's office on June 3, 2003. She continued to have the same pain complaints at the same high levels. She reported the pain was severe and constant. She described how she was "hearing some popping noises coming from her low back area any time she moves just a little bit." Pt. F reported falling while carrying an empty laundry basket, which she attributed to persistent numbness in her feet. She continued to be denied insurance coverage for the IDET procedure. She was given a physical examination and encouraged to do physical therapy. She stopped taking Trileptal due to getting a rash. MS Contin 30 mg. (60) was added for her pain. She was also prescribed Zanaflex 4 mg. (180), Elavil

⁵³ I could not locate copies of prescriptions for March 27, 2003 in Pt. F's medical records (Exhibit 43).

150 mg. (30), Lidoderm patch (90), and Percocet 10/325 mg. (180). She was again prescribed a lumbar back brace. (Ex. 43: 352-353/1481-1482; 609/1738 & 621/1750.)

25. On June 13, 2003, Dr. Janet O. Yardley, for Pt. F's insurer, wrote to Dr. Ogoke concerning the IDET procedure request. She also copied the letter to Dr. Thau. She explained that the IDET procedure was being denied because there had "not been adequate research studies to substantiate the benefit of this procedure." She also expressed her concern about Pt. F undergoing the procedure:

I ... have concerns about the number of epidural steroid injections and ganglion blocks this member has had. I am concerned that she may not respond to additional treatments and the potential risks of the treatments may not be indicated.

(Ex. 43, 623/1752.)

26. Pt. F was seen at Dr. Ogoke's office on July 1, 2003. Her pain continued at the 10/10 level. She described the pain as "deep achy" radiating into her lower extremities to her ankles. She was having trouble walking, sitting or standing for long, and doing her daily activities. She was given a physical examination. The treatment plan was to stop the MS Contin and start Oxycontin 40 mg. (60). She was also prescribed Percocet 10/325 mg. (180), Elavil 150 mg. (30), and Zanaflex 4 mg. (90). She was given a physical therapy order and encouraged to use heat, Epsom salt baths, and take an anti-inflammatory medicine. (Ex. 43: 349-351/1478-1480; 620/1749 & 622/1751.)

27. On July 11, 2003, Dr. Ogoke was contacted to provide treatment information on Pt. F for the Massachusetts Rehabilitation Commission's Disability Determination Services. Dr. Ogoke completed a detailed questionnaire to provide his assessment of Pt. F's condition, which he backed-up with objective and clinical findings including diagnoses and prognoses. He opined on Pt. F's abilities to perform work given her limitations. (Ex. 43, 646-651/1775-1780.)

28. On July 31, 2003, Pt. F was seen at Dr. Ogoke's office. She continued to complain of the same severe pains, radiating from her back through her legs to her feet where she had pins and needles sensations. She had been refused coverage by her insurer for the IDET procedure and was now interested in paying for it herself. Dr. Ogoke sought permission to do the procedure at Noble Hospital. Pt. F was given a physical examination. Her assessments remained unchanged. Her Zanaflex medication was stopped and she was prescribed Flexeril 10 mg. (90) instead. Her medications were adjusted to be Oxyir 5 mg. (180), Neurontin 300 mg., Elavil 150 mg. (30), and Oxycontin 10 mg. (60) and 40 mg. (60). (Ex. 43; 346-348/1475-1477 & 642-645/1771-1774.)

29. Pt. F was seen by Dr. Ogoke on August 29, 2003. She continued to complain of the same severe pain levels in her spine with radicular symptoms into her lower extremities. She continued to suffer from falls. Pt. F asserted her compliance with her medication regimen which was not giving her expected benefits. Dr. Ogoke concluded that Pt. F had shown a poor response to conservative management of her pain. The IDET procedure at the L3-4 and L4-5 levels where she had discogenic pain, was denied. Dr. Ogoke gave Pt. F a physical examination. He did a review of her medical records and recommended that Pt. F undergo percutaneous disc decompression at the levels of her disc herniations and bulging at the L3-4 and L4-5 levels. He opined this procedure would cost less than the IDET procedure. No changes were made to her assessments. Dr. Ogoke prescribed Zanaflex 4 mg. (90), Oxy IR 5 mg. (180), Elavil 100 mg. (30), and Oxycontin 20 mg. (60). Pt. F was to do physical therapy. He wrote a note on September 11, 2003 to excuse Pt. F from jury duty because her pain prevented her from being able to sit for more than ten minutes at a time. On September 15, 2003, Pt. F's appeal to her insurer of the denial of coverage for the IDET procedure was affirmed. At a September 29, 2003

visit to Dr. Ogoke's office, Pt. F complained of the same severe pain, including in her hips. She was prescribed Oxycontin 20 mg. (60) and 40 mg. (60), Lidoderm Patch 3 boxes, Elavil 150 mg. (30), Zanaflex 4 mg. (90), Percocet 10/325 mg. (120), and Topamax 25 mg. (21). (Ex. 43: 592-594/1721-1723, 623/1761, 641/1770 & 342-345/1471-1474. Ex. 55.)

30. On October 9, 2003, Dr. Thau called Dr. Ogoke's office about the percutaneous disc decompression procedure. By letter of October 10, 2003, the Massachusetts Rehabilitation Commission requested background medical information from Dr. Ogoke about Pt. F in terms of her claim of a disability. On October 30, 2003, Pt. F had a right side hip trochanteric bursa injection. At this visit, she reported a pain level of 8/10 in her hips and 10/10 in the low back that radiated into her lower extremities. She was prescribed Zoloft 50 mg. (35), Oxycontin 40 mg. (120), Skelaxin 400 mg. (90), Percocet 10/325 mg. (90), and Elavil 150 mg. (30). (Ex. 43: 339-341/1468-1470; 580-583/1709-1712 & 637-640/1766-1769.)

31. On November 13, 2003, Pt. F was prescribed Ativan 1 mg. (5), and Dr. Ogoke gave Pt. F the percutaneous disc decompression at the L3-4 and L4-5 levels at Noble Hospital. There were no complications. This procedure involved placing a needle into a disc and putting pressure and tension in the lining of a disc to stretch nerves to take tension off a bulge that was causing pain. The procedure tried to remove and/or vaporize some of the disc material. Pt. F was seen at Dr. Ogoke's office on November 18, 2003. She reported a 10/10 pain level with no pain relief from the disc decompression procedure. She was prescribed Oxycontin 80 mg. (15), Zoloft 100 mg. (30), Skelaxin 300 mg. (90)⁵⁴, Elavil 75 mg. (30), and Percocet 10/325 mg. (90). She reported that she wanted to consider weaning off narcotic medication. Pt. F was instructed to do physical therapy, and consideration would be given to weaning her off narcotic

⁵⁴ Exhibit 43, 565/1694 appears to be 300 mg. or 800 mg. of Skelaxin.

medications. Pt. F was seen at Dr. Ogoke's office on November 20, 2003. She received a prescription for Oxycontin 80 mg. (30) and her prior prescription for Oxycontin from November 18, 2003 was retained by Dr. Ogoke's office. She was seen at Dr. Ogoke's office on December 4, 2003. She announced that she had stopped taking all her medications except for Zoloft and Elavil, because she was 'fed-up' having to take so many pills that were not helping her with pain relief. She reported a pain level of 10/10. She reported having no chills or fever or sweats as a result of stopping her medications for about ten or eleven days, but she appeared anxious and was teary-eyed. She stood during the entire visit. The treatment plan was to have her pursue the IDET procedure because she was willing to pay for it. Pt. F was to discuss paying for this procedure with Dr. Ogoke's billing office. She was prescribed Methadone 10 mg. (120) and Ambien 10 mg. (14). (Ex. 43: 333-338/1462-1467; 565-567/1694-1696; 577/1706; 595/1724 & 627-628/1756-1757. Testimony of Dr. Trescot, Vol. XIV, 2814-2815.)

32. Pt. F was seen at Dr. Ogoke's office on January 5, 2004. She reported constant pain at a 10/10 level. Dr. Ogoke gave Pt. F a right sided hip trochanteric bursa injection. She was prescribed Bextra 20 mg. (15), Oxycontin 80 mg. (60), Ambien 10 mg. (30), and Oxy IR ?mg.⁵⁵ (120). On January 15, 2004, Pt. F had a lumbar spine MRI that showed "[v]ery minimal disc herniation at L4-5. No significant nerve root displacement. Mild facet joint arthropathy at L4-5 and [L5-S1]." Pt. F was seen on February 9, 2004 at Dr. Ogoke's office. She reported a 50% decrease in pain as a result of the hip injection on January 5, 2004, but reported an ongoing 10/10 level pain in her back that was deep, constant, and radiating. She was losing weight. She reported having stopped taking all her medications because they were not helping to relieve her pain. She was waiting for her insurance to approve her having the IDET procedure. She was

⁵⁵ The amount of the Oxy IR mg. could not be deciphered off of Exhibit 43, 244/1373 or off of Exhibit 58.

given a physical examination. She received a referral to Dr. Scott Cowan for consideration of possible fusion surgery to her back. Her treatment plan was revised to discontinue the OxyContin and the Oxy IR, and to start a Duragesic patch 50 mcg. (10) and Percocet 10/325 mg. (90). She was also prescribed Celebrex 200 mg. Also on February 9, 2004, Dr. Ogoke completed a questionnaire setting forth his care of Pt. F for her attorney, Richard C. Roth. (Ex. 43: 244/1373; 328-332/1457-1461; 457/1586; 504-521/1633-1650 & 562-564/1691-1693. Exs. 56, 57 & 58.)

33. Dr. Scott Cowan, an orthopedic surgeon, evaluated Pt. F for possible lumbar disc fusion surgery. In a March 5, 2004 report, Dr. Cowan understood Pt. F had no past medical history contributing to her current condition⁵⁶ of,

severe back and bilateral radiating leg pain over 13 years. Slow and gradual in onset but fairly progressive. At this point [it] is worse and excruciating. She has some bilateral radiating leg pain. Her back pain is worse than [pain in] her legs.

Dr. Cowan understood that she had not had surgery to her back but had undergone a percutaneous decompression procedure, and had tried “multiple blocks and epidural cortisone injections none of which have provided her any sustained relief.” Dr. Cowan understood her current medications were Percocet, Duragesic Patch, Celebrex, Ambien, and a Lidoderm patch. He gave a physical examination. He concluded she had a degenerative disc condition that was progressive and causing severe low back pain “requiring narcotics for [pain] control.” He needed to review Pt. F’s lumbar spine MRI to determine whether fusion surgery might help her. He sent this report to Dr. Ogoke and Dr. Thau. (Ex. 43, 498/1627. Ex. 57.)

34. Pt. F was seen at Dr. Ogoke’s office on March 10, 2004. She reported an On-going pain level of 10/10. The effectiveness of the medications she was taking was discussed. As a result she had some of her medications changed. She was given a physical

⁵⁶ In Dr. Cowan’s report, he does not note Pt. F’s two electrocutions.

examination. The assessments were unchanged. She was to do follow-up with Dr. Cowan concerning the possible fusion surgery. She was prescribed Neurontin 800 mg. (90), Gabitril 4 mg. 800 mg. (60), Elavil 50 mg. (60), Avinza 60 mg. (30), Celebrex 200 mg. (60), and Oxy IR 5 mg. (90). On March 11, 2004, she was prescribed MS Contin 30 mg. (60). Pt. F was seen at Dr. Ogoke's office on March 24, 2004. There was no change in her pain complaints. She reported "constant, severe and achy" pain radiating into her legs with numbness in her feet causing balance difficulties. She was given a physical examination. The assessments were unchanged. Pt. F had her medications changed so that she discontinued the MS Contin and the Oxy IR, and was prescribed Oxycodone 15 mg. (90). She was to do follow-up with the neurosurgeon to explore having lumbar fusion surgery. (Ex. 43: 324-327/1453-1456; 496/1625; 499/1628 & 501-502/1630-1631.)

35. Pt. F was seen by Dr. Ogoke on April 5, 2004. She continued to have the same 10/10 pain level. Pt. F expressed her concern "that her pain has stayed very severe." They discussed the possible fusion surgery and having an EMG study. She was again instructed to do follow-up with Dr. Cowan. They discussed her medications and some changes were made. The Oxy IR was replaced with MSIR 30 mg. (60). She was also prescribed Avinza at 90 mg. (10), Gabitril 4 mg. (90), Elavil 150 mg. (30), Celebrex 200 mg. (60), and Neurontin 800 mg. (90). Pt. F was seen on April 20, 2004 at Dr. Ogoke's office. She had her medications refilled, although the prescription for the long-acting morphine based Avinza was never able to be filled because her insurance would not cover it. She was prescribed Oxycodone 15 mg. (90), Percocet 10/325 mg. (90), and Norflex 100 mg. At this time Pt. F reported that she was planning to have the fusion surgery. (Ex. 43: 221/1350; 321-323/1450-1452; 488/1617 & 492-494/1621-1623.)

36. Pt. F was seen on May 7, 2004 at Dr. Ogoke's office. She was given a right sided

hip trochanteric bursa injection. At this visit she was prescribed Oxycodone 30 mg. (120), Percocet 10/325 mg. (120), Zanaflex 4 mg. (90), Elavil 100 mg. (60), and Celebrex 200 mg. (60). Pt. F was seen on June 2, 2004 at Dr. Ogoke's office. She reported "no change in intensity of the pain or the quantity of the pain ... no new symptoms" in her back. She reported that the hip injection from May 7th provided her with 100% relief that had been maintained. Pt. F was given a physical examination. She was seeking medication refills and was prescribed Celebrex 200 mg. (60), Oxycodone 30 mg. (120), Elavil 100 mg. (60), Ambien 10 mg. (30), Zanaflex 4 mg. (90), Percocet 10/325 mg. (120), and Prilosec (30). Pt. F was seen on June 25, 2004 at Dr. Ogoke's office. She reported her pain as severe, constant, sharp, achy, and burning 10/10 level. She sought refills of her medications. Her low back lumbar fusion surgery with Dr. Cowan was scheduled for July 12, 2004. She was given a review of systems and a physical examination. (Ex. 43: 147-155/1276-1284; 526-531/1655-1660 & 535-552/1664-1681.)

37. Pt. F was seen on August 11, 2004 at Dr. Ogoke's office. She was seeking refills of her prescriptions. She had undergone the fusion surgery at the L3-4 and L4-5 levels on July 12, 2004 with Dr. Cowan, and was doing follow-up care with him. She was given a physical examination and prescribed Elavil 100 mg. (60), Percocet 10/325 mg. (180), Ambien 10 mg. (30), and Oxycodone 30 mg. (240). Dr. Ogoke was asked by letter of August 21, 2004 to answer a questionnaire on Pt. F's condition for purposes of disability income/SSI benefits. (Ex. 43: 146/1275; 198-200/1327-1329 & 454/1583.)

38. Pt. F was seen at Dr. Ogoke's office on September 3, 2004, while still having post-surgery follow-up care with Dr. Cowan. She was given a physical examination. She received refills of her prescriptions and was prescribed Percocet 325/10 mg. (180), Oxycodone 30 mg. (240), and Gabitril 4 mg. (60). Pt. F was seen by Dr. Ogoke on September 27, 2004. She

reported “marked improvement following her lumbar [fusion] surgery.” At this time she was not on “any high dose non-steroidals because of concerns of Dr. Cowan that she may not heal well and an anti-inflammatory response may be blocked by the non-steroidals.” She was given a physical examination. Her Elavil was renewed at 100 mg. (60), the Percocet was stopped, the NSAIDs were stopped, and the Oxycodone was continued at 30 mg. (240). Dr. Ogoke sent Pt. F’s insurer requests to authorize some of the medications he was prescribing for her. (Ex. 43: 142-145/1271-1274; 165-170/1294-1299 & 182-197/1311-1326. Testimony of Dr. Trescot, Vol. XIV, 2816-2818.)

39. On October 20, 2004, Dr. Ogoke gave Pt. F a right sided hip trochanteric bursa injection. At this visit, she was also prescribed Flexeril 10 mg. (90), Oxycodone 30 mg. (240), and Elavil 100 mg. (60). On November 2, 2004, Pt. F’s attorney, Richard C. Roth, sought Pt. F’s medical records from Dr. Ogoke in connection with her claim for SSI disability benefits. The records were sent November 22, 2004. On November 10, 2004, Dr. Ogoke gave Pt. F a bilateral SI injection with fluoroscopy. At this visit, she received prescriptions of Oxycodone 30 mg. (240), Methadone 40 mg., Flexeril 10 mg. (90), Elavil 100 mg. (60), and Ibuprofen 600 mg. (45). She was seen by Dr. Ogoke on November 11, 2004 for follow-up and to discuss her use of Oxycodone. Pt. F reported not having experienced pain relief from her recent lumbar fusion surgery. She continued to report significant back pain. She was counseled on how to take her Oxycodone medication. The strength of it was not altered. Pt. F was seen at Dr. Ogoke’s office on November 30, 2004, Pt. F reported that the medications were helping her as did the SI injection. She was prescribed Elavil 100 mg. (60), Oxycodone 30 mg. (120), Flexeril 10 mg. (90), Ibuprofen (IBU) 800 mg. (90), and Methadone 40 mg. (75). By letter of December 8, 2004, Dr. Ogoke was asked to provide background medical records on his care of Pt. F in connection

with her efforts to secure disability benefits. When seen on December 31, 2004 at Dr. Ogoke's office, Pt. F continued to report that the fusion surgery had not significantly decreased her back pain, and the recent SI injection had not given her lasting pain relief. She reported constant on-going moderate to severe pain. She reported having some pain relief from her medications. She was given a review of systems and a physical examination. She was prescribed Methadone 40 mg. (90), Oxycodone 30 mg. (180), and Boclofen 10 mg. (90). A UDS test was done and the results showed Pt. F was compliant with taking her medications. Pt. F received prescriptions on January 31, 2005 of Oxycodone 30 mg. (180) and Methadone 40 mg. (90). (Ex. 43: 132-141/1261-1270; 156-164/1285-1293; 286/1415; 451-453/1580-1582; 459-466/1588-1596; 474-477/1603-1606; 479-482/1608-1611 & 486-487/1615-1616. Ex. 44)

40. By now, Pt. F had been taking Oxycodone 30 mg., 2 tablets every 4 hours or 6 a day which was 360 mg. a day. This is about an 800-900 mg. of Morphine equivalence. Still, Pt. F reported a pain level of 10/10 at the time Dr. Ogoke started her on Methadone at a dose that was half the dose, after calculating a Morphine equivalence. Oxycodone 30 mg. was prescribed for her to use for break-through pain. This prescribing was done because of Pt. F's very severe pain levels. Dr. Trescot opined that this dosage of Methadone was reasonable and within the standard of care. (Ex. 43, 474/1603. Testimony of Dr. Trescot, Vol. XIV, 2820-2821.)

41. At a March 1, 2005 evaluation by Dr. Ogoke, Pt. F reported significant pain although she felt "slightly improved" in her lower back despite her lower extremity pain that made her feel unstable. She had fallen three nights ago hurting her left wrist. She reported that along with the severe pain, she had suffered a large weight loss, but within the last two months she had been gaining weight. She had an issue with retaining her food due to gastric motility dysfunction, and was treating with Dr. Samuels and taking Reglan. She reported trying to wean off her Elavil

medication because she believed it was not working to help her sleep, and instead, tried Diphenhydramine to help her sleep. Dr. Ogoke had her stop that medication and instead prescribed Doxepin 100 mg. (30) with the plan to titrate up as needed. She was given a physical examination. Dr. Ogoke prescribed Methadone 40 mg. (90), Oxycodone 30 mg. (180) and Neurontin 600 mg. (90). The treatment plan was to continue physical therapy for post-surgery improvement, and to schedule another SI injection as soon as possible. Pt. F was seen again on March 31, 2005 at Dr. Ogoke's office. Her complaints were the same. She was given a physical examination. The treatment plan was changed to discontinue the Neurontin because it upset her stomach. She was prescribed Methadone 40 mg. (120), Oxycodone 30 mg. (180), Doxepin 100 mg. (30), and Ambien 10mg. (14). (Ex. 43; 127-130/1256-1259 & 288-289/1417-1418.)

42. Pt. F was seen at Dr. Ogoke's office on April 29, 2005. She reported significant pain in her lower extremities. The treatment plan was to consider a lumbar transforminal ESI series and an SI injection after the first lumbar transforminal ESI. The IDET procedure was again considered. At this visit, Pt. F was prescribed Doxepin 100 mg. (30), Ambien 10 mg. (14), Oxycodone 30 mg. (180), and Methadone 40 mg. (120). Pt. F was seen at Dr. Ogoke's office on June 7, 2005. She had the same pain complaints including achy and constant back and leg pain, and numbness in her feet. As in the past, she reported that the pain made it hard for her to sleep. She had resumed using Elavil. Pt. F was given a physical examination. Pt. F was seeking refills of her prescriptions. She was prescribed Oxycodone 30 mg. (180), Norflex 100 mg. (60), Elavil 100 mg. (30), and Methadone 40 mg. (120). Pt. F was seen at Dr. Ogoke's office on July 7, 2005 with the same pain complaints and seeking medication refills. She was given a physical examination. She was prescribed Norflex 100 mg. (60), Elavil 100 mg. (30), Methadone 40 mg. (120), and Oxycodone 30 mg. (180). Because she had left knee pain, she had left knee x-rays on

July 7th that were normal. At an August 4, 2005 visit to Dr. Ogoke's office, Pt. F complained of continuing left knee pain. A physical examination was done focusing on the knee. An MRI of the left knee was ordered. At this visit, Pt. F was prescribed medications.⁵⁷ The MRI was done on August 15, 2005, and included a finding of significant left knee globular degeneration of the posterior horn of the medial meniscus. (Ex. 43: 122-126/1251-1255; 291-299/1420-1428 & 302-303/1431-1432.)

43. On September 8, 2005, Dr. Ogoke gave Pt. F a right sided hip trochanteric bursa injection. Pt. F was prescribed Methadone 40 mg. (120) and Oxycodone 30 mg. (180). On October 11, 2005, Pt. F was prescribed Oxycodone 30 mg. (180), Methadone 40 mg. (120), and Elavil 150 mg. (30). On November 22, 2005, Pt. F at an evaluation at Dr. Ogoke's office, she reported a pain level of 10/10. She was prescribed Oxycodone 30 mg. (180), Methadone 40 mg. (120), and Elavil 150 mg. (30). (Ex. 43: 119-121/1248-1250; 300-301/1429-1430 & 305-307/1434-1436.)

44. On January 7, 2006, Dr. Ogoke gave Pt. F a right sided hip trochanteric bursa injection. A specimen may have been taken for a UDS test. Pt. F was prescribed Methadone 40 mg. (120), Oxycodone 30 mg. (180), Elavil 150 mg. (30), and Ambien 5 mg. (7). (Ex. 43; 117-118/1246-1247 & 308-312/1437-1441.)

45. Pt. F was referred to Dr. Robert S. Howe, to address abnormal menses and fertility issues she was having because she wanted to start a family. In a February 7, 2006 report to Dr. Ogoke, Dr. Howe opined that Pt. F was suffering from a "clinical situation of ... narcotic induced abnorrhea." He prescribed "clomiphene ... [and] checking a semen analysis." Dr. Howe concluded that Pt. F's odds of getting pregnant "were low" because of her age. (Ex. 43,

⁵⁷ I was not sure what medications were prescribed from reviewing the copies of prescriptions at Ex. 43, 298/1427.

313/1442. Ex. 61.)

46. Pt. F was seen by Dr. Ogoke on February 21, 2006. She complained of persistent low back and lower extremity pain which she depended on her medications to control. Dr. Ogoke did a review of systems and gave a physical examination. Pt. F now had hypothyroidism. The assessments remained unchanged otherwise. He had a UDS done to monitor Pt. F's compliance with her medication regimen. Dr. Ogoke noted in the report of this visit that the specimen taken January 7, 2006 for a UDS, may not have involved a proper specimen collection so Dr. Ogoke decided to "disregard any result" from that UDS.⁵⁸ The result from the February 21, 2006 specimen collection was positive for the Oxycodone screen.⁵⁹ The treatment plan was to schedule the first in a series of lumbar bilateral transforminal ESIs and then to do an SI injection. In the interim, Dr. Ogoke renewed Pt. F's current medications including Ambien 5mg. (7), Methadone 40 mg. (120), Oxycodone 30 mg. (180), Elavil 150 mg. (30), and Flexeril 10 mg. (90). (Ex. 43:107-116/1236-1245; 287/1416; 408-409/1537-1538 & 314-315/1443-1444.)

47. On March 27, 2006, Dr. Ogoke gave Pt. F lumbar right side transforminal ESI injections with fluoroscopy at the L2, L3, L4, and L5 levels. She came to this appointment with a pain level of 10/10. She was prescribed Ambien 5 mg. (10), Ativan 2 mg. (2), Elavil 150 mg. (30), Oxycodone 30 mg. (180), and Methadone 40 mg. (120). On April 27, 2006, Pt. F was seen at Dr. Ogoke's office. She reported pain located mostly in her right hip, and radicular pain in her right lower extremity. She reported a "slight decrease" in pain following the March 27, 2006 procedure. She was given a physical examination. The treatment plan she agreed to was to do another lumbar transforminal ESI, and consider doing a right hip trochanteric bursa injection. A

⁵⁸ Ex. 43, 311/1440, contains a note that Pt. F claimed she did not have a specimen collection on January 7, 2006.

⁵⁹ I could not locate the results of the full screen in Pt. F's medical records (Exhibit 43).

UDS was done. The Oxycodone screen was positive. Pt. F's current medications were renewed of Methadone 40 mg. (120), Oxycodone 30 mg. (89), and Elavil 150 mg. (30). (Ex. 43: 410-411/1539-1540; 101-106/1230-1235; 417/1546 & 419-422/1548-1551.)

48. On May 9, 2006, Dr. Ogoke gave Pt. F a second lumbar right-sided transforminal ESI procedure with fluoroscopy at levels L2, L3, L4, and L5. She came to this visit complaining of a 9/10 pain level. She was prescribed Valium 10 mg. (2) for the procedure, Lunesta 3 mg. (20) and EC-Naprosyn 375 mg. (60), because Pt. F wanted to try another anti-inflammatory medication besides Celebrex. On May 30, 2006, Dr. Ogoke gave Pt. F the third right-sided transforaminal ESI procedure with fluoroscopy at levels L2, L3, L4, and L5. She was prescribed Methadone 40 mg. (120), Oxycodone 30 mg. (180), Elavil 50 mg. (30), Norflex 100 mg. (60), Valium 10 mg. (2), and Lunesta 3 mg. (20). Pt. F had UDS testing. The UDS test results were positive for the Oxycodone screen. (Ex. 43: 95-100/1224-1229; 282-283/1411-1412; 423-424/1552-1553; 441/1570; 443-444/1573-1574; 446-447/1575-1576 & 449-500/1578-1579.)

49. Pt. F was seen at Dr. Ogoke's office on June 28, 2006. At this session, her history of pain issues was discussed. More recently, she had developed right hip and left knee pain, and was diagnosed by New England Orthopedic Surgeons with a right hip trochanteric bursitis and a left knee torn meniscus. She received cortisone injections to her hip and to her knee with "improvement in pain and gait." By this time, Pt. F was wearing a TENS Unit for her low back pain. She had experienced a "20%" pain decrease from a May 30, 2006 lumbar ESI procedure. She reported at this time that her pain medications were "less effective" than they had been. She was given a physical examination. The assessment of her condition was found to be: lumbar radiculopathy; right trochanteric bursitis; left knee pain; sacroiliitis; cervical strain; cervical radiculopathy; cervicogenic headache; post lumbar laminectomy syndrome; lumbar degenerative

disc disease; and, lumbar herniated nucleus pulposus. She received prescriptions for Lunesta 3 mg. (20), Norflex 100 mg. (60), Oxycodone 30 mg. (180), Valium 10 mg. (2) for procedures, Elavil 50 mg. (30), and Methadone 40 mg. (120). In terms of the Oxycodone dose, Pt. F was to discuss this with Dr. Ogoke at her next visit. She was to do follow-up with the New England Orthopedic Surgeons, and schedule a lumbar facet joint ESI injection with Dr. Ogoke. Pt. F had a UDS done. Pt. F was seen at Dr. Ogoke's office on July 31, 2006. She had the same pain complaints. She wanted to have an SI injection. On physical examination, her right SI joint had more tenderness than her left side. The treatment plan was to schedule an SI injection and a lumbar facet joint ESI. She had a scheduled a follow-up visit with New England Orthopedic Surgeons where she had a right hip injection. A UDS was done on August 1, 2006 that was positive for the Oxycodone screen. She was to stop taking Elavil due to a high TCA result from her last UDS of June 28, 2006. She was prescribed her ongoing medications other the muscle relaxants because they were not helping her. She was prescribed Robaxin 500 mg., four times a day (120), Lunesta 3 mg. (14), Methadone 40 mg. (120), Valium 10 mg. (2) for procedures, and Oxycodone 30 mg. (180). (Ex. 43: 88-90/1217-1219; 92-94/1221-1223; 428-433/1557-1562 & 435-439/1564-1568. Exs. 59 & 60.)

50. On August 30, 2006, Dr. Ogoke gave Pt. F a bilateral SI injection with fluoroscopy. A UDS was done. The result showed her compliant in taking her Oxycodone medication.⁶⁰ Her medications were renewed; Robaxin 500 mg. (120), Methadone 40 mg. (120), Oxycodone 30 mg. (180), Lunesta 3 mg. (14), and Valium 10 mg. (2) for procedures. Pt. F had an EKG on August 30, 2006, which was normal. Ex. 43: 85-87/1214-1216; 254-262/1383-1391; 266-280/1395-1409 & 425-426/1554-1555.)

⁶⁰ There were a number of copied UDS results in Pt. F's medical records (Exhibit 43) that I could not decipher due to very faint copies.

51. Pt. F was seen on October 2, 2006 at Dr. Ogoke's office. She reported cervical pain brought on headaches, and a pain level of 7/10 in her neck and mid to low back area. She reported an 80% pain decrease that lasted six days following the SI injection on August 30, 2006. She had stopped taking Elavil, reported Lunesta was not helping her to sleep, and wanted to try another medication. She was taking Levothroid for hyperthyroidism. She was given a physical examination. No changes were made to the assessments. A UDS was done. The result was positive for Oxycodone. Her treatment plan was to do another SI injection as soon as possible, and to consider a cervical ESI injection. She was to stop taking Lunesta and take Trazodone instead for sleep. She was to stop Robaxin and take Flexeril instead for her muscle spasms. She was prescribed Oxycodone 30 mg. (180), Methadone 40 mg. (120), Trazodone 50 mg. (30), Flexeril 10 mg. (90), and Valium 10 mg. (2) for procedures. On November 1, 2006, Dr. Ogoke gave Pt. F a bilateral SI injection with fluoroscopy. She was prescribed Valium 10 mg. (2), Lyrica 150 mg. (60), Lunesta 3 mg. (14), Oxycodone 30 mg. (180), Methadone 40 mg. (120), Ambien 12.5 mg. (9), and Robaxin 500 mg. (120). Pt. F was seen on December 4, 2006 at Dr. Ogoke's office. She was prescribed Valium 10 mg. (2), and on December 5, 2006, Lunesta 3 mg. (14), Lyrica 150 mg. (60), Methadone 40 mg. (120), and Oxycodone 30 mg. (180). A UDS was done.⁶¹ (Ex. 43: 81-84/1210-1213; 226-228/1355-1357; 230-233/1359-1362; 235-236/1364-1365; 242-243/1371-1372; 245-247/1374-1376; 251-253/1380-1382 & 319-320/1448-1449.)

52. On January 3, 2007, Pt. F was seen by Dr. Ogoke. Pt. F had stopped taking Elavil, undergone an EKG that was essentially normal, and could not have the planned SI injection due to building renovations at Dr. Ogoke's office. She was given a physical examination. A UDS

⁶¹ The UDSs done in October and December 2006 were ordered to include results covering more than Oxycodone, but some of the pages in Pt. F's medical records (Exhibit 43) that may have shown the other results from these UDSs were too faint to read. I could not locate the results from the December 5, 2006 UDS.

was done to ensure Pt. F continued to be compliant in taking her medications as prescribed.⁶² The diagnoses made were: sacroiliitis; lumbar degenerative disc disease; lumbar herniation and radiculopathy; post lumbar laminectomy syndrome; insomnia; cervical strain; cervical radiculopathy; and, cervicogenic headaches. The treatment plan was: stop Lunesta and start Elavil at 50 mg. and titrate up the dose as tolerated; do a repeat EKG to ensure Pt. F had no adverse cardiac effects while taking the tricyclic anti-depressant; and, start the SI injection series as soon as possible. She was prescribed Lyrica 150 mg. (60), Valium 10 mg. (2) for procedures, Elavil 50 mg. (60), Methadone 40 mg. (120), and Oxycodone 30 mg. (180). On February 6, 2007, Pt. F was seen by Dr. Ogoke. She reported a pain level of 8/10 at this visit, with “pain in the sacroiliac notch region on both sides ... [was] unhappy with her current level of pain control status post [lumbar fusion] surgery, and ... [continued] to complain of persistent pain requesting ... some kind of interventional pain management to help her overall.” She was given a physical examination. The assessments made were unchanged other than the addition of, “rule out facet mediated pain at the lumbar level.” Dr. Ogoke gave Pt. F a bilateral SI injection with fluoroscopy. A UDS was done. The results from Ameritox, the outside laboratory Dr. Ogoke used, were positive for the medications she as taking and negative for any illicit drugs or other medications not prescribed. Pt. F’s treatment plan was to include “possible lumbar facet diagnostic blocks.” Dr. Ogoke included a note that Pt. F was receiving prescriptions for Valium to take before her interventional procedures due to “her fear of needles and anxiety.” At this visit, Pt. F was prescribed Lyrica 150 mg. (60), Methadone 40 mg. (120), Oxycodone 30 mg. (180), Elavil 50 mg. (60), and Valium 10 mg. (2). (Ex. 43: 39-40/1168-1169; 45-46/1174-1175; 48/1177; 52-56/1181-1185; 70-74/1199-1203 & 76-78/1205-1207. Exs. 62 & 66.)

53. On March 5, 2007, Dr. Ogoke gave Pt. F a lumbar bilateral transforaminal facet joint

⁶² I could not locate in Pt. F’s medical records (Exhibit 43) the results from this UDS test.

ESI procedure with fluoroscopy at levels L2, L3, L4, L5, and S1. A UDS was done. She reported a pain level of 8/10 in her back. She was prescribed Methadone 40 mg. (120), Oxycodone 30 mg. (180), Valium 10 mg. (2) for procedures, and Elavil 50 mg. (60). On April 5, 2007, Dr. Ogoke gave Pt. F a lumbar bilateral transforminal facet joint injection with fluoroscopy, at the same five levels. She completed a brief pain inventory form and had a UDS done. She reported a pain level of 9/10 in her back and legs. An opioid renewal form was completed showing Pt. F's last UDS result from March 5, 2007 revealed a high TCA (tricyclic anti-depressant) level. No prior narcotic agreement violation was listed. At this visit she was prescribed Norflex 100 mg. (60), Valium 10 mg. (2) for procedures, Methadone 40 mg. (120), Oxycodone 30 mg. (180), and Elavil 50 mg. (60). On May 3, 2007, Dr. Ogoke gave Pt. F another lumbar bilateral transforminal facet joint injection with fluoroscopy at the same five levels. She completed a brief pain inventory form, and a UDS was done. She reported a pain level of 10/10 in her back and legs. An opioid renewal form was completed showing Pt. F had no narcotic agreement violation and that results from her last UDS were pending. She was prescribed Oxycodone 30 mg. (180), Methadone 40 mg. (120), Elavil 50 mg. (60), Norflex 100 mg. (60), and Valium 10 mg. (2) for procedures. (Ex. 43: 12-13/1141-1142; 17-18/1146-1147; 20-21/1149-1150; 23-24/1152-1153; 26-27/1155-1156; 30-33/1159-1162; 35/1164; 37-38/1166-1167; 41-42/1170-1171 & 59-69/1188-1198. Exs. 101 & 106.)

54. Dr. Satwicz opined on Dr. Ogoke doing multi-level bilateral injections during one procedure. For Dr. Satwicz, doing bilateral lumbar facet joint injections at five lumbar spine levels during one procedure, could be dangerous, especially when the patient was receiving an overall dose of 200 mg. of Depo-Medrol; 20 mg. from ten needle injection sites. Only 20 mg. of Depo-Medrol was being injected at a time, but Dr. Ogoke had as many as five needles at one

time left in the lumbar spine during the procedure. The needles not being used at the moment for the injection were left in the patient to help guide the needle giving the injection. For Satwicz, performing the procedure this way was too risky. Even though Valium was taken to help relax the patient during the procedure, if a patient moved during the injections being administered with five needles still in the patient, the patient could suffer harms. The patient was not unconscious/not anesthetized during the procedure, and only received a local anesthetic. In addition, the Depo-Medrol overall dose during one procedure was high and could have had significant side effects such as steroid psychosis, immunosuppression, and elevated blood sugar level. For Dr. Satwicz, during one procedure to inject bilaterally at five lumbar levels would have signified widespread disease that may have needed better evaluation before undertaking this kind of procedure. More often, two or three levels of lumbar spinal facet joint injections would be done at one time. To do four lumbar levels bilaterally during one procedure was borderline excessive. A method Dr. Satwicz was taught on cadavers at physician clinical training meetings as safe was to leave only one extra needle in as a marker in the lumbar spine to guide the placing of the next needle before injecting the Depo-Medrol. That marker needle would be removed once the injection site was secured. Multiple lumbar levels receiving injections was not necessarily inappropriate, because this process might help to reach the source of the pain in the spine that might have involved an overlap of spine levels. The source of musculoskeletal pain might have been bone, disc or nerves. Dr. Satwicz opined that even if Dr. Ogoke did not violate an established standard of care against doing the five level bilateral lumbar facet injections during one procedure, it was very risky for Pt. F to have and done using Dr. Ogoke's method. (Testimony of Dr. Satwicz, Vol. X, 1920-1927.)

55. The method Dr. Ogoke used to give the five level injections bilaterally within one

procedure was consistent with how he and other pain management specialists were taught to do this interventional procedure by the American Society of Interventional Pain Physicians (ASIPP) and the International Spine Injection Society. The overall dose of 200 mg. of Depo-Medrol was not excessive according to the training he received. Pt. F did not suffer any unintended damage to her lumbar spine from Dr. Ogoke's multi-level bilateral lumbar facet joint injections. (Ex. 106. Testimony of Dr. Ogoke, Vol. VI, 1328-1335 & Dr. Tre Scot, Vol. XIV, 2822, 2827-2832.)

56. Also on May 3, 2007, Pt. F spoke to Dr. Ogoke, reporting that she felt his treatments were not helping her. She had now received a bilateral SI injection in February, and the five lumbar level bilateral transforaminal facet joint injection procedures, in March, April and May. She had lost a lot of weight, was on a lot of medication, had undergone many injection procedures even prior to those in 2007, and had been treating with Dr. Ogoke for pain control over many years. Pt. F told him she felt like she was dying. She had found at this point that some of the injection procedures were painful, and she would cry out to stop them while she was receiving them, but a particular injection procedure would not last that long and she would finish the procedure. She felt at times "like a pincushion." Pt. F believed the injections were actually hurting her. Dr. Ogoke explained to Pt. F that there were no other kinds of treatments he could offer her than all he had tried with her over the years, and that termination would be her only option if she did not want to continue with his treatment plans that included doing interventional procedures in addition to a pain medication regimen. He explained her options if her care was terminated with his practice. She could go into a detox facility to address the opioid medications she was taking to taper off of them. She could treat with her PCP or with another pain management clinic. Dr. Ogoke told her he could begin to taper her off her pain medications if she wanted that. He explained that she could use the next thirty day time period, receiving her

on-going narcotic pain medications once care terminated with him and locate her next caregiver for her pain issues without needing to do a tapering off these medications. Dr. Ogoke would include an additional month of her pain medication prescriptions if that was needed for her to locate further pain management care. After having this discussion, Pt. F did not report what she wanted to do, and did not agree to follow her treatment plan because she did not want further injection procedures. She also told Dr. Ogoke that she had been double-billed in connection with a UDS and that this was wrong. Dr. Ogoke told her to take her concern up with his billing department. She felt Dr. Ogoke had not reacted well to the double-billing claim because he left the room. Pt. F had not been double-billed. Dr. Ogoke's office had divided the UDS analyses between two laboratories, Baystate and Ameritox. One lab did the analysis on some of the drugs and the other lab did the analysis on the other set of drugs tested from Pt. F's same urine specimen. After Dr. Ogoke left the room, a staff person entered the room and handed Pt. F a termination of care letter. The letter was also mailed to her by certified mail. The letter informed her that as of May 3, 2007 she ceased being Dr. Ogoke's patient. She was informed that she could continue care at another pain management clinic of her choice. Mentioned as places she could go to were the Bay State Medical Center Pain Management Center and the Mercy Medical Center Pain Clinic. She was also informed that for the next thirty days, she could return to Dr. Ogoke's office for emergencies. (Ex. 43; 16/1145 & 22/1151. Testimony of Pt. F, Vol. III, 580-582, 592-604, 721-738 & Dr. Ogoke, Vol. V, 1348-1358.)

57. On May 11, 2007, the results of Pt. F's last UDS done on May 3, 2005 showed she was compliant in taking the medications prescribed. (Ex. 43, 12-13/1141-1142.)

58. On June 1, 2007, Pt. F was seen at Dr. Ogoke's office. She completed a brief pain inventory form. A UDS was done. A physical examination was given. She was prescribed

Elavil 50 mg. (60), Oxycodone 30 mg. (180), Methadone 40 mg. (120), Rozerem 8mg. (30), Valium 10 mg. (2), and Norflex 100 mg. (60). At no time following this visit did Pt. F explain where she had sought, or was going to get, continuing care for her pain issues. She did not ask to have Dr. Ogoke's office taper her off the opioid medications she was on. She had signed a form at Dr. Ogoke's office to receive a copy of her medical records, but had not received them by June 1st. Pt. F did not ask that her medical records be transferred to any other facility or physician. Pt. F did not return to ongoing care with Dr. Ogoke after this visit. (Ex. 43, 9-11/1138-1140. Exs. 64-65. Testimony of Dr. Ogoke, Vol V, 1352-1358.)

59. Pt. F filed a complaint against Dr. Ogoke with the BORM in November 2007. She claimed she had been overbilled for a UDS. She checked-off on the complaint form that Dr. Ogoke engaged in; substandard care, professional misconduct, sexual misconduct, rude or discourteous behavior, a failure to provide medical records, drug dealing, patient neglect/ abandonment, unlawful discrimination, failure to supervise staff, false advertising, and fraud. Pt. F believed she had been discharged from care because she mentioned to Dr. Ogoke that she had been billed twice for the same services involving the UDS analysis. She felt he "went crazy" over her claim, telling her "why are you wasting my time with this, that is why I have a staff," after which he abruptly left her in the room. She reported that right after Dr. Ogoke left, a staff person entered and handed her a termination of care letter. Pt. F informed the BORM that she returned to Dr. Ogoke's office for refills of her prescriptions about a month following her termination of care, and that she received her prescriptions at all the same dose levels. She was aware that Dr. Ogoke was not tapering her off the medications. She did not ask Dr. Ogoke to help taper her off her medications. Pt. F complained to the BORM that she had been too heavily medicated while under Dr. Ogoke's care and that she had undergone too many injection

procedures. She complained that she felt she had become a “drug addict.” Overall, she informed the BORM that she felt worse than when she had first treated with Dr. Ogoke in 2002. She found some of the procedures he had done to her to be painful and difficult to undergo. Pt. F complained that once she stopped care with Dr. Ogoke, she went through months of difficult withdrawal symptoms from getting off the medications he had prescribed, and that she had lost much weight. She reported to the BORM that she tried to wean off the Oxycodone and Methadone with her own methods of reducing doses. She had also sought her medical records from Dr. Ogoke’s office, but never received them in a timely manner. She believed this prevented her from going into care with another pain management clinic or other physician. The medical records were sent out to Pt. F on January 29, 2008.⁶³ (Ex. 43, 8/1137. Ex. 83. Testimony of Pt. F, Vol. III, 557-567, 608-609, 633-634.)

60. Dr. Ogoke was aware that the doses of Oxycodone and Methadone that Pt. F was on at the time of her termination of care were high doses, and that his last prescriptions for these narcotics were for the ongoing high doses she had been taking. He did not engage in any process with Pt. F for tapering off these medications. He had no information before him when his practice wrote her last prescriptions on June 1, 2007, that she had transferred her care to another physician or pain management clinic. (Ex. 43, 9-11/1138-1140 & 57-58/1186-1187. Testimony of Dr. Ogoke, 1348-1352.)

61. Dr. Satwicz opined that Dr. Ogoke had violated the standard of care when he did not ensure that Pt. F had transferred her care to another physician or pain management center or detox center before terminating her from his care. Nothing in Pt. F’s medical records showed any such transfer of care had occurred after her termination of care with Dr. Ogoke. Nothing

⁶³ Late receipt of medical records from Dr. Ogoke was not a charge the BORM made against Dr. Ogoke in his care of Pt. F.

showed Dr. Ogoke tapered Pt. F off her opioid medications. Without some continuing care, Dr. Ogoke would know that Pt. F would suffer withdrawal symptoms. It would have been clear to Dr. Ogoke that with Pt. F on such high opioid doses at the time of her termination from care and last prescriptions, another physician would at least be reluctant to assume this same level of opioid prescribing. (Testimony of Dr. Satwicz, Vol. X, 1913-1918.)

62. Pt. F had sought copies of her many medical records from Dr. Ogoke. Having made this request when she received the termination of care letter, and when months had passed, she began calling Dr. Ogoke's office to find out why she had not received her medical records. She did not ask Dr. Ogoke's office, and did not know, if the pain management clinics she contacted after ending care with Dr. Ogoke such as Bay State Medical Center, or her new PCP, ever sought her medical records from Dr. Ogoke. Upon approaching them to help her with her pain control needs, Pt. F understood that she could not treat with them unless they had her medical records from Dr. Ogoke's office. Pt. F did not ask them to help her obtain these medical records, and did not continue to pursue care with them for her pain management. When Pt. F received her medical records from Dr. Ogoke's office on or about January 29, 2008, a cover letter was included. Dr. Ogoke's office apologized for the delay in locating and copying her entire file. She was offered further assistance with the medical records if she needed it. (Ex. 43, 8/1137. Ex. 83. Testimony of Pt. F, Vol. III, 556-567.)

63. Since ending care with Dr. Ogoke, Pt. F has treated for her pain management with her PCP, with a spine specialist doctor, and with a psychologist. She has taken Oxycodone 5 mg. two times a day for pain, Clonazepam, Benzodiazepam, Flexeril, and medicine for her thyroid condition. She had left knee surgery in 2008 and may need another left knee surgery. She still suffers from chronic and constant pain that has her lying down every few hours for

relief. The pain can be throbbing. In October 2010 she had a spinal cord stimulator removed. (Testimony of Pt. F, Vol. III, 622-626.)

Conclusion and Recommendation

Dr. Ogoke was charged with misconduct in his care of Pt. F as follows: prescribed excessive doses of opioids to treat Pt. F's clinical conditions; gave Pt. F painful injection procedures and risky lumbar spine multi-level bilateral injections; yelled at Pt. F when she told Dr. Ogoke about a billing discrepancy she had found that triggered him terminating her from his care; and, failed to taper Pt. F off her opioid medications before terminating her from his care that resulted in Pt. F experiencing painful withdrawal symptoms. The BORM has not proven these charges.

Pt. F treated with Dr. Ogoke between 2002 and May 2007. The findings show there were long periods of time, including within 2006-2007 leading up to the time Dr. Ogoke terminated care with Pt. F, when her pain complaints did not seem to reach any significant resolution or come under any long-term control. This was her situation despite being on high opioid doses, undergoing SI injections, multi-level lumbar ESI procedures, and having undergone lumbar fusion surgery. Dr. Ogoke acknowledged that Pt. F's medical conditions involved treatments with a number of specialists. She started care with Dr. Ogoke having already undergone numerous interventional pain control procedures and having been on narcotic medications for pain relief. Her circumstances included having experienced two electrocutions, and having degenerative disc disease, sacroiliitis, and lumbar disc herniation. She underwent x-rays, MRIs, and diagnostic procedures toward uncovering what was producing her significant constant pain and where the core pain areas were located. Her medical profile of difficult to control chronic pain, supported Dr. Ogoke's assessment that she had constant and severe pain limiting her life

activities and movements. The course of evaluations, physical examinations, assessments, and ongoing accounts of Pt. F's pain complaints demonstrated that the sources of her significant chronic pain were hard to treat to produce a significant control for her pain. At best, the combination of pain medication and interventional procedures helped to control her pain.

Pt. F came to Dr. Ogoke in 2002 hoping his expertise could provide her with a treatment, whether with medications or through interventional procedures, that would provide a path of care where she could be off all her pain medications. Pt. F had hopes of getting pregnant at some point. Dr. Ogoke gave Pt. F diagnostic tests and various treatment procedures, including many injection treatments, with the goal of locating the sources of the pain in her back to focus the administering of pain medication directly to her primary pain sources, to hopefully, result in less need for oral pain medication to control her chronic pain. Certainly, Pt. F's testimony and her medical records show she agreed to this course of treatment for her difficult to control pain. Pt. F signed various treatment forms, including the narcotics agreement. She had frequent office visits and she always agreed to the particular scheduled interventional treatments with signed consent forms and forms explaining the procedures. One interventional procedure that Dr. Ogoke wanted for Pt. F, the IDET procedure, was not covered by her insurer, not even after the neurosurgeon who eventually performed the lumbar fusion surgery, joined Dr. Ogoke in support of doing this procedure before the fusion surgery. It was viewed by her insurer as too experimental at the time. Pt. F did not have this procedure despite numerous efforts to gain the insurer's approval.

Dr. Ogoke prescribed physical therapy treatments for Pt. F. Those treatments were not extensive or ongoing. In her testimony Pt. F did not discuss physical therapy as aiding in her pain control issues, and she testified she never did physical therapy through Dr. Ogoke. The

medical records show he did order physical therapy treatments a number of times. Pt. F's complaints of pain included not being able to sit or stand for any length of time as well as episodes of falling due to symptoms of numbness in her feet.

Due to the opioids she was taking for long periods of time, Dr. Ogoke had Pt. F undergo UDS tests to determine if she was compliant in taking her prescribed pain medications. There were no times during her care with Dr. Ogoke when she was determined to be diverting her medications or using illicit drugs. Up to the time she ended care with Dr. Ogoke, she had not been found to have violated the narcotics agreement she signed and understood.

Toward the end of her care, Pt. F told Dr. Ogoke that she did not want further interventional procedures and only wanted to continue to get pain medicine, including wanting high doses of opioid medications, but Dr. Ogoke was acting properly by not agreeing to her request that was contrary to the treatment plan she had agreed to pursue. Pt. F was seeing Dr. Ogoke because he was an interventional pain management specialist. If she was refusing his specialty care of providing interventional procedures, then there was no reason for Dr. Ogoke to alter his treatment plan for Pt. F that included as an integral component, Pt. F undergoing interventional procedures. I conclude Pt. F had no reason to expect that she could simply stay on high doses of opioid medications under Dr. Ogoke's care. Nothing in any of the medical records toward the end of her care showed that Dr. Ogoke altered her treatment plan to only include high doses of opioid medication as the primary treatment for her pain. She was always aware of her need to be compliant in following Dr. Ogoke's full treatment plan.

Dr. Satwicz opined that there were three courses of conduct that Dr. Ogoke engaged in with Pt. F that violated the standard of care as alleged by the BORM in the Statement of Allegations.

One objectionable course of conduct Dr. Satwicz described was over-prescribing high doses of opioids to Pt. F and for long periods of time. Dr. Satwicz did not ground his conclusion on specific language with a clear prohibition in a particular law or regulation or guideline adopted by the BORM against the prescribing Dr. Ogoke did for Pt. F. Rather, Dr. Satwicz's conclusion was the result of his analysis of Pt. F's care with Dr. Ogoke for the kind of physical conditions she had. Dr. Satwicz opined that the nature of Pt. F's pain complaints were of underlying musculoskeletal pain complaints with diagnostic findings that did not justify such high dose on-going pain medicine prescriptions, including strong opioid doses. Dr. Satwicz's opinion was based on his hospital based pain management practice, including with patients suffering like Pt. F was. He wanted such patients to engage actively in treatments such as behavior modifications and physical therapies, and not to rely heavily on opioid medications for pain control. Mostly, he would not end up being the primary opioid prescriber and would leave that function to the patient's PCP or other treating physicians. He would be in contact with these other physicians in a team approach to managing the patient's conditions and related chronic pain. Dr. Satwicz did not see evidence in his review of the medical records that Dr. Ogoke engaged in this kind of team approach to care for Pt. F. If he had, Dr. Satwicz opined that the medication Pt. F received would not have reached the high dose on-going opioid use that carried with it very serious risks of side effects from the opioids, over-dependence and possible addiction.

Dr. Satwicz's opinion concerning the high doses of opioids Pt. F took for a long time under Dr. Ogoke's care was thoughtful, but did not adequately fit the circumstances of Dr. Ogoke's care of Pt. F. The differences between the circumstances of Dr. Satwicz's hospital practices and Dr. Ogoke's private practice in pain management were significant. Although Pt.

F's medical records with Dr. Ogoke and the testimony from both Pt. F and Dr. Ogoke demonstrated that she was being seen periodically by more physicians than Dr. Ogoke, it was clear that Dr. Ogoke was her primary source for treating her chronic pain; that doing this treatment was not at all divided up among Dr. Ogoke and other physicians Pt. F saw at times over the years she treated with Dr. Ogoke. Dr. Trescot's testimony was persuasive in acknowledging the difference between a hospital pain management practice and a private practice during the time period Pt. F treated with Dr. Ogoke.

I found Dr. Satwicz's opinion too general because he failed to adequately address; the impact on Pt. F's chronic pain of Pt. F having been a victim of two electrocutions, and having a post-lumbar laminectomy fusion surgery pain syndrome. Both of these conditions played a significant role in why Pt. F had a high level of pain that was a challenge to treat effectively to provide her with adequate pain control. I saw in the medical records that Pt. F's pain complaints had not easily been controlled and had significantly impacted her quality of life. In expressing his opinion that Dr. Ogoke gave Pt. F much too high doses of pain medication for the kind of pain she was experiencing, Dr. Satwicz never concluded that Pt. F was exaggerating her pain symptoms or was engaged in improper conduct to divert the narcotic medication she was receiving. Dr. Satwicz never adequately supported his strong position, that Pt. F's pain never merited having to take high opioid medication doses on an on-going basis. I was not persuaded by his opinion that a pain management specialist practices in violation of the standard of care by long-term prescribing of high doses of opioid medication to a patient with Pt. F's underlying conditions.

Dr. Trescot explained in detail the harms that can occur from electrocutions including: internal burning and scarring causing destruction of nerves; contractions of muscles that might

produce broken bones; muscles ripping away from bones; memory loss; personal behavior changes; and, severe confusing pain episodes. It was after the lightening strike event that Pt. F began treatments for difficult to treat severe and constant pain. Although Dr. Ogoke had Pt. F on high opioid doses for long periods of time, there was sufficient proof that Dr. Ogoke engaged in reasonable efforts to lessen the amount of pain medication Pt. F was receiving: through his attempts at doing various interventional procedures; doing the disc compression procedure; having MRIs and x-rays taken; and, trying to gain insurance approval for the IDET procedure that even the neurosurgeon Dr. Cowan was in favor of doing before Pt. F should have back surgery. No evidence demonstrated that the many interventional procedures, including the multi-lumbar level injections that Dr. Ogoke gave Pt. F, would not have been expected to produce pain relief to help reduce the need to take the high dose opioid medications.

Dr. Trescot and Dr. Ogoke adequately explained that Pt. F's intake of high doses of opioids was monitored at all times, including with UDSs done. No evidence showed that Pt. F was out of compliance in taking her medications, or that she was dishonest in reporting her pain symptoms to Dr. Ogoke in order to stay on the high opioid doses. She was seen at Dr. Ogoke's office mostly on a monthly basis, and she received physical examinations that were consistent with her reported pain complaints. Pt. F reported that the pain medication provided her with some measure of pain control and better quality of life. There were no episodes within the medical records where the high doses of opioids taken on an on-going basis resulted in further harms to Pt. F. Even when she saw Dr. Howe, he had a medication for her to take to counter the opioids' impact on her menses and ability to become pregnant.

At the time Dr. Ogoke was treating the patients listed in the Statement of Allegations, Dr. Satwicz represented a group of physicians with one viewpoint on the use of high doses of opioids

to treat non-cancer chronic pain patients while Dr. Trescot and Dr. Ogoke represented another group of physicians with the contrary view. All three physicians acknowledged this debate existed at the times in question. Dr. Satwicz did not point to any particular time when Pt. F was treated by Dr. Ogoke when he overstepped the bounds of standard of care demonstrating a clear violation of any law, regulation or guideline adopted by the BORM in terms of his prescribing of medication to Pt. F. This charge against Dr. Ogoke has not been proven.

A second course of conduct that Dr. Satwicz found objectionable and that formed a basis for finding Dr. Ogoke was violating the standard of care in treating Pt. F, was his giving Pt. F multi-level bilateral lumbar transforminal injections at levels L2 through S1 during one interventional procedure, and doing more of these same procedures in a series of treatments. For Dr. Satwicz, Dr. Ogoke's practice of leaving the injection needles in the back while this procedure was being carried out posed a large risk of doing great harm to Pt. F if she moved during the procedure; something that could be expected to happen since she was not under more than a local anesthetic and a calming medication like Valium. Dr. Satwicz explained that the multi-level injections could have been more safely performed by addressing one side of the spine at a time, taking needles out after each injection was given, and also doing fewer than five lumbar levels at a time bilaterally. For Dr. Satwicz, Dr. Ogoke was giving Pt. F very high doses of Depo-Medrol in her body during one procedure of 20 mg. of Depo-Medrol per injection site with ten injection sites to reach 200 mg. of Depo-Medrol within one procedure. Dr. Satwicz does interventional procedures on patients, and he explained the risks as including: damage to the joint; side effects such as steroid psychosis; immunosuppression; and, an elevated blood sugar level. Dr. Satwicz was aware that the injections entered the body one after the other. He saw that Dr. Ogoke used fluoroscopy and aligned the injection sites properly from what he could

tell from a review of the medical records. Nevertheless, he still felt Pt. F was put in a situation of unacceptable and avoidable risks. In addition, Pt. F testified credibly that the procedures could cause her discomfort or pain where she would perhaps want to bite into the pillow on the procedure bed.

Dr. Trescot agreed that during these procedures Pt. F was receiving high doses of Depo-Medrol. She also testified that receiving the 200 mg. of Depo-Medrol within one interventional procedure was within the standard of care at the time, as addressed by existing guidelines. Dr. Trescot and Dr. Ogoke explained that the way the dose is received with each injection, is very specific. The Depo-Medrol stays in the one injection site releasing its dose over time before dissipating. They both acknowledged that having injections can produce discomfort and pain when the injection reaches the part of the body where the pain source resides. Dr. Ogoke was fine with any patient in this circumstance biting into the procedure bed's pillow to help get through the procedure. He explained that patients all deal differently with facing these procedures. They are conscious during them and receive only the local anesthetic and a sedative medication to calm them down before undergoing the procedure. He explained that some patients might need a burst of pain relief during the procedure, and he would prescribe the fast-acting drug Actiq. He also noted how closely his patients were monitored while undergoing interventional procedures.

No evidence demonstrated that Pt. F suffered some significant side-effects or harms as a result of having these multi-lumbar level bilateral injections the way Dr. Ogoke did them. Nevertheless, having so many injections during one procedure and keeping needles all in the back at one time, appears to not have been the only way these procedures could have been carried out by Dr. Ogoke. Dr. Satwicz's testimony was persuasive that the risks to Pt. F of

moving while having sharp needles left in the back during the bilateral multi-level lumbar injection procedure could have been avoided by removing needles after the injection was made. Nevertheless, I conclude that Dr. Ogoke did these procedures within the standard of care at the time, and within the guidelines of the ASIPP.

A third course of conduct by Dr. Ogoke with Pt. F that Dr. Satwicz opined violated the standard of care concerned Dr. Ogoke failing to ensure that Pt. F avoided expected difficult opioid withdrawal symptoms upon her termination of care. Dr. Ogoke provided her with contact information on other area pain management centers where she could pursue further pain control. Dr. Ogoke informed her that she could seek further pain control care with her PCP. The medical records did not show any follow-up done with Pt. F to learn whether she had come under alternative pain management care. Pt. F did not secure further pain control care and complained that she suffered difficult withdrawal symptoms because Dr. Ogoke did not taper her off the her high dose opioid medications she was taking at the time of her termination of care, including for the next month when she received prescriptions for the opioids at the same high doses. Dr. Satwicz saw no evidence in the medical records that Pt. F sought treatment at a detoxification center or with another physician. And, Pt. F was terminated because she did not want to follow Dr. Ogoke's treatment plan that included interventional procedures and not because she had violated her narcotics agreement or used illicit drugs.

Pt. F credibly testified that she tried by herself to taper off her opioid medications, but without success. She suffered some significant withdrawal symptoms that lasted for months, particularly from her effort to get off Methadone. She had sought copies of her medical records at and around the time of her termination of care with Dr. Ogoke, and faced months of delay in receiving them, securing them about eight months after her initial request despite calls to Dr.

Ogoke's office to get them once her June 2007 prescriptions had run out. Pt. F's complaint to the BORM (Ex. 83) bolstered her testimony about the difficulty this caused for her. Pt. F claimed that she could only secure pain management care elsewhere, even with her new PCP, if she had her medical records from treating with Dr. Ogoke; that without them, no facility or physician would agree to treat her.⁶⁴

Dr. Ogoke did not owe Pt. F pain management care that included just prescribing pain medication. Pt. F was aware of that. Pt. F never asked Dr. Ogoke to taper her off her opioid medications at the time of her termination of care, or when she sought the June 1, 2007 renewal of her opioid and other pain medications. She knew those would be her last prescriptions from Dr. Ogoke's office unless she was willing to follow her treatment plan and have injection procedures. Pt. F also never asked her PCP or any pain management center she may have approached, for help to secure her medical records from Dr. Ogoke's office. Pt. F did not seek care from even her PCP to help her with withdrawal symptoms. No evidence showed that she was as helpless in facing the withdrawal symptoms as she testified she was. I did not find sufficient her claim that no one would treat her for her withdrawal symptoms because she could not provide any new caregiver with her medical records from Dr. Ogoke's care.

Dr. Satwicz's opinion imposes on Dr. Ogoke a duty of care to taper Pt. F off her high opioid doses upon terminating her care. He needed to ensure that she had arranged alternative pain management care in order to avoid the obligation to taper Pt. F off her opioid medications. Dr. Satwicz did not ground that opinion in a particular clear statute or regulation or guideline adopted by the BORM having been violated. Rather, he explained that the duty to ensure Pt. F had a new pain management caregiver, or that Pt. F was being helped in detoxing or weaning off

⁶⁴ Not timely receiving requested medical records was not a charge within the Statement of Allegations concerning Pt. F.

the opioid medication, was sound medical practice. This was because without alternative care after her termination, Dr. Ogoke was fully aware that Pt. F was going to experience withdrawal symptoms. There is nothing in writing in any of Pt. F's medical records showing Dr. Ogoke's office understood from Pt. F that she had a new pain management caregiver or was gaining help somewhere to wean off her opioid medications. Nevertheless, Pt. F knew she would face withdrawal symptoms and did not seek detoxification care, or alternative care, even with her PCP upon experiencing withdrawal symptoms. It is not Dr. Ogoke's specialty to treat detoxing former patients. He provided Pt. F with contact information where she could secure detoxification treatment and she did not pursue that. This charge of a violation of standard of care was not proven by the BORM.

Pt. F contended that Dr. Ogoke terminated her care with him because he got angry and yelled at her when she told him he had caused her to be billed twice for the same UDS analysis. She saw two different laboratories testing her one urine specimen. This double billing was never proven. In fact, Dr. Ogoke explained that two laboratories were needed to do different tests on the one urine specimen. He told Pt. F that this was an issue for her to take-up with his staff in charge of billing. He did not terminate her from care for questioning his billing practices. I did not find Pt. F's testimony to be credible that Dr. Ogoke yelled at her and walked away from her, slamming the door. Dr. Ogoke had no recollection of Pt. F making this assertion of why her care was terminated. Dr. Ogoke credibly explained that he had no reason to engage in outrageous conduct with Pt. F when there was no merit to her claim of double billing. This charge by Pt. F was not proven to be why Dr. Ogoke terminated his care with Pt. F instead of ending his care with her because she refused further injection treatments.

Patient G

Summary

Patient (Pt.) G did not testify.

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Inappropriately prescribed opioids to Pt. G.
- Gave Pt. G several multiple level injection procedures.
- Failed to address several of Pt. G's failed urine drug screen results showing Pt. G had been using marijuana.
- Decided to terminate Pt. G from his care because she had expressed her desire not to continue to undergo injection treatments.

The facts the BORM alleged to support its allegations include the following:

- Pt. G had low back and leg pain. Her diagnoses included: post-lumbar laminectomy syndrome; lumbar degenerative disc disease; lumbar degenerative joint disease; lumbar radiculopathy; lumbar herniated discs at levels L3 through S1; lumbar facet arthropathy; cervicogenic headaches; cervical strain; right sided sternoclavicular strain; and, left lateral epicondylitis.
- During her treatment from 2003 through 2007, Dr. Ogoke prescribed opioid medications for Pt. G's pain complaints, including Oxycodone and Methadone 40 mg. to take three times a day, an excessive dose for the non-cancer pain Pt. G had.
- Dr. Ogoke did not routinely include the doses of the opioids he was prescribing for Pt. G within the reports of her office visits.
- Despite Pt. G's use of marijuana as revealed by urine drug screen tests, Dr. Ogoke failed to comment on these results, and Pt. G continued to receive on-going treatments, including interventional procedures and opioid medication.
- On several occasions between 2003 through 2007, Dr. Ogoke performed multi-level injection procedures. Pt. G had epidural steroid injections, sacroiliac joint injections, facet injections, transforaminal injections, and facet block injections.
- Pt. G found the injection procedures to be uncomfortable, but Dr. Ogoke continued to give them.

- Dr. Ogoke terminated his care of Pt. G after she told him that she did not want to continue having the injection treatments because they were not working. She also had a failed drug test in her medical records.

Findings of Fact

1. Pt. G, born in 1953, had worked as an x-ray technician. During the summer of 1999, she was diagnosed with a ruptured lumbar disc and spinal stenosis. An October 1999 lumbar spine MRI showed a decreased T2 signal and narrowing at the L4-5 disc with marked stenosis and a suspected left L3-4 foraminal disc herniation. A November 1999 lumbar spine myelogram showed severe stenosis at L4-5. In November 1999, she had lumbar laminectomy surgery without disc excision. She had severe back pain by January 2000. She was given lumbar epidural steroid injections (ESI), put on rest, given medication for pain, and attended physical therapy, all without lasting relief for her high pain level. A January 2000 MRI showed no significant L3-4 disc protrusion in the foramen with post-operative changes at L4-5, moderate foraminal stenosis at L4-5, and some small degree of spondylolisthesis at L4-5. On May 17, 2000, Pt. G was seen by orthopedic surgeon, Dr. Marc A. Linson, for ongoing low back radiating pain, mostly in the left leg. Her pain was worse with standing and walking. By then, she was taking Prozac, Zyrtec and Percocet. She had flexion and extension x-rays showing grade I spondylolisthesis at L4-5. Dr. Linson opined that a posterior fusion surgery was a reasonable option. By June 28, 2000, Pt. G had undergone decompression surgery with posterior fusion at L4-5. After this surgery, her severe pain symptoms had largely resolved, but she was left with left leg radiating pain that was constant and persistent. The fusion surgery gave her spine stability. She was found to be neurologically intact. Pt. G treated with Dr. Raymond Auletta of the Westfield Pain Clinic who suggested she might be helped by a discogram procedure. She received aquatic therapy that did not help her pain very much. Her primary care physician (PCP)

prescribed a Duregesic Patch. When she saw Dr. Linson on January 23, 2003, Pt. G was reluctant to the interventional procedure Dr. Linson was going to give her since the first one she had did not provide her with much pain control. Pt. G was given a lumbar ESI at the L3-4 level by Dr. Linson. She received 60 mg. of Depo-Medrol. Dr. Linson counseled her on at this same visit that he would not also be prescribing her pain medication because she was receiving it elsewhere. Pt. G had x-rays that showed a spinal cord stimulator and spinal fusion stimulator with anterior and posterior lumbar fusions that were solid. Pt. G was given a lumbar ESI procedure by Dr. Auletta. On March 13, 2003, Pt. G was hospitalized following a pain flare-up from doing physical therapy. Dr. Linson advised Pt. G that the pain flare-up should get better with "time, patience and rest." (Ex. 43: 22/1891; 213-214/2082-2083 & 217-218/2086-2087.)

2. A spinal cord stimulator is a device to mask the feeling of pain. It is,

an implanted TENS Unit [a device used for pain relief] ... trying to exchange pain for tingling ... [A] catheter ... is placed in the epidural space and then hooked up to a generator that is placed underneath the skin and programed under the skin.

(Testimony of Dr. Trescot, Vol. XIV, 2833-2834.)

3. On June 9, 2003, Pt. G had a CT scan of the lumbar spine for failed fusion surgery that was ordered by Dr. Auletta. She had findings consistent with left-sided herniation with disc material at L3-4 in the neural foramen with the nerve root appearing to be exit impeded. Also detected was a possible large herniation of disc material, a narrowing of the neural foramen at L4-5 with the L4 nerve root exit unimpeded, narrowing of the central canal, and post-operative changes. Seen also was possible significant stenosis and a small central herniation of disc material at L5-S1 not causing any thecal sac compression. Pt. G had x-rays the same day showing post-operative changes, degenerative changes, and possible sclerosis. A whole body scan was recommended. Pt. G decided to stop treating with Dr. Auletta and saw Dr. Linson on

June 20, 2003. She wanted Percocet for her pain, which Dr. Linson prescribed for her. He opined that a recent CT scan had shown some new findings in her spine not present in her December 2002 myelogram. A June 26, 2003 myelogram showed status post-L4-5 fusion surgery and a possible disc bulge at L3-4. Dr. Linson found this myelogram essentially negative, although he noted the L3-4 disc issue had previously been detected. He recommended that Pt. G have an L3-4 disc and fusion exploration. She agreed to this. (Ex. 43; 210-212/2079-2081 & 215-218/2084-2087.)

4. Pt. G started care with Dr. Ogoke on July 18, 2003. She was referred to him by Pt. G's PCP, Dr. Paul Bothner. She completed Dr. Ogoke's new patient forms that included signing the Narcotics Prescription Policy & Agreement (narcotics agreement). She was 50 years old. Dr. Ogoke took her full medical history. He had her medical record information from Dr. Linson and the results of the diagnostic tests she had previously undergone. He was aware of her prior fusion surgeries. He understood she had a failed back syndrome. He understood her pain onset was gradual and emerged to require care by August 1999. Pt. G reported low back pain radiating into her left leg. She described the pain as burning, aching, shooting, constant, and worse when she walked around or used stairs. She reported her pain level as 9/10 with a pain level never lower than 4/10. She was not able to work, had no social activities, and an unraveling family life. She was not on workers compensation and had no pending litigation regarding her condition. Pt. G reported three fusion surgeries with Dr. Linson, and that the two posterior fusion surgeries failed to provide pain relief and the one anterior fusion surgery gave a good result. Pt. G reported having had two knee surgeries and a hernia operation. She had diabetes. She was taking Percocet, a Duragesic Patch at 100 mcg., Prozac, Topamax, and Lipitor. Dr. Ogoke gave a comprehensive physical examination and reached various assessments. He

ordered a physical therapy evaluation and a cervical spine MRI. He prescribed Celebrex 400 mg. (60) and Norflex 100 mg. (60). (Ex. 43: 22-26/1891-1895; 207-209/2076-2078 & 219-226/2088-2095.)

5. Pt. G came into Dr. Ogoke's care as a patient with very difficult to control chronic lumbar pain despite surgeries, multiple interventional treatments, use of a spinal cord stimulator, and use of opioids. For Dr. Trescot, on a continuum of chronic pain patients, Pt. G's pain was "[p]retty much the worst of the worst." This was shown to Dr. Trescot by her "[m]ultiple surgeries, multiple prior interventions, a spinal cord stimulator which is one of the last things we have to offer, a revision of the spinal cord stimulator which means she has had problems with it, and then opioids." (Ex. 43, 22-25/1891-1894. Testimony of Dr. Trescot, Vol. XIV, 2833-2836.)

6. Pt. G received a prescription from Dr. Ogoke's office on August 1, 2003 for a Duragesic Patch 100 mcg. (10). A cervical spine MRI on August 6, 2003 revealed "mild intervertebral disc space narrowing at C7-T1 level with questionable soft tissue prominence posterior to the C7-T1 level." On August 14, 2003, Dr. Ogoke gave Pt. G a bilateral sacroiliac joint (SI) injection with fluoroscopy. Pt. G was seen at Dr. Ogoke's office on August 28, 2003. She reported a pain level of 6/10, having experienced about "50%" of pain relief for ten days from the SI injection. Noted at this visit were her prior "8 surgeries in her back ... [and that] last month ... [she] had the hardware removed," but "still has a spinal cord stimulator ... and a bone stimulator." Pt. G was given a physical examination. Her diagnostic test results and x-ray results were reviewed with Pt. G who had no questions. The assessments reached were: a possible soft tissue prominence posterior to C7-T1 level and a need for an MRI to rule out a lesion on the cervical spine; post-lumbar laminectomy syndrome; lumbar degenerative disc disease; lumbar degenerative joint disease; localized sclerosis within S3 segment on lumbar

spine from x-ray and a need to do a whole body bone CT scan to rule out a lesion; lumbar radiculopathy; lumbar facet arthropathy; lumbar herniated discs, L3-4, L4-5 and L5-S1; cervicogenic headaches; cervical strain; right sided sternoclavicular strain; left lateral epicondylitis; left medial epicondylitis; and, sacroiliitis. The treatment plan included cervical spine and lumbar spine MRIs as soon as possible to rule out lesions, continue physical therapy, and consider a lumbar ESI series. Pt. G asked to be weaned off narcotic medication and wanted to decrease the dose of the Duragesic Patch. The dose of Pt. G's Duragesic Patch was lessened from 100 mcg. to 75 mcg., and she was also prescribed Celebrex 400 mg. (60), Norflex 100 mg. (60), and the narcotic, Vicodin (90). Pt. G had a bone scan on August 29, 2003. The impression was: "No significant abnormal activity in the sacrum in the region of questioned sclerotic abnormality on the right ... Arthritic changes of the thoracic and lumbar spine and left knee." (Ex. 43: 19-21/1888-1890; 194-197/2063-2066 & 200-206/2069-2075.)

7. Pt. G was seen at Dr. Ogoke's office on September 29, 2003. She reported "strong pain" in her low back that radiated down both legs. The planned injection procedure for the lumbar radiculopathy was not done because she had an appointment to see Dr. Linson the next day. She reported that she only wanted whirlpool physical therapy. Her Duragesic Patch strength was increased back to 100 mcg. She was prescribed Vioxx 25 mg., Vicodin HP (90) and Norflex 100 mg. She also reported symptoms associated with withdrawal from her Duragesic Patch when she was not using the Patch for some days. She was referred to Dr. Kishore, an addictionologist, to help her with her withdrawal symptoms. On October 3, 2003, Dr. Ogoke gave Pt. G a lumbar ESI with fluoroscopy at the L5-S1 levels. On October 21, 2003, Dr. Ogoke gave Pt. G another lumbar ESI with fluoroscopy at the L5-S1 levels. Pt. G returned to Dr. Ogoke's office on October 28, 2003 with severe pain complaints although she reported some

relief from the lumbar ESI injections. She needed medication refills, which she received; Vicodin HP (30) and a Duragesic Patch 100 mcg. (3). Her condition continued to be assessed as one of intractable chronic pain. (Ex. 43: 12-18/1881-1887; 178/2047; 186-188/2055-2057 & 190-193/2059-2062.)

8. On November 7, 2003, Dr. Ogoke gave Pt. G a lumbar left-sided transforaminal ESI with fluoroscopy at levels L4, L5, and S1. She ended her use of the Duragesic Patch in early November 2003. In order to see if there could be better pain control for her, Dr. Ogoke prescribed Methadone 40 mg. (120) and 10 mg. (60). She had not taken Methadone previously. Pt. G was seen at Dr. Ogoke's office on November 20, 2003. She reported a pain level of 10/10 in her low back and left leg. She reported that the left leg pain was not improved by the recent injection procedure although the low back pain decreased by "50%" for about a week. She reported having symptoms since starting the Methadone of nausea, sweating, increased anxiety, and minimal pain relief. She was now taking Prozac, Celebrex, Methadone, and Topamax. She had a physical examination. The side effects of Methadone were discussed with her. Noted within the assessments made for Pt. G were her withdrawal symptoms upon starting Methadone. The treatment plan was to continue her on Methadone, give her another lumbar transforaminal ESI like she had on November 7, 2003, and for her to continue physical therapy. At this visit, she was prescribed Methadone 10 mg. (60) and Topomax 25 mg. (42). On December 4, 2003, Dr. Ogoke gave Pt. G her next lumbar left-sided transforaminal ESI with fluoroscopy at levels L4, L5 and S1. She complained that day of a 9/10 pain level in her lower back and both legs. She was prescribed Methadone 40 mg. (90) and 10 mg. (60). Pt. G was seen at Dr. Ogoke's office on December 23, 2003. She reported a pain level of 5/10. She was planning to see Dr. Linson concerning her spinal cord stimulator. She was given a physical examination. She was

prescribed Elavil 25 mg. (60), Methadone 40 mg. (90), and Celebrex 200 mg. samples. The Topamax was discontinued. She was prescribed whirlpool physical therapy. (Ex. 43: 4-11/1873-1880; 163-168/2032-2037; 170/2039; 173-174/2042-2043; 176-177/2045-2046 & 241/2110.)

9. Dr. Satwicz opined that starting Pt. G on the high doses of Methadone was excessive for her pain needs. (Testimony of Dr. Satwicz, Vol. X, 1930-1931.)

10. Dr. Trescot opined that given Pt. G's intractable pain, choosing Methadone was a good choice for long-term use of needed pain medication. (Testimony of Dr. Ogoke, Vol. VII, 1368.)

11. On January 2, 2004, Dr. Ogoke gave Pt. G an epidurogram to address her lumbar post-laminectomy syndrome. He also gave her the next lumbar left-sided ESI with fluoroscopy. Her treatment plan was to have a lysis of adhesion procedure at the left lumbar level. Pt. G was seen on January 22, 2004 at Dr. Ogoke's office. She reported a pain level of 6/10 in the low back and left leg. She explained that her pain increased with walking. She reported four falls in the last six months due to her left leg giving out. She reported going to a hospital emergency room recently for right ear pain, and was prescribed Biaxin that she had taken for the last eight days with the pain persisting. Dr. Ogoke's office gave her a referral to an ear, nose and throat specialist. The epidurogram had "revealed complete blockage of dye midline L5-S1 level on the left side ... is waiting to schedule for lysis of adhesion." She was given a physical examination. Pt. G's treatment plan was to continue her current medications and physical therapy regimens. She was prescribed Vioxx 25 mg. (samples), Methadone 10 mg. (90), and Elavil (60). On January 22, 2004, Dr. Ogoke's office filled out a form for Pt. G's insurer about her medical conditions being treated by Dr. Ogoke. Pt. G was seen at Dr. Ogoke's office on January 30,

2004. She reported a pain level of 7-8/10. She sought medication refills. Pt. G was given a physical examination. She was prescribed Methadone 40 mg. (90). (Ex. 43: 155-162/2024-2031; 265-270/2134-2139 & 272-276/2141-2145.)

12. Pt. G was seen at Dr. Ogoke's office on February 17, 2004. She reported having fallen on ice on February 15, 2004 and had right buttock and back pain. She was prescribed Elavil 50 mg. (60) and Celebrex 200 mg. (60). Pt. G was seen on February 20, 2004 at Dr. Ogoke's office. She complained of severe buttock pain from the fall on ice. She was given a physical examination. She had lumbar spine x-rays that showed no lumbar spine fracture or subluxation, and post-operative changes at L4-L5. She had hip x-rays that showed no abnormalities. She was prescribed Vioxx 25 mg. (14) and an increase to Methadone 40 mg. (120). On February 26, 2004, Dr. Ogoke gave Pt. G a lumbar epidural lysis of adhesion procedure with fluoroscopy. She was seen at Dr. Ogoke's office on March 11, 2004. She needed medication refills. On March 18, 2004, Dr. Ogoke gave Pt. G another lumbar epidural lysis of adhesion procedure with fluoroscopy, and was prescribed Levaquin 500 mg. (4) to take for the procedure. She was also prescribed Methadone 40 mg. (120). (Ex. 43: 143-154/2012-2023; 240-241/2110-2111; 247-249/2116-2118 & 252-266/2121-2135.)

13. On April 2, 2004, Dr. Ogoke's office prescribed Pt. G Elavil 25 mg. (60) and Celebrex. On April 9, 2004, Pt. G had a lumbar spine myelogram with Dr. Linson that showed "moderate focal scar versus disc herniation" at the L3-L4 level. Dr. Linson did not recommend further lumbar spine surgery at that time. On April 16, 2004, Dr. Ogoke's office prescribed Pt. G Methadone 40 mg. (120). On April 20, 2004, Pt. G had a normal chest x-ray. On May 12, 2004, Dr. Ogoke gave Pt. G a third lysis of adhesion procedure with fluoroscopy. She was prescribed Levoquin 500 mg. for the procedure. This procedure was done to continue to treat her post

lumbar laminectomy syndrome and her lumbar radiculopathy in the lower extremity. She also received prescriptions of Celebrex 200 mg. (60) and Methadone 40 mg. (120). She had a urine drug screen (UDS) that was positive for Methadone. Pt. G was seen at Dr. Ogoke's office on May 25, 2004. She complained of a pain level of 8/10 with low back pain radiating into her right buttock, groin and thigh. She reported her pain had not decreased from the third lysis of adhesion procedure the way it had with the prior two procedures. She had a physical examination. The assessments made were: cervical strain; cervical prominence posterior to C7-T1; cervicogenic headaches; right-sided sternoclavicular joint strain; left-sided lateral medial epicondylitis; lumbar strain; lumbar radiculopathy; lumbar facet arthropathy; lumbar degenerative disc disease; post-lumbar laminectomy syndrome; lumbar disc herniations from L3 through S1; and, sacroiliitis. She was prescribed Elavil 25 mg. (60) and Celebrex 200 mg. (60). The treatment plan was explained in the visit report: "Need to consider patient to be on maintenance medications as interventional procedures in the past have only provided temporary, short-term relief." Pt. G was seen at Dr. Ogoke's office on June 11, 2004. Her pain was still at a high level and she felt she needed further back surgery. She was given a physical examination. She was assessed as needing an increase in her Methadone dose. She was given prescriptions for Elavil 50 mg. (60), Percocet 10/325 mg. (90), Methadone 40 mg. (120) and 10 mg. (60), and Celebrex 200 mg. (60). (Ex. 43: 134-142/2003-2011; 229-239/2098-2108 & 327-328/2196-2197.)

14. Pt. G was seen on July 8, 2004 at Dr. Ogoke's office. She reported a pain level of 7/10 in the low back that radiated into both extremities, worse on the right that was "constant, moderate-to-severe, deep, achy, and intermittently sharp." She was scheduled for low back surgery with Dr. Linson on July 14, 2004. She had a physical examination. At this visit she was

prescribed Methadone 40 mg. (120) and 10 mg. (60), and Percocet 10/325 mg. (120). Pt. G was seen at Dr. Ogoke's office on August 9, 2004. She had undergone the low back surgery with Dr. Linson and was to do follow-up with him. At this visit, she was prescribed Methadone 40 mg. (120) and 10 mg. (60). She was prescribed Percocet 10/325 mg. (120) on August 11, 2004. Pt. G was seen at Dr. Ogoke's office on September 1, 2004, still having pain complaints and still in follow-up with Dr. Linson. She was given a physical examination. She was prescribed Methadone 40 mg. (120) and 10 mg. (60), Elavil 50 mg. (60), Percocet 10/135 mg. (120), and Celebrex 200 mg. (60). Pt. G was seen on October 4, 2004 at Dr. Ogoke's office. She reported problems with her medical insurance coverage and had been off her medications for about three days. She reported her pain level as 10/10 versus at 5-7/10 when on her medications. She reported a "pressure sensation at the base of the neck" and some dizziness at times along with some left arm pain. She was given a physical examination. The assessments made were: cervical strain and radiculopathy; cervical prominence posterior C7-T1; cervicogenic headaches; sternoclavicular joint strain; left lateral medial epicondylitis; lumbar strain and radiculopathy; lumbar facet arthropathy; lumbar degenerative disc disease; lumbar disc herniation at L3 through S1; post lumbar laminectomy syndrome; and, sacroiliitis. She was to continue in care with Dr. Linson and to follow-up with her PCP regarding her dizziness. Consideration was given to doing an SI injection. She was prescribed Elavil 50 mg. (60), Celebrex 200 mg. (60), Methadone 40 mg. (120) and 10 mg. (60), and Percocet 10/325 mg. (120). (Ex. 43: 127-133/1996-2002; 318-323/2187-2192 & 325/2194.)

15. Pt. G was seen on November 2, 2004 at Dr. Ogoke's office. She reported a pain level of 10/10 in the low back and in her extremities. She was given a physical examination. The treatment plan was to continue her on her medication regimen and to schedule an SI

injection. She was prescribed Valium 10 mg. (2) for the procedure, Methadone 10 mg. (60), Celebrex 200 mg. (60), and Elavil 50 mg. (60). On November 3, 2004, she was prescribed Percocet 10/325 mg. (120). On November 17, 2004, Dr. Ogoke gave Pt. G a bilateral SI injection with fluoroscopy for her sacroiliitis. She reported her pain level at 8/10 at this visit. Pt. G was seen on November 30, 2004 at Dr. Ogoke's office. She reported that the medications were helping. Pt. G reported a pain level of 7-8/10. She had a physical examination. She had a UDS done that was positive for Methadone. Pt. G was seen by Dr. Ogoke on December 28, 2004. She reported a pain level of 7/10 in the low back primarily radiating into the left lower extremity. She reported that the lumbar transforaminal ESI she had done about a year prior had been "quite beneficial for her ... provided her with the most relief." She reported that the lumbar spine surgery had not helped to lessen her pain. She reported the "high dose of Methadone" was helping her. Dr. Ogoke was concerned because the dose level was "increasing over time," so he wanted to focus on her pain generators through interventional procedures to lessen use of the narcotic medications. Dr. Ogoke was concerned because she had undergone three lysis of adhesion procedures and other interventional procedures that had "not resolved her pain." Dr. Ogoke noted that the UDSs done had found Pt. G compliant in taking the Methadone, but she needed UDSs done that included the Oxycodone screen. She was given a physical examination. The assessments reached were: severe lumbar radiculopathy on the left side; lumbar herniation at L3-4, L4-5, and L5-S1 status post lumbar surgery; post lumbar laminectomy syndrome; and, percutaneous disc decompression done recently by orthopedic surgeon, Dr. Marc Linson, at the L3-4 level. The treatment plan was to review her current medications⁶⁵ and to consider giving her a percutaneous disc decompression at L5-S1 or at L4-5. (Ex. 43; 119-126/1988-1995 & 312-

⁶⁵ I could not locate any prescriptions written on December 28, 2004 within Pt. G's medical records (Exhibit 43).

317/2181-2186.)

16. Pt. G was seen on January 26, 2005 at Dr. Ogoke's office. She reported a pain level in her low back and left leg of 6/10. She was given a physical examination. A UDS was done. She was prescribed Valium 10 mg. (2) in preparation for a lumbar transforminal ESI to be scheduled as soon as possible. The treatment plan was to consider a percutaneous disc decompression procedure if the lumbar ESI was not helpful in controlling the pain. Pt. G was prescribed Percocet 10/325 mg. (120), Celebrex 200 mg. (60), Methadone 40 mg. (120) and 10 mg. (60), and Elavil 50 mg. (60). On February 3, 2005, Dr. Ogoke gave Pt. G a left-sided lumbar transforaminal ESI with fluoroscopy at levels L3, L4, L5 and S1. This procedure was to treat her lumbar radiculopathy. On February 7, 2005, the results from a January 26, 2005 UDS test were produced by Labgenex. They were negative for Oxycodone and positive for Marijuana. On February 23, 2005, Pt. G was seen at Dr. Ogoke's office. She reported a pain level of 7/10 in her low back and left leg. She was given a physical examination and prescribed Percocet 10/325 mg. (120), Methadone 40 mg. (120) and 10 mg. (60), and Valium 10 mg. (2) for procedures. On February 24, 2005, Dr. Ogoke gave Pt. G a left-sided lumbar transforaminal ESI with fluoroscopy at L3, L4, L5 and S1. She came with a pain complaint of 5/10 level in her low back and left leg. She was prescribed Valium 10 mg. (2) for procedures. Pt. G was seen at Dr. Ogoke's office on March 23, 2005. She reported pain relief from the February 24, 2005 procedure, but the pain was back at an 8/10 level in the low back. Pt. G explained that it has been hard for her to schedule more injections sooner, her last injection procedure having been a month ago, because of difficulty locating someone to take her home after a procedure. Another UDS was done. By March 23rd, the results of the January 26th UDS were known. Pt. G was given a referral to Dr. Kishore, an addictionologist who Dr. Ogoke referred patients to when

there was a need for detoxing off an illicit drug before he could continue to treat the patient. At this visit, Pt. G was given a physical examination and prescribed Valium 10 mg. (2) for procedures, Percocet 10/325 mg. (30), and Methadone 40 mg. (28) and 10 mg. (14). The prescriptions contained less amounts of the narcotics. On March 29, 2005, Dr. Kishore cleared Pt. G to continue with Dr. Ogoke for pain management. Dr. Ogoke's protocol when a patient's UDS was positive for an illicit drug, was for his staff to highlight that finding for him to be discussed with his patient at the next visit. Then, the protocol was to require the patient to have the illicit drug use addressed with detoxification at a center or through an addictionologist such as Dr. Kishore. If Dr. Kishore cleared the patient for continued use of opioid medications, then Dr. Ogoke would resume treating the patient with opioid prescriptions. Pt. G was seen on March 31, 2005 at Dr. Ogoke's office. She reported a pain level of 7/10 in her back. She reported that the pain medication helped control her pain. She was given a physical examination. She was prescribed Percocet 5/325 mg. (90), and Methadone 40 mg. (60) and 10 mg. (30). A UDS result from the Univ. of Massachusetts Memorial Medical Center on April 13, 2005 was positive for Methadone. On April 15, 2005, Dr. Ogoke gave Pt. G a left-sided lumbar transforaminal ESI with fluoroscopy at levels L3, L4, L5 and S1. At this visit, she reported a pain level of 7/10 in her back. She was prescribed Elavil 50 mg. (60), Methadone 40 mg. (120) and 10 mg. (60), and Percocet 5/325 mg. (120). Pt. G was seen at Dr. Ogoke's office on April 19, 2005. She was prescribed Valium 10 mg. (2) for procedures. (Ex. 43: 106-118/1975-1987; 288-290/2157-2159; 293-299/2162-2168; 302-304/2171-2173; 306/2175 & 308-310/2177-2179. Testimony of Dr. Ogoke, Vol. VII, 1369-1390.)

17. Pt. G was seen at Dr. Ogoke's office on May 12, 2005. She reported a pain level of 7.5 /10 with not very much pain relief realized following her last lumbar transforaminal ESI.

She felt her left leg radiating pain was worsening. She now believed her July 2004 surgery at the L3-4 level had helped her pain relief in her back. At this time Pt. G had a lumbar spinal cord stimulator on the left side that was not in use. She was told to consider having the spinal cord stimulator removed. Under consideration was giving Pt. G a percutaneous disc decompression procedure. Pt. G agreed to seek removal of the spinal cord stimulator. The treatment plan she agreed to included: a discogram to rule out discogenic low back pain; an IDET (Intradiscal Electrothermal Therapy) procedure over having a percutaneous disc decompression procedure at L5-S1; and, to continue her current medication regimen. At this visit, she was prescribed Percocet 5/235 mg. (120).⁶⁶ At a June 10, 2005 evaluation with Dr. Ogoke, Pt. G reported her pain level at 7-10/10 especially in her left leg. She explained how engaging in even mild to moderate activity triggered unbearable pain. She reported having "fairly good" pain control on her current medication regimen that included Methadone, Elavil, and Celebrex. Dr. Ogoke gave her a physical examination. He assessed her conditions to be: post lumbar laminectomy syndrome; lumbar degenerative disc disease and radiculopathy; lumbar herniation at levels L2-3, L3-4, and L5-S1; lumbar facet arthropathy; cervicogenic headaches; cervical prominence posterior to C7-T1; cervical strain; and, sacroiliitis. Dr. Ogoke opined that Pt. G had "individual areas of pain generators, like sacroiliac joint area inflammation as well as facet joint mediated pain." He opined that using interventional procedures such as therapeutic and diagnostic blocks would help in treating her levels of pain. The treatment plan agreed to was: do a diagnostic lumbar facet joint injection to explore facet mediated pain as the primary pain source; schedule a series of SI injections as soon as possible; do lumbar spine x-rays regarding any spine stability issues; renew her current medications; and, see Dr. Linson about removing the spinal cord

⁶⁶ I could not locate in Pt. G's medical records (Exhibit 43) any other prescriptions written on May 12, 2005.

stimulator and to learn of options he may have to help her. Pt. G was prescribed MSIR 15 mg. (90).⁶⁷ (Ex. 43: 100-102/1969-1971; 103-104/1972-1974 & 285-286/2154-2155.)

18. On July 5, 2005, Pt. G was seen by Dr. Ogoke. She reported a 6/10 pain level. Dr. Ogoke gave her a bilateral lumbar facet joint injection with fluoroscopy for lumbar facet arthropathy at levels L2-3, L3-4, L4-5 and L5-S1. She was prescribed Elavil 50 mg. (60).⁶⁸ On July 7, 2005, she had a lumbar spine CT scan ordered by Dr. Linson. The results showed “[p]ost-operative changes with satisfactory appearing anterior and posterior fusions ... no central spinal stenosis ... moderate epidural fibrosis at L3-L4 and L4-L5.” Pt. G was seen at Dr. Ogoke’s office on August 2, 2005. She reported a 7/10 pain level in her back and left leg. She was given a physical examination. She was prescribed Elavil 50 mg. (60), Methadone 40 mg. (120) and 10 mg. (60), and MSIR 15 mg. (90). On August 30, 2005, Dr. Ogoke gave Pt. G a bilateral lumbar facet joint injection with fluoroscopy for lumbar facet arthropathy at levels L1-2, L2-3, L3-4, L4-5 & L5-S1. She came to this visit reporting a pain level of 8.5/10 in her back and knees. She was prescribed MSIR 15 mg. (90), Elavil 50 mg. (60), Celebrex 200 mg. (60), and Methadone 40 mg. (120) and 10 mg. (60). When Pt. G was seen on September 27, 2005 at Dr. Ogoke’s office, her current medications were continued of Elavil 50 mg. (60), Celebrex 200 mg. (60), MSIR 15 mg. (90), and Methadone 40 mg. (120) and 10 mg. (60). She was seen at Dr. Ogoke’s office on October 24, 2005. She reported constant pain at an 8/10 level. She was given a physical examination. She was prescribed Oxycodone 18 mg. (180), Elavil 50 mg. (60), Celebrex 200 mg. (60), and Methadone 40 mg. (120) and 10 mg. (120). (Ex. 43: 91-99/1960-

⁶⁷ I could not locate in Pt. G’s medical records (Exhibit 43) any other prescriptions written on June 10, 2005.

⁶⁸ I could not locate in Pt. G’s medical records (Exhibit 43) any other prescriptions written on July 5, 2005.

1968; 277-285/2146-2154; 318-323/2187-2192 & 377-385/2246-2254.)

19. On November 21, 2005, Pt. G was scheduled for a bilateral SI injection with Dr. Ogoke, but it was not done. Instead, Dr. Ogoke gave Pt. G an evaluation. She reported a pain level of 10/10 in her right side radiating into her thigh. She claimed that she had been compliant taking her medications. A UDS was done. She reported pain relief for awhile from the last lumbar facet joint injection done August 3, 2005, but the base pain had now returned. Her medications were renewed; Oxycodone 15 mg. (180), Elavil 50 mg. (60), Celebrex 200 mg. (60), and Methadone 40 mg. (120) and 10 mg. (120). Pt. G was given directions to take the Methadone 40 mg. "p.o. four times a day ... Methadone 20 mg. p.o. twice a day ... Celebrex at 200 mg. "p.o. twice a day ... Elavil at 500 mg. one to two tablets a day."⁶⁹ The UDS was positive for Methadone. On December 19, 2005, Pt. G was prescribed Elavil 50 mg. (60), Methadone 40 mg. (120) and 10 mg. (120). On December 20, 2005, Pt. G was prescribed Oxycodone 30 mg. (90). She had a chest x-ray on December 24, 2005 showing:

No acute pulmonary disease. Spinal stimulator electrodes are present, with the top in the spinal canal at the level of the lower thoracic spine at the level of the lower thoracic spine. No abnormality is seen in the region of the sternoclavicular joints. However, if more detailed evaluation is indicated, dedicated sternoclavicular joint radiographs, or CT scan, may be considered.

(Ex. 43; 84-90/1953-1959 & 369-376/2238-2245.)

20. Dr. Satwicz did not find justification for increasing Pt. G's Methadone dose. He explained that Methadone typically lasts for eight hours so that taking Methadone more frequently is excessive. He found this was high doses prescribed of opioids "over an extended

⁶⁹ The strengths of some of the medications prescribed on November 21, 2005 as shown in the visit report do not match the copies of the prescriptions written on that date for Pt. G. I concluded that the copies of the prescriptions were correct. The prescriptions with discrepancies are for Methadone 10 mg. (120) and not 20 mg. (Ex. 43, 376/2245), and for Elavil 50 mg. (60) and not 500 mg. (Ex. 43, 376/2245). I could not decipher the strength of the Celebrex (60) dose on the copy of this prescription (Ex. 43, 376/2245). Also written for Pt. G on November 21, 2005 but not mentioned in Dr. Ogoke's visit report, was a prescription for Oxycodone 15 mg. (180) (Ex. 43, 375/2244).

period.”

[T]hese are extraordinary high doses and the frequency of the Methadone four times a day is unusual ... [T]ypically, the length of time, Methadone has a very, very long half life ... The pain relieving portion of its effect ... is usually around eight hours, so typically, it is ordered three times a day or every eight hours. To order that four times a day is ... not unheard of because some people metabolize it very quickly, but to order 40 mg. four times a day is ... just a lot of opioid for non-malignant pain. And, to make it 60 mg. [of Methadone] twice a day and the other dose of 40 mg. is even more so.

(Testimony of Dr. Satwicz, Vol. X, 1930-1931, 1932.)

21. On January 3, 2006, test results showed Pt. G was negative for the rheumatoid factor. On January 9, 2006, Dr. Ogoke gave Pt. G a bilateral SI injection with fluoroscopy for sacroiliitis. She was complaining of a pain level of 8/10. She was prescribed Actiq 600 mcg. (2) for procedures. On January 18, 2006, Dr. Ogoke gave Pt. G a left-sided lumbar transforaminal ESI with fluoroscopy for lumbar radiculopathy at levels L3, L4, L5 and S1. She was prescribed Methadone 40 mg. (120) and 10 mg. (120), Oxycodone 30 mg. (90), and Elavil 50 mg. (60). On February 14, 2006, Pt. G had a follow-up visit with Dr. Ogoke. She reported a 6/10 pain level and she reported “making some progress” especially in her left leg and less progress with her low back pain. On the other hand, she refused to have a procedure done this day. Dr. Ogoke counseled her on “the need for compliance with both medication and the planned care” that she had agreed to. Dr. Ogoke did a review of systems and gave her a physical examination. His assessments made were: lumbar radiculopathy; sacroiliitis; lumbar facet arthropathy; cervical strain and radiculopathy; sternoclavicular joint strain; lumbar herniation at L3-4, L4-5 and L5-S1; and, post-lumbar laminectomy syndrome. The treatment plan from this visit was to prescribe her Ativan 2 mg. (2) for “pre-medication” before having an interventional procedure. She was to continue on her Oxycodone and Methadone medications, and then review her progress on them. She was prescribed Oxycodone 30 mg. (90), and Methadone 40 mg. (120) and 10 mg. (120). A

UDS was done. The results of the UDS specimen taken February 14, 2006 were produced by February 23, 2006, and were positive for Methadone and Oxycodone, but also for Marijuana. (Ex. 43: 68-83/1937-1952; 348-349/2217-2218; 351-355/2220-2224; 357-362/2226-2231 & 364-366/2233-2235.)

22. Dr. Satwicz found prescribing Actiq for procedures to be excessive as it is a fast-acting cancer drug and Pt. G's non-cancer conditions did not require this strong opioid medication for breakthrough pain. (Testimony of Dr. Satwicz, Vol. X, 1875-1876.)

23. On March 11, 2006, Dr. Ogoke gave Pt. G a left side lumbar transforaminal ESI with fluoroscopy at levels L3, L4, L5 and S1 for lumbar radiculopathy. She reported a 6/10 pain level. She was prescribed Elavil 25 mg. (60), Oxycodone 30 mg. (90), and Methadone 40 mg. (120) and 10 mg. (120). No mention of the February 23, 2006 UDS results were made in the visit report. At an April 13, 2006 follow-up visit at Dr. Ogoke's office, Pt. G reported a pain level of 7/10. She reported experiencing a "25% decrease in pain for seven days" following her last injection procedure and was "pleased with the improvement." Because of her "long-standing history of left knee pain," with a "damaged ACL," she had discussed with her surgeon a possible total knee replacement. She was given a physical examination and her treatment plan included doing another left lumbar transforaminal ESI as soon as possible. Her current medications were renewed of Methadone 40 mg. (120) and 10 mg. (120), Elavil 25 mg. (60), and Oxycodone 30 mg. (90). A UDS was done. The results were produced by April 19, 2006 were positive for Methadone and for Marijuana. (Ex. 43: 63-67/1932-1936; 340-344/2209-2213 & 346-347/2215-2216.)

24. On May 8, 2006, Pt. G was prescribed Valium 10 mg. (2) for an upcoming procedure. On May 10, 2006, Dr. Ogoke gave her a left-sided lumbar transforaminal ESI with

fluoroscopy at levels L3, L4, L5 and S1 for lumbar radiculopathy. Pt. G reported a pain level of 8/10 before the procedure. She was prescribed Elavil 25 mg. (60), Oxycodone 30 mg. (90), and Methadone 40 mg. (120) and 10 mg. (120). No mention was made in any visit report of the April 19, 2006 UDS result that was positive for Marijuana. On May 19, 2006, an order was made for Pt. G to have sensory nerve conduction threshold testing. Dr. Ogoke also gave her a left-sided medial/lateral epicondyle injection with fluoroscopy. She reported a pain level of 6/10 in her elbow and fingers at this visit. A UDS was done, and the results produced by May 24, 2006 were positive for Methadone, Oxycodone, and Marijuana. On May 24, 2006, Dr. Ogoke gave Pt. G another left knee injection with fluoroscopy. She reported a pain level of 8/10 at this visit. On June 9, 2006, Dr. Ogoke gave Pt. G a left side lumbar ESI with fluoroscopy at levels L3, L4, L5 and S1 for lumbar radiculopathy. She reported a pain level of 6/10 at this visit. She was prescribed Methadone 40 mg. (120) and 10 mg. (120), Elavil 25 mg. (60), and Oxycodone 30 mg. (90). No mention was made in any visit report of the positive for Marijuana UDS result from May 24, 2006 that was positive for Marijuana. A UDS was done at the June 9, 2006 visit. The UDS results were produced by June 12, 2006, and were positive for Methadone, Oxycodone, and Marijuana. On June 16, 2006, Pt. G underwent a sensory nerve conduction threshold evaluation. She was seen in follow-up on June 21, 2006 at Dr. Ogoke's office. She reported not having experienced much pain relief from the knee injection. She reported about a "40%" decrease in pain that had lasted about two weeks from her last left side lumbar transforaminal ESI. She reported "dizziness" when flexing her neck and some left finger numbness. She was given a physical examination. The treatment plan was for her to have a facet injection for diagnostic purposes and to consider another left knee injection. She agreed to this plan. She was given a prescription for Valium 10 mg. (2) for the upcoming procedure. There were still no

mentions of now a number of UDS results that had shown Pt. G was positive for Marijuana.

(Ex. 43: 46-62/1915-1931; 331-332/2200-2201; 334-336/2203-2205; 419-428/2288-2297 & 430-437/2299-2306.)

25. On July 6, 2006, Pt. G came to Dr. Ogoke's office scheduled to have a bilateral lumbar facet joint injection. She reported a pain level of 6/10. She waited three hours to have her injection procedure, and then understood from office staff that Dr. Ogoke would not be back in the office for another two hours. She was very upset about this, wrote up a complaint letter, and decided to leave and reschedule the injection procedure. Pt. G had been able to reschedule before waiting the three hours in the office, but decided to wait for Dr. Ogoke. Nevertheless, she had an evaluation with a physician assistant that included a physical examination and having a UDS done. The assessments made were: lumbar radiculopathy; post lumbar laminectomy syndrome; sacroiliitis; and, left knee pain. She received a renewal of her prescriptions of Methadone 40 mg. (120) and 10 mg. (120), Elavil 25 mg. (60), and Oxycodone 30 mg. (90). "Treatment compliance was [also] discussed," but there was no discussion referring to her prior UDS results that were positive for Marijuana. The UDS results from her July 6, 2006 specimen were produced by July 18, 2006 and showed she was positive for Marijuana again. On August 1, 2006, Dr. Ogoke gave Pt. G a bilateral facet joint injection with fluoroscopy at levels L1-2, L2-3, L3-4, L4-5, and L5-S1 for facet arthropathy pain. She reported a pain level of 7/10. She received a renewal of her prescriptions of Methadone 40 mg. (120) and 10 mg. (120), Elavil 25 mg. (60), Oxycodone 30 mg. (120), and Valium 10 mg. (2) for injection procedures. She had a UDS done that showed a positive result for Oxycodone. On August 30, 2006, Dr. Ogoke gave Pt. G a bilateral lumbar facet joint injection with fluoroscopy at levels L1-2, L2-3, L3-4, L4-5, and L5-S1 for facet arthropathy pain. Pt. G reported a pain level of 7/10, but reported a "50%"

improvement in pain symptoms that lasted for about three weeks following the previous injection procedure. On September 20, 2006, Dr. Ogoke gave Pt. G a bilateral lumbar facet joint injection at the same five lumbar levels with fluoroscopy for facet arthropathy pain. She reported a pain level of 8/10 before having the procedure that included the back and both legs. She had a physical examination. She was prescribed Valium 10 mg. (2) for procedures, and received a renewal of her medications of Methadone 40 mg. (120) and 10 mg. (120), Elavil 25 mg. (60), and Oxycodone 30 mg. (90). (Ex. 43: 33-40/1902-1909; 42-45/1911-1914 & 409-418/2273-2287.)

26. It is important that a patient's UDS results come back within a relatively short time in order to ensure that the patient is being compliant and not using any illicit drugs. Over a week's wait is a long time for results to come back from testing. Dr. Ogoke experienced long delays in receiving some of Pt. G's UDS results, and he and his physician assistants may have been prescribing opioids for Pt. G at times when she was using Marijuana without them knowing this due to these delays. The protocol was for his staff to immediately make available for his review any of his patients' UDS results that showed non-compliance and especially use of any illicit drugs. Whether long delays in receipt of UDS results or failure on the part of his staff to timely show him UDS results, Dr. Ogoke did not learn until October 9, 2007, that the August 23, 2007 and September 12, 2007 UDSs on Pt. G showed she was using Marijuana. Dr. Ogoke may not have been presented with the prior UDS test results also positive for Marijuana. Because of this lack of knowledge, received renewals of her long-term opioid prescriptions up until October 9, 2007. (Testimony of Dr. Ogoke, Vol. VII, 1372-1375, 1377, 1379-1390 & Dr. Satwicz, Vol. X, 1936-1937, 1946-1950.)

27. A lumbar bilateral facet joint injection at five levels with ten injection sites using

fluoroscopy, involved giving Pt. G during one interventional procedure, 200 mg. of Depo-Medrol medication; 20 mg. injected at each of the ten lumbar sites. At times Pt. G experienced pain when the injection of the Depo-Medrol occurred to reach the source of pain on the spine. Finding the sources of the pain on the spine is the purpose of the injection procedure in order to secure for the patient, optimal targeted pain relief to lessen the need to depend on oral narcotic medications at high doses. Doing a series of such interventional procedures not too far apart in time is how these procedures can provide the best opportunity to give the patient better pain control. The injected medication stays in the area of the injection and provides relief over time. The medication at all the injection sites does not go throughout the body upon injection. Just one injection is administered at a time. Sometimes needles are left in the prior injection site to help line-up the proper location for the next injection, which is what Dr. Ogoke did. The reason for removing needles not used at the moment for an injection of Depo-Medrol, is to guard against the patient, who is conscious, being harmed by sharp needles if the patient moves too much. Doing as many as five bilateral lumbar levels of injections is not as typical as doing two or three bilateral lumbar levels with injections. Four bilateral lumbar levels of injections is a lot, and doing five bilateral lumbar levels is quite a lot. There was no standard of care to prohibit the interventional pain management specialist from doing five bilateral lumbar levels of injections during one procedure, or to have multiple needles in the body at one time when only one needle was being used at a time for an injection. Pt. G showed no signs of having had any improperly performed or harmful outcomes from her interventional procedures with Dr. Ogoke, including those she received of five bilateral lumbar levels of injections during one procedure. At each follow-up visit after an injection procedure, Pt. G would report how the procedure helped with pain relief and for how long. (Exs. 83 & 84; Testimony of Dr. Satwicz, Vol. X, 1920-1926; Dr.

Trescot, Vol. XIV, 2850-2853 & Dr. Ogoke, Vol. VII, 1366-1367, 1391-1392, 1421.)

28. Pt. G was seen at Dr. Ogoke's office on October 27, 2006. She completed a brief pain inventory form and reported a recent motor vehicle accident. She reported having pain at a 7/10 level with low back pain that radiated into her left leg, and that the pain increased with her activity level. She still had a spinal cord stimulator in her back that was perhaps displaced from the recent injury. She was going to see Dr. Linson soon and this issue would be addressed with him. She was to provide Dr. Linson with her recent nerve conduction study results. Pt. G reported a "50%" decrease in pain for about three weeks following her last injection procedure. She was given a physical examination. She was prescribed Oxycodone 40 mg. (120) and 30 mg. (90), Methadone 10 mg. (120), Elavil 25 mg. (60), and Valium 10 mg. (2) for procedures. A UDS was done. The UDS result was negative for Oxycodone. When Pt. G was seen at Dr. Ogoke's office on November 27, 2006, she had seen Dr. Linson. She reported that Dr. Linson opined her back was unstable with possible spondylolisthesis, and that her spinal cord stimulator should be removed. Dr. Ogoke's office renewed Pt. G's medications at this November 27, 2006 visit; Methadone 40 mg. (120) and 10 mg. (120), Elavil 25 mg. (60), and Oxycodone 30 mg. (90). Another UDS was done. By the time Pt. G was seen at Dr. Ogoke's office on December 27, 2006, Dr. Linson had removed the spinal cord stimulator on December 5, 2006, and Pt. G had undergone lumbar spine and cervical spine MRIs, and a thoracic spine MRI was scheduled for December 28, 2006, all under Dr. Linson's care. She had a physical examination at Dr. Ogoke's office at this visit. Interventional procedures were put on hold pending the results from the MRIs. Another UDS was done. The result was negative for Oxycodone.⁷⁰ (Ex. 43: 28-

⁷⁰ I could not tell from the UDS results from the December 28, 2006 specimen that was negative for Oxycodone whether that reflected results from an Oxycodone screen. I could not locate or decipher a test result for the November 27, 2006 UDS done in Pt. G's medical records (Exhibit 43).

32/1897-1901; 388-389/2257-2258; 391/2260; 394-402/2263-2271; 483/2352 & 552/2421.)

29. Pt. G was seen on January 26, 2007 at Dr. Ogoke's office. Since October 27, 2006, Dr. Ogoke's planned interventional treatment of a "RFL lumbar facet nerves" procedure had been put on hold. No direct information had come from Dr. Linson, but Pt. G explained that she did not want further interventional procedures. She complained of pain at a 6/10 level in her back. She was given a physical examination. Dr. Ogoke's office was going to seek MRI test results to review. She was prescribed Methadone 40 mg. (120) and 10 mg. (120), Oxycodone 30 mg. (90), and Elavil 25 mg. (60). Pt. G was told that she might face having to end care with Dr. Ogoke due to refusing further interventional treatments. Another UDS was done. The result was positive for Oxycodone. Pt. G was seen by Dr. Ogoke on February 23, 2007. They discussed Pt. G's concern about not having the interventional treatments that had been planned of an SI injection and a facet joint injection, both as soon as possible. From this discussion, Pt. G felt that the risks of doing these were not as great as she had thought. She was provided with information to review about the procedures. She had a physical examination. Dr. Ogoke assessed her conditions as: lumbar herniation; lumbar facet arthropathy; lumbar radiculopathy; sacroiliitis; and, status-post removal of spinal cord stimulator. Pt. G was prescribed Methadone 40 mg. (120) and 10 mg. (120), Elavil 25 mg. (60), and Oxycodone 30 mg. (90). Another UDS was done.⁷¹ On March 15, 2007, Pt. G was scheduled to have an SI injection, but she refused to have it. Another UDS was done. Pt. G was seen again on March 23, 2007, reporting a pain level of 5/10. She completed a brief pain inventory form. Dr. Ogoke gave her a bilateral SI injection with fluoroscopy for her sacroiliitis. An opioid renewal form filled out for this visit that listed no prior narcotics agreement violations, that her last UDS was normal, and that she had last received

⁷¹ I could not locate or decipher in the medical records for Pt. G (Exhibit 43) the results of the February 23, 2007 UDS.

prescriptions on February 23, 2007. There was no indication on this form about her prior UDS results that were positive for Marijuana. She had her ongoing medications renewed of Methadone 40 mg. (120) and 10 mg. (120), Elavil 25 mg. (60), and Oxycodone 30 mg. (90). (Ex. 43: 475-478/2344-2347; 482-486/2351-2355; 545/2414; 547-548/2416-2417 & 550-556/2419-2425.)

30. On April 5, 2007, Pt. G was hospitalized for left knee surgery of a total knee arthroplasty. Her discharge diagnoses included; diabetes, "chronic pain syndrome, maintained on narcotics," and "nine low back surgeries." She was discharged with prescriptions for Coumadin and other medications relating to the surgery, as well as to maintain her current medication regimen under Dr. Ogoke, although the frequency of use of Oxycodone was increased. Pt. G was seen by Dr. Ogoke on April 20, 2007. She reported good pain relief in her left knee post-surgery, but still complained of low back and sacroiliac notch region radiating pain on both sides. She completed a brief pain inventory form and she reported that her treatment "plan works to keep me comfortable ... [Injections] help, but only last for 2-3 wks. Oral med[s] are just right." She also had an opioid renewal form completed that showed her last prescription was on March 23, 2007, her last UDS was positive for Marijuana, that she no prior narcotics agreement violations, and no changes to her medications were being made. Dr. Ogoke did not fill out this form. Dr. Ogoke's visit report contained no mention of this last UDS being positive for Marijuana. No changes were made to be made to Pt. G's medications. His visit report, stated that Pt. G was compliant in taking her prescribed medications. He gave her a physical examination. The assessments reached were: knee osteoarthritis status-post left knee replacement; sacroiliitis; lumbar herniation and radiculopathy; lumbar strain and rule out lumbar facet arthropathy; and, post-lumbar laminectomy syndrome. The treatment plan was to give her

an SI injection as soon as possible and then a facet joint injection. She was to do follow-up with her knee surgeon. The Coumadin medication was to be stopped for three days prior to a procedure being given and then resumed after the procedure. A UDS was done that was positive for Oxycodone. At this visit, Pt. G was prescribed Methadone 40 mg. (120) and 10 mg. (120), Elavil 25 mg. (60), and Oxycodone 30 mg. (90). (Ex. 43: 471-474/2340-2343; 522-523/2391-2392; 535-539/2404-2408 & 541/2410.)

31. On May 10, 2007, at a visit at Dr. Ogoke's office, Pt. G completed another brief pain inventory form, had another opioid renewal form completed showing a normal prior UDS result and no prior narcotics agreement violations, so that no mention was made about the prior positive UDS for Marijuana. Pt. G reported an 8/10 pain level in her lower back. Dr. Ogoke gave her a bilateral SI injection with fluoroscopy. Another UDS was done. The result was positive for Oxycodone. Pt. G was seen on May 17, 2007 at Dr. Ogoke's office. Another opioid renewal form was completed showing that UDS results were pending and listing no prior narcotic agreement violations. Another UDS was done. Dr. Ogoke gave Pt. G a bilateral lumbar facet joint injection with fluoroscopy at levels L2-3, L3-4, L4-5 and L5-S1 for lumbar facet arthropathy pain. Her medications were renewed of Methadone 40 mg. (120) and 10 mg. (120), Oxycodone 30 mg. (90), and Elavil 25 mg. (60). Pt. G was seen on June 16, 2007 at Dr. Ogoke's office. Another opioid renewal form was completed showing her last prescriptions were from May 17, 2007, no prior narcotics agreement violations, and her May 10, 2007 UDS was pending. Pt. G reported a pain level of 9/10 in her lower back. She had a bilateral lumbar facet joint injection with fluoroscopy at levels L2-3, L3-4, L4-5 and L5-S1 for lumbar facet arthropathy pain. She was prescribed Methadone 40 mg. (120), Elavil 25 mg. (60), and Oxycodone 30 mg. (90). She had another UDS done. (Ex. 43: 459-470/2328-2339; 514/2383; 519/2388; 521/2390;

525/2394 & 527-532/2396-2401.)

32. On July 16, 2007, Pt. G was seen by Dr. Ogoke. She completed a brief pain inventory form, and an opioid renewal form was completed showing the last prescriptions were from June 16, 2007, no prior narcotics agreement violations, and the June 16, 2007 UDS was pending.⁷² She reported a pain level of 10/10 in her low back area. She had recently undergone lumbar spine fusion surgery with Dr. Linson. The fusion surgery addressed her “level of osteopenia or osteoporosis that was present.”

[She was in] a rigid lumbar brace ... appears sore but feels she is beginning to regain sensation in the lower extremity where she has not had it for several years now ... At this point ... defer any further procedures, including sacroiliac joint injection and continue to maintain ... her current oral medications and re-evaluate as needed. The dose of Methadone will go up to 40 mg., four times ... a day ... discontinue the Methadone 20 mg. twice a day, which had been the case prior to surgery, and the patient seems to be doing well with that.

A physical examination was done. The treatment plan reached was to renew her medications for thirty days, do a follow-up in about four weeks, and for Pt. G to do her follow-ups with Dr. Linson. She was prescribed Oxycodone 30 mg. (120), Methadone 40 mg. (120), and Elavil 25 mg. (60). A UDS was done. The UDS was positive for Oxycodone. On August 15, 2007, Pt. G was seen by Dr. Ogoke. She completed a brief pain inventory form. An opioid renewal form was completed listing no prior narcotics agreement violations. A UDS was done that was positive for Oxycodone. At this time, Pt. G was being followed by Dr. Linson for her post-fusion surgery related complaints and was wearing a rigid lumbar brace. She was doing well on her pain medication regimen so that Dr. Ogoke found no reason to increase her opioid doses. She had a physical examination. Her treatment plan was to renew her medications for thirty days and defer the SI injection for a week. She was prescribed Methadone 40 mg. (120), Elavil 25 mg. (60) and Oxycodone 30 mg. (120). Pt. G had a UDS done August 22, 2007 that was positive

⁷² The result of the June 16, 2007 UDS was positive for Oxycodone. (Ex. 43, 514/2383.)

for Marijuana. (Ex. 43: 452-458/2321-2327; 497/2366; 505-513/2374-2382 & 515-518/2384-2387.)

33. Dr. Trescot opined that when prescribing Methadone, the dosage can be increased to achieve adequate pain relief, or until there is a difficult side effect. Dr. Trescot opined:

[T]his is true with any medicine that doesn't have a recommended ceiling level ... That's the same ... with Morphine or Oxycodone or Fentanyl or any other opioid ... There is ... no organ toxicity ... no liver toxicity or kidney toxicity to limit it, and so there is not an identifiably toxic limit.

(Testimony of Dr. Trescot, Vol. XVI, 3179.)

34. Pt. G was seen on September 12, 2007 by Dr. Ogoke. He gave her a bilateral SI injection with fluoroscopy for sacroiliitis. She completed a brief pain inventory form, and an opioid renewal form was completed showing her last UDS was normal despite the August 22, 2007 specimen to have tested positive for Marijuana. At this September 12, 2007 visit, Pt. G sought Lyrica for her nerve pain in place of the Elavil she had been taking. She wrote this in a note. Elavil is amitriptyline. Like Lyrica, it is not an opioid. Pt. G was prescribed Lyrica 75 mg. (14) and 150 mg. (60), Methadone 40 mg. (120), and Oxycodone 30 mg. (120). Pt. G reported that since her last visit, she had tripped and fallen over some boots left in a walkway, hitting her left knee and right hip. She reported pain in her groin area down the front of her legs. She reported a pain level of 8/10. No medical record about this visit addressed the positive UDS finding for Marijuana from the August 22, 2007 specimen. The UDS result from the September 12, 2007 specimen was also positive again for Marijuana. (Ex. 43: 448-451/2317-2320; 496-500/2365-2369 & 501-504/2370-2373. Exs. 88 & 89.)

35. Pt. G was seen at Dr. Ogoke's office on October 9, 2007. An opioid renewal form was completed. The form showed her last prescriptions were written on September 12, 2007, she had a UDS result positive for Marijuana, and she had a prior narcotics agreement violation. At

this visit Pt. G was expecting a renewal of her prescriptions. Pt. G was in the waiting area when she was heard and seen by Dr. Ogoke's staff telling other patients that Dr. Ogoke was "bad." Staff heard her telling persons in the waiting area that they could treat with other doctors. They heard her providing the telephone numbers of other doctors. A staff member came over to her and told her to stop talking this way about Dr. Ogoke's practice. She became upset and left the office without taking her prescriptions with her. Once she left, a staff person telephoned her about forgetting her prescriptions. She arranged to come the next morning to get them. This incident was written down by a staff member. Dated October 9, 2007, a form termination letter was sent to Pt. G by certified mail. The letter explained that her care was ending with Dr. Ogoke and that she should seek further pain management care elsewhere. The letter referred her to Baystate Medical Center or Mercy Medical Center Pain Clinics. The letter informed her that she could secure further help during the next thirty days through Dr. Ogoke's office while she lined up her future care. Pt. G received the certified letter. (Ex. 43: 441/2310; 446-447/2315-2316; 481/2350 & 494/2363.)

36. Pt. G returned on October 10, 2007 to Dr. Ogoke's office and was seen by Dr. Ogoke who gave her an evaluation. An opioid renewal form was completed. Although it did not check-off that Pt. G had shown any aberrant behavior, the form listed Pt. G was positive from UDS testing for Marijuana, and that she had a prior narcotics agreement violation. She was confronted by Dr. Ogoke with her narcotics agreement violations for using Marijuana in August and September 2007. She insisted that this use should not prevent her from continuing to have her regular prescriptions filled, because she had been able to get them written in the past when she also had been using Marijuana. Dr. Ogoke explained that this could not happen, and that before she could return to his care and receive any opioid medications, she would need to be

treated at a detox center or be cleared as off the illicit drug by a psychologist before she could be considered for further care from him with opioid medication. Pt. G was not cooperative during the physical examination so that not much was done. She reported a pain level of 7/10 in her low back and left leg. A UDS was done.⁷³ Pt. G left with only her prescription for “Lyrica 150 mg. p.o. twice a day.” The visit report noted that Pt. G continued to be “argumentative and confrontational” with Dr. Ogoke. She received the termination letter of October 9, 2007. She understood that she could return within the next thirty days for any care she would need pending her addressing the use of the illicit drug and/or her transfer of care to a new caregiver who would help her address her illicit drug use. She was handed a list of facilities where she could receive detox care with their telephone numbers. The report of this visit listed her assessments as: illicit drug use (THC); sacroiliitis; post laminectomy syndrome of the lumbar spine area; lumbar facet arthropathy; and, status post facet joint injection last done June 16, 2007. The report listed her treatment plan as: discontinue all opioids now due to narcotics agreement violation; renew prescription for “Lyrica 150 mg. p.o. twice a day;” and, provide Pt. G with a list of facilities or hospitals where she could receive detox treatment. She was informed how she could locate other pain management caregivers in the area. The Lyrica was not prescribed as a step in tapering her off her high doses of opioid medication. Lyrica is not a drug used to help with opioid withdrawal. (Ex. 43: 441-447/2310-2316; 479-481/2348-2350 & 487-494/2356-2363. Exs. 83 & 93. Testimony of Dr. Ogoke, Vol. VII, 1404-1413, 1417-1421 & Dr. Satwicz, Vol. X, 1940.)

37. Dr. Ogoke followed his protocol. Upon learning that Pt. G had two recent positive UDS results for the illicit drug of Marijuana, he required her to be seen by an addictionologist or be treated at a detoxification center in order to be cleared for continued prescriptions for opioid medications. In addition to her illicit drug use and admission that she had been taking Marijuana

⁷³ I could not locate in Pt. G’s medical records (Exhibit 43) results of the UDS done on October 10, 2007.

in the past and that had not stopped her receipt of her opioid medication, Pt. G also engaged in inappropriate behavior in the wait area with Dr. Ogoke's other patients on October 9, 2007. He decided that he would not reconsider his need to terminate his care with Pt. G. She had now shown she would not be compliant in taking her medications without any illicit drug use. She had shown a breakdown in her relationship with Dr. Ogoke where she could not be trusted by him to pursue her treatment plan properly. She had engaged in disruptive conduct in his waiting area in his office. At no time in this termination process with Pt. G did Dr. Ogoke offer to taper Pt. G off her opioids once she located a detox program or addictionologist for care. Pt. G did not ask him to taper her off narcotic medication, and just wanted renewals of her ongoing pain medications, including opioids. To detox a patient off illicit drugs was not within Dr. Ogoke's medical specialty. He could not taper Pt. G off her opioid medication while she was using Marijuana. (Testimony of Dr. Ogoke, Vol. VII, 1369-1390, 1404-1418.)

38. Dr. Satwicz opined that Dr. Ogoke was under an obligation and violated the standard of care by not ensuring that when Pt. G was terminated from his care that she had lined up a detox center or counselor to address her illicit drug use. No information that this occurred for Pt. G is in her medical records. Without having a transfer of care in place, Dr. Satwicz opined that Dr. Ogoke had violated the standard of care. He explained:

This patient is now in a very precarious state. She is on very high doses of opioids and now is being cut off and asked to go to a detox center which may or may not be available, she may or may not have access to that. So while it's not proper to continue to write opioids on an open-ended scale, the referring to a detox center is appropriate but that needs to be nailed down before you send somebody out the door with nothing.

She clearly violated the [narcotics] contract ... The violation is grounds to terminate ... But either a taper has to be written or ... a transfer to somebody else who is going to take ownership.

(Testimony of Dr. Satwicz, Vol. X, 1938-1941.)

39. Dr. Ogoke did not list in every progress note or office visit report, Pt. G's full prescription information on each medication prescribed at that visit. He did not require his physician assistants to do this. He did require that a legible copy of all prescriptions written for each medication for Pt. G be included in her medical records. That copy would contain all the details about the particular prescription. (Ex. 84. Testimony of Ms. Dawes, Vol. XI, 2122, 2126-2129.)

40. Pt. G filed a complaint against Dr. Ogoke with the BORM in December 2007. She checked off on the complaint form that he: engaged in professional misconduct; was rude to her as was his staff; engaged in patient neglect-abandonment; failed to supervise his staff adequately; was negligent in administering cortisone and with other injections; and, held back medications that could have helped her in order that she agree to have injections. She complained that there were times when she felt so much pain during an injection procedure that she "begged him to stop, but he just keeps pushing and digging until I'm screaming in pain and he won't stop." She felt at times she was left in the procedure room unattended and in a state where she could have fallen off the fluoroscopy table. She noted how he had continued to write her prescriptions that included high doses of Methadone even after she had tested positive for Marijuana. (Ex. 83.)

Conclusion and Recommendation

The BORM charged Dr. Ogoke with standard of care violations in how he treated Pt. G by: inappropriately prescribing opioid medication to her; providing her with many multiple level injection procedures; failing to address her numerous UDS results that were positive for Marijuana over a number of months; and, ending his care of her when she had expressed her desire not to undergo any more injection treatments. The BORM has proven that Dr. Ogoke violated the standard of care by his failure to adequately address the many UDS results that were

positive for Marijuana. The BORM has not proven the remaining charges.

Pt. G did not testify, so it is difficult to support her claims as set forth in her complaint to the BORM (Exhibit 83), and to find support from her complaint that she was treated outside the standard of care by Dr. Ogoke. Her medical records with reports of her progress in pain control following interventional procedures, and her pain complaints at visits to Dr. Ogoke's office, provided a description of her interactions with Dr. Ogoke and his physician assistants. The visit reports also showed Dr. Ogoke's treatment reactions to Pt. G's pain complaints and to what her physical examinations revealed. Dr. Ogoke provided explanations to Pt. G about how he was going to treat her pain with both pain medications and interventional procedures. I was able to uncover Dr. Ogoke's course of care given to Pt. G over many years. This included lining up almost all the copies of the prescriptions written at each visit.

Pt. G suffered from progressively worsening underlying conditions starting in and around 2000 despite back surgeries, various interventional procedures, use of opioid pain medication, and an implanted spinal cord stimulator. None of these treatments seemed to help control Pt. G's pain. She had difficulty to treat severe chronic pain. She had high pain level complaints by the time she began care with Dr. Ogoke in 2003, who treated her with on-going opioid and other non-narcotic pain medications. Dr. Ogoke ordered various diagnostic tests such as MRIs, x-rays, and nerve conduction studies to gain insights into possible causes of Pt. G's pain. Also, her medical records show Pt. G was at times in care with Dr. Marc Linson, her orthopedic surgeon, and had undergone lumbar fusion surgeries with him as late as July 2007. Dr. Ogoke kept track of this care and factored Dr. Linson's care into his treatment decisions as shown in Pt. G's medical records.

Dr. Ogoke tried to locate sources of Pt. G's pain by doing various interventional

procedures. After many of these procedures, Pt. G would report some pain relief, just not long-lasting pain relief. She was unable to work due to her medical conditions. She found her social and family relationships suffered due to her medical conditions and constant severe pain. There is no evidence that refutes her pain was severe and chronic. The pain complaints in the low back and left leg were never able to become so diminished that Pt. G was able to stop care for her pain. She had pain upon walking or sitting for too long. She suffered falls as a result of her medical conditions. No evidence demonstrated that upon starting care with Dr. Ogoke, Pt. G had been diverting her narcotics medication or had been treated for detoxification for use of illicit drugs. Given her diagnostic test results, her clinical findings, her prior back surgeries, her prior interventional procedures, and her use of narcotic medications for pain, Dr. Ogoke had good cause to view Pt. G as having significant and hard to treat constant low back pain radiating into her left leg that was negatively impacting her quality of life.

Charge of Overprescribing Opioids

Dr. Satwicz's opinion was not persuasive that Pt. G's underlying conditions, even if causing chronic pain, did not merit use of high doses of opioid medications to aid Pt. G in having a better quality of life. Her high pain level complaints were not suspect based on the results of the physical examinations she received at her frequent visits under Dr. Ogoke care, and support the kind of care that Dr. Ogoke gave Pt. G. Dr. Ogoke did not just maintain Pt. G on pain medication. He was diligent in investigating diagnostic interventional procedures that could help to locate the core areas of her pain, and he performed injection procedures to target those suspected core areas. Dr. Ogoke's testimony, as supported by Pt. G's medical records, showed that the interventional procedures would often result in at least a lessening of the high pain levels for a few weeks.

There was insufficient proof that somehow continuing to prescribe the high opioid doses over long periods of time, including the Methadone prescriptions, was not good practice of medicine to meet Pt. G's needs for pain management. Dr. Trescot opined that Dr. Ogoke's treatment plan of interventional procedures and prescribing high dose opioid medication that included long-acting opioid medication and opioid medication for breakthrough pain, was within the standard of care at the time. She opined that when prescribing on-going high doses of opioid medication the pain management physician has to engage in monitoring the worth of such medication to the patient's pain control. Dr. Trescot's review of Pt. G's medical records demonstrated that Dr. Ogoke was monitoring Pt. G's medication use appropriately as seen in the visit reports. Pt. G was seen primarily monthly over her many years of care with Dr. Ogoke. Dr. Trescot emphasized that at the time Pt. G was receiving the high doses of long-acting and short-acting opioid medication, including Methadone, that there was no required ceiling on the dose of any of the opioids. Dr. Satwicz did not testify to such ceilings on opioid doses, including Methadone. The BORM did not present any such proof. Dr. Satwicz's opinion was insufficient to prove that Pt. G would have secured the same or a better pain relief level for her chronic intractable pain had she not been on the high opioid doses. No evidence showed that Pt. G's underlying conditions and levels of pain were made worse by being on high doses of opioid medication. No evidence showed that the high doses of opioid medication did not help with Pt. G's pain control.

Dr. Satwicz explained that the patient with non-cancer chronic pain should engage in lifestyle changes such as weight loss and exercise as an alternative to being treated with high doses of opioids that carry the risks of addiction and other difficult side effects. Pt. G's medical records showed that she tried some physical therapy treatments such as whirlpool physical

therapy, but concluded that physical therapy often worsened her pain levels. She would experience pain even when walking for any length of time. Dr. Ogoke was not careless or negligent in his prescribing of these opioid medications. The medical records also contain ample information that Pt. G's medications were often modified to try non-opioid medications, and that Methadone was prescribed as a good long-term pain control option for Pt. G.

All three experts, Dr. Ogoke, Dr. Trescot, and Dr. Satwicz, acknowledged that interventional procedures can be painful at times to the patient who is fully conscious during it, albeit under local anesthetic and often sedated to keep the patient calm. Dr. Satwicz emphasized that at no time should such a patient, even to help with pain during interventional procedures, receive the powerful cancer pain drug, Actiq, because the use of that medication has no place in the treatment of non-cancer chronic pain. Although Dr. Trescot agreed that Actiq is a known opioid to use for cancer pain, she persuasively explained this did not mean it could not be used the way Dr. Ogoke used it for Pt. G to address her pain during interventional procedures. Dr. Satwicz never opined that it was prohibited for use for other than cancer pain. The BORM never produced evidence that it was prohibited for use for other than cancer pain. No evidence showed that Pt. G suffered a harm from taking Actiq during an interventional procedure. I only located a few times when Pt. G was prescribed use of Actiq for help with pain control during interventional procedures. I concluded that Actiq was never prescribed to Pt. G as part of her ongoing medication regimen to help with her overall pain control. The BORM has not proven that adding-in prescriptions for Actiq to be used by Pt. G for pain experienced during interventional procedures was overprescribing an opioid medication to Pt. G.

The BORM did not prove the charge that Dr. Ogoke overprescribed opioid medication to Pt. G during her course of care.

Charge of Substandard Injection Procedures

The BORM charged Dr. Ogoke with violating the standard of care by giving Pt. G several multiple injection procedures. Given Dr. Satwicz's testimony and the BORM's brief, I conclude this charge is more correctly stated that Dr. Ogoke violated the standard of care by giving Pt. G within one interventional procedure, multiple lumbar injections, each injection giving her 20 mg. of Depo-Medrol, and doing four and even five bilateral lumbar ESI injections within one procedure. The course of care showed that Pt. G would receive such interventional procedures in a series of visits close in time. Dr. Satwicz's opinion was that doing so many injections within one procedure was giving Pt. G too much Depo-Medrol drug with side-effect risks, and that Dr. Ogoke's method of leaving in the sharp needles during the procedure exposed Pt. G to a risk if she moved during the procedure.

For Dr. Trescot, Dr. Ogoke carefully investigated and analyzed how best to go about helping to control Pt. G's chronic significant pain. She opined it was appropriate and Dr. Satwicz did not opine to the contrary, that Dr. Ogoke acted properly in using interventional procedures to uncover and then treat the particular sources of the pain in Pt. G's lumbar spine, a very time consuming process that had no guaranteed outcome that the pain generators would be uncovered. Dr. Trescot relied on Pt. G's reports in the visit reports that she experienced pain relief following many of the interventional procedures, even when some of them involved pain upon the injections reaching the sources of the pain. Unfortunately, Pt. G had limited time periods of pain relief with the high pain levels returning in just weeks. Nevertheless, the medical record showed that the interventional procedures were an integral part of Pt. G's treatment plan with Dr. Ogoke as he tried to lessen her need to only gain pain relief from high opioid medication doses.

There was insufficient proof presented that giving Pt. G a number of different interventional procedures, including giving her bilateral lumbar multi-level injection procedures, did nothing significant to help with Pt. G's pain management. In pursuing on-going injection procedures for Pt. G, particularly in light of her progressing degenerative disease in her lumbar spine and her prior back surgeries, Dr. Ogoke was seeking to locate her major pain triggers to focus medication on those specific parts of her lumbar spine. He explained well how that process worked; that the Depo-Medrol would not move throughout Pt. G's body, but it would work at the injection site over time until its effect wore off. The hope in doing this was at least to maintain and not need to increase further, her opioid doses for pain control.

Dr. Satwicz opined that Dr. Ogoke did not have to deliver the Depo-Medrol to each of the lumbar injection sites using just one procedure, but could have spread-out these lumbar injections over more than one procedure. He persuasively explained that doing four and five bilateral lumbar injections was unusual and not commonly done. When this method was combined with the overall dose during one procedure that Pt. G received of Depo-Medrol, 180 mg. (four bilateral lumbar levels) and 200 mg. (five bilateral lumbar levels), Dr. Satwicz opined that the procedures were too risky and were outside the standard of care. Dr. Satwicz opined this even though he recognized that at the time there were any clear guidelines against performing four and five bilateral lumbar levels of injections during one procedure with the patient receiving high steroid doses of 180 mg. or 200 mg. of Depo-Medrol medication. Dr. Satwicz also recognized that at the time Dr. Ogoke treated Pt. G, there were not any clear guidelines against leaving in the patient's back, eight to ten needles while only one needle was administering the drug. Nevertheless, Dr. Satwicz opined that the conscious patient was at undue and needless risk of potential serious consequences if she moved during the procedure,

and that the patient was receiving high doses of steroids that could trigger serious side effects. He also emphasized that he had never been trained to do such multi-level injection procedures with leaving so many needles in the back during the procedure even if leaving in some needles could help guide a needle to reach the next injection site.

Countering Dr. Satwicz's testimony was the testimony of both Dr. Ogoke and Dr. Trescot. They disputed that there was any violation of standard of care in leaving in the needles during multi-level injections within one procedure. Neither Dr. Ogoke nor Dr. Trescot disputed the possible side effects that could occur with multi-level bilateral lumbar spine injections when eight or ten sites each received 20 mg. of Depol-Medrol steroid. But, each of them noted the care in monitoring Pt. G during the procedures and the importance of using the fluoroscopy technology well. At no time did Pt. G experience a lasting harm due to a number of needles being in the spine during the procedure. Also, Dr. Trescot persuasively explained that injecting during one interventional procedure 180 or 200 mg. of Depo-Medrol, although high doses, was still well within the accepted range of milligrams to inject under prevailing guidelines and practices for the time period involved. Neither Dr. Ogoke nor Dr. Trescot agreed with Dr. Satwicz that the only way to do multi-level injection procedures was to leave in just one needle to help guide the needle that would next deliver the injection.

The BORM has failed to prove that Dr. Ogoke violated the standard of care in giving Pt. G four and five bilateral lumbar multi-level injection procedures, or in using the particular method he did of leaving the needles in the spine during the procedure.

Charge of Failing to Timely Address Illicit Drug Use

Besides his counseling of Pt. G to be compliant in how she took her pain medications, Dr. Ogoke gave Pt. G UDS tests as a tool to help him learn if she was being compliant in taking her

medications as prescribed, and to check if she was taking any illicit drugs. Unfortunately, there were too many occasions when Pt. G had UDS test results that showed she had been using the illicit drug, Marijuana.

On January 26, 2005, Pt. G had a UDS test that showed she had used Marijuana. This became known to Dr. Ogoke by the time of Pt. G's March 23, 2005 visit. Pt. G was counseled never to use illicit drugs and that doing so was a narcotics agreement violation. As a result of this violation, Pt. G was referred to Dr. Kishore, an addiction specialist, to be evaluated and to receive care to stop her use of Marijuana before Dr. Ogoke would consider continuing to have her as his patient. This clear violation of her narcotics agreement did not require Dr. Ogoke to end his care of Pt. G, although that was an option he had. The medical records and Dr. Ogoke's testimony showed by March 29, 2005 that Dr. Kishore had cleared Pt. G to return to full care with Dr. Ogoke. At the March 23, 2005 visit, Pt. G still received her on-going opioid medication but with decreased amounts of these medications, including the long-acting Methadone 40 mg. Dr. Ogoke came to accept Pt. G's return into his full care, and her regular opioid medication doses and amounts were resumed. After this event, the medical records showed Pt. G had an increase in the number of UDS tests she was given. This showed Dr. Ogoke had stepped-up his monitoring of her use of her pain medications, and to check to ensure she was not again using illicit drugs.

Unfortunately, during the time period he treated Pt. G, Dr. Ogoke had continued trouble receiving the results of UDS testing in a timely manner. This was shown by his two month wait to have the results of the January 26, 2005 UDS results received from the outside laboratories he used. Despite the increased monitoring with more frequent UDS testing, Pt. G returned to using Marijuana that was picked-up by the UDS testing, but with the UDS test results not reaching Dr.

Ogoke. This occurred as the medical records showed in February, April May, June, July, and October 2006, as well as in February, March, August and September 2007. Only the August and September 2007 UDS results positive for Marijuana came to Dr. Ogoke's attention and triggered a reason for his termination of her care in October 2007. This meant Pt. G came to many office visits knowing she had used Marijuana. Perhaps she felt she was just lucky that her use of Marijuana was not caught. Certainly, she knew she was using Marijuana in violation of her narcotics agreement. If she had admitted use of Marijuana, Dr. Ogoke would have addressed this narcotics violation. This was a very long time period when she used Marijuana and also had many UDSs done.

For Dr. Satwicz, Dr. Ogoke was in violation of the standard of care by not taking action to address Pt. G's use of the illicit drug, Marijuana, much sooner than he did. Both Dr. Ogoke and Dr. Trescot agreed that a patient who violated the narcotics agreement through use of illicit drugs should stop receiving prescriptions for narcotics. None of the three physicians took issue with working with such a patient once use of an illicit drug was uncovered, and to counsel the patient to seek detoxification care at a facility or with an addictionologist before any consideration would be given to resuming care of the patient with opioid medication. Dr. Ogoke was credibly testified about the problems he had in not receiving UDS results at all timely from the laboratories he used for testing. If he had known about all these many UDS results that were positive for Marijuana, he would have taken action with Pt. G. He would have required her to secure detoxification treatment, or receive an evaluation by Dr. Kishore, or he would have terminated his care of Pt. G and provided her with places to secure detoxification treatment. He would not have continued to prescribe on-going high doses of opioids if he had he known of these UDS results.

Dr. Satwicz was persuasive in opining that if Dr. Ogoke was having difficulties with the laboratories he was using to secure timely UDS results, he should have found different laboratories to use. Although the UDS testing was but one tool to help ensure the patient was not violating the narcotics agreement, it was a good one to uncover use of illicit drugs. Pt. G's red flags from her positive UDS results were not addressed timely, and she continued to use Marijuana with no repercussions. It rendered the UDS testing not much of a compliance tool. What was troublesome was that within the visit reports there was never any mention about waiting for UDS results. After many months having gone by Dr. Ogoke should have done something else to address whether Pt. G was being compliant in taking her pain medication and in not using illicit drugs. So many of the visit reports during this time period did not report discussions held with Pt. G about whether she claimed she was being compliant in using her pain medications as prescribed, or was denying any use of illicit drugs. The visit reports should have addressed the UDS results not being received. Whether the outside laboratories never sent the UDS results at all timely, or whether for whatever reason Dr. Ogoke's staff failed to show him the UDS results positive for Marijuana, Dr. Ogoke must bear responsibility for this failure of continuing to prescribe high doses of opioid medication for Pt. G for months while she was using Marijuana. Dr. Ogoke should have taken actions that addressed these delays since he depended so much on UDS testing to ensure Pt. G was compliant with the narcotics agreement.

The BORM has proven this charge against Dr. Ogoke.

Charges of Improper Termination of Care

When Dr. Ogoke finally became aware on October 9 or 10, 2007, that Pt. G had been using Marijuana at least from August and September 2007 based on the UDS results from those months, Dr. Ogoke acted credibly in deciding that Pt. G's violations of her narcotics agreement

were inexcusable violations of the narcotics agreement, and sufficient grounds for terminating his care of Pt. G. This was a particularly supportable decision due to Pt. G acknowledging to Dr. Ogoke her use of Marijuana while receiving her high dose opioid medications. Pt. G was not blind-sided by this decision despite her claim in her complaint to the BORM that she thought it didn't matter that she was using Marijuana. She was a long-term a patient of Dr. Ogoke, always aware of the narcotics agreement she had violated, and had the 2005 experience when her use of Marijuana stopped her care until she was evaluated by Dr. Kishore and cleared to resume care.

Dr. Ogoke also had proper grounds for terminating his care of Pt. G due to her wrongful behavior on October 9, 2007 while in the office waiting area. Pt. G caused an unnecessary commotion and disruption at Dr. Ogoke's office by being accusatory about Dr. Ogoke not providing good care and letting other patients and Dr. Ogoke's staff hear her claims. Pt. G was showing she had lost trust in her doctor-patient relationship, something Dr. Ogoke explained was necessary to being able to treat his chronic pain patients.

In terminating her care, Dr. Ogoke gave Pt. G the options to seek treatment to end her use of Marijuana and to gain clearance to resume care with him. Dr. Ogoke gave Pt. G a list of facilities where she could detox off the marijuana. Pt. G rejected this path that she knew would end her prescriptions for her opioid medications until she was cleared to resume care again with Dr. Ogoke. She wanted to continue to receive her regular doses of her opioid medications.

All these reasons that occurred simultaneously supported the decision by Dr. Ogoke to terminate his care of Pt. G as reasonable and justifiable.

For whatever reason, and not well explained in her complaint to the BORM (Ex. 83), Pt. G was adamant in front of Dr. Ogoke at the time of her termination from care, that she had been double-billed for a UDS test. Dr. Ogoke told her to address this issue with his billing

department. She would not accept that answer from Dr. Ogoke for some reason, and contended in her complaint to the BORM that because she raised this issue, Dr. Ogoke terminated her from his care. This charge against Dr. Ogoke as to why he terminated Pt. G's care was not proven by the BORM. And, Dr. Ogoke was able to explain at the hearing that there was no double-billing because one of her UDS specimens was tested by two different laboratories. At the time Pt. G raised this claim, there would have been no way for Dr. Ogoke to obtain an instant answer to Pt. G's allegation so that referring her to the billing department was reasonable and proper, and not used as a pretext to stop treating Pt. G because he was in her view angry she raised this matter.

Upon her termination of care with Dr. Ogoke, no evidence showed Pt. G asked Dr. Ogoke to taper her off her opioid medications. Dr. Satwicz opined that Dr. Ogoke had an obligation he did not meet to ensure Pt. G ended up in a detoxification program or that Dr. Ogoke at least entered into a tapering-off program for Pt. G to stop her opioid medication use. In requiring this, it is not clear how Dr. Ogoke could have been sure while he was doing this that Pt. G would also not be continuing to use Marijuana. Dr. Ogoke credibly explained that he is not an expert in detoxing persons off illicit drugs. This was not a situation where a Pt. G was not using illicit drugs and agreed to have Dr. Ogoke taper her off her high dose opioid medication. The BORM has not proven that Dr. Ogoke violated a standard of care by not tapering Pt. G off her opioid medications in connection with her justifiable termination of care from Dr. Ogoke's practice.

Until a January 26, 2007 visit at Dr. Ogoke's office, Pt. G had agreed to have interventional procedures that had always been a key part of Dr. Ogoke's treatment plan for her. At that time, she reported not wanting further injection procedures. She was counseled that she would likely have to leave Dr. Ogoke's care if she did not agree to have these procedures. She

had a discussion with Dr. Ogoke at her next visit on February 23, 2007 about the need to have injection procedures as part of her treatment plan. This visit report mentioned that after this discussion, she appreciated that the risks of having injection procedures was not as great as she had thought. After that, she continued to undergo scheduled injection procedures. And, up until the time of her termination of care, the medical records showed that she was having interventional procedures despite her misgivings. Even through the time of her termination of care, there was no discussion in her medical records that Pt. G had refused to have any of her scheduled interventional procedures. Dr. Ogoke did not terminate her care because of her misgivings about having injection procedures. The BORM's charge that Pt. G was terminated from care because she refused having any more injection procedures is not shown by the course of events, and was not proven.

Patient H

Summary

Patient (Pt.) H did not testify but his mother did concerning his care with Dr. Ogoke. Pt. H's attorney, Thomas O'Grady, testified, concerning his request for Pt. H's medical records.

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Dr. Ogoke failed to identify the doses of the opioids he had prescribed within reports of Pt. H's visits.
- Dr. Ogoke renewed some of Pt. H's opioid prescriptions early without documented good cause.
- Dr. Ogoke failed to timely send to Pt. H his requested medical records.

The facts the BORM alleged to support its charges include the following:

- Most of the progress reports on Pt. H did not contain the names of medications prescribed at each visit, including no listing of the dosage or number of pills/tablets prescribed.
- In February 2007, Dr. Ogoke renewed Pt. H's opioid prescriptions nine to ten days early.
- Pt. H had left Dr. Ogoke's care by April 2007 and sought his medical records for continuing his pain management care elsewhere, but never received them. Through his attorney, on several occasions in August and September 2007, Pt. H requested his medical records, but did not receive them all until February 2008.

Findings of Fact

1. Pt. H is a male born in 1982, and a US Marine Corp veteran who sustained injuries in combat in Iraq in 2004 that included shrapnel injuries to his chest and left shoulder area. He had several surgeries in 2004 and 2005 as a result, and underwent pain control treatments at the West Haven, Connecticut Veterans Administration (VA) Hospital. Pt. H wanted to find pain management treatment closer to home. He came to Dr. Ogoke's office on June 22, 2006. At that time, he completed various new patient registration forms, including insurance information,

consent forms, and Dr. Ogoke's Narcotics Prescription Policy & Agreement (narcotics agreement). Pt. H was taking non-narcotic medications that included Diazepam, Etodolac, and Neurontin (Gabapentin). He complained of constant severe shooting, burning, and sharp pain in his left shoulder, left chest area, neck, and hip. He reported that the pain could be triggered by mere touch, and that medications only lessened the pain and any activity increased the pain. When he filled out Dr. Ogoke's patient questionnaire form, he reported his pain level as 8/10. His military disability rating from February 2006 was 29-30% for "left shoulder joint instability," "restrictive lung disease secondary to residual fibrosis," "shrapnel injury causing a grade III-A open clavicle fracture and intra thoracic debris," and "hearing loss." Sensory nerve conduction threshold testing was planned, and Dr. Ogoke's physician assistant wrote Pt. H prescriptions for Elavil 25 mg. (60) and Oxycontin 20 mg. (60). (Ex. 43: 4/2429; 6-18/2431-2443; 125/2550; 147-152/2572-2577 & 177-180/2602-2605.)

2. Dr. Trescot has a background of treating shrapnel wounds and traumatic wound injuries of the kind Pt. H had. She thought that Pt. H's pain complaints were consistent with her experience with shrapnel wound victims. She opined:

These wounds are often very extensive. The surgery to try and repair those wounds often leads to even more pain, and the nerve injuries that occur from these wounds can be devastating causing tremendous intractable pain.

(Testimony of Dr. Trescot, Vol. XV, pg. 2869-2870.)

3. Pt. H was living with his mother, who most of the time accompanied her son to his medical appointments at Dr. Ogoke's office. She kept informed about her son's medical issues, including his use of medications. She was able to monitor his progress with pain control from her observations and talks with him. She would be in the waiting area of Dr. Ogoke's office while he received interventional procedures and follow-up evaluations that also included his

receipt of prescriptions to fill and renew. She was familiar with the content of the prescriptions and that they were for help to control her son's pain. She also understood that the injection procedures he received were meant to help with pain control. (Testimony of Pt. H's mother, Vol. I, 93, 96-98, 101, 121.)

4. On June 29, 2006, Dr. Ogoke gave Pt. P a bilateral cervical facet joint injection procedure with fluoroscopy at five levels; C3-4, C4-5, C5-6, C6-7 and C7-T1. He came to this visit with a pain complaint at a 10/10 level. This was the first in a series of such injections planned for his cervical facet arthropathy pain. Dr. Ogoke had the results of the cervical nerve conduction studies on June 29, 2006 that showed "severe bilateral cervical radiculopathy." He was prescribed Percocet 7.5/325 mg. (120) at this visit. (Ex. 43: 124/2549; 126-127/2551-2552; 137/2562 & 140-146/2565-2571.)

5. On July 3, 2006, Pt. H had a cervical spine CT scan that Dr. Ogoke had ordered. It showed "mild straightening of the normal cervical lordosis which may be secondary to patient positioning and/or muscular spasm; clinical correlation is required." An MRI was recommended for evaluating the cervical radiculopathy. (Ex. 43, 122-123/2547-2548.)

6. On July 21, 2006, Pt. H was seen at Dr. Ogoke office. Pt. H reported no relief from the last injection procedure and declined having another one. Dr. Ogoke did not yet have the results from the cervical CT scan. Pt. H was given a physical examination. The impressions reached were: cervical radiculopathy; complex regional pain syndrome left shoulder and chest wall area; incisional neuroma left anterior chest wall; left clavicular fracture; neuroma left clavicular wound; cervical strain; cervical facet arthropathy; and, history of concussion. The treatment plan was to do a trigger point injection (TPI) incisional neuroma left shoulder clavicular area as soon as possible because this procedure in the past had provided pain relief to

Pt. H. Pt. H wanted this done. Doing a urine drug screen (UDS) was planned. His medications were renewed.⁷⁴ The report of this visit referenced reviewing Pt. H's chart for his medications. (Ex. 43, 137-139/ 2562-2564.)

7. Pt. H was seen on August 11, 2006 at Dr. Ogoke's office. He reported a pain level of 8/10 in his left clavicular area. He received a physical examination, and a UDS was done. His medications were renewed with the addition of a Lidoderm Patch. A TPI procedure for the neuroma in the left clavicular area was planned for as soon as possible, followed by a review by Dr. Ogoke. At this visit Pt. H was refusing facet joint injections. By this visit Dr. Ogoke's office was aware that Pt. H has been seen by a surgeon at the VA Hospital in West Haven, Dr. Karen Sutton, and received a "consultation regarding his chronic pain, status post clavicular fracture and shrapnel injury to the left chest wall." Dr. Sutton had "performed a trigger point injection of the plate in his left clavicle." Pt. H reported "some improvement, which was apparently diagnostic for end plate contributing to pain." Dr. Sutton opined "that the left brachial plexus may be the primary pain generator ... due to trauma." Dr. Ogoke's office was also aware that Pt. H was scheduled for a consultation with a thoracic surgeon with the VA for the possible removal of the shrapnel left in the left chest wall. A reference to viewing Pt. H's chart was made in the report of this visit. By now, it was not clear Pt. H would stay in care with Dr. Ogoke beyond the TPI procedure.⁷⁵ (Ex. 43, 133-135/2558-2560.)

8. Dr. Ogoke's protocol was to always keep the record of what he and his physician assistants were prescribing for Pt. H's pain management, not by listing within the report of the visit the details of the prescriptions written at the visit, but by placing copies of the prescriptions

⁷⁴ I could not locate or decipher the copies of the prescriptions renewed at this July 21, 2006 office visit in Pt. H's medical records (Exhibit 43).

⁷⁵ I could not locate or decipher within Pt. H's medical records (Exhibit 43) the results of the UDS done at the July 21, 2006 visit, or copies of the prescriptions written at this August 11, 2006 visit.

within the patient's medical records. If changes to on-going medications were made, that would often be discussed in the report of the visit. The visit report would otherwise remark that existing medications were renewed, and often without the names of the medications included in the report. (Ex. 84. Testimony of Dr. Ogoke, Vol. IV, 806.)

9. Dr. Trescot did not think this practice violated a standard of care in Dr. Ogoke's care of Pt. H so long as the copied prescription was within the patient's medical records. She opined that there was sufficient information within the visit reports about Pt. H's pain levels, reactions to use of medications, reported pain relief following injection procedures, and about medication alterations or discontinuances, to support Dr. Ogoke's treatment and prescribing decisions. (Testimony of Dr. Trescot, Vol. XIV, 2685-2689; Vol. XV, 3073-3074; Vol. XVI, 3211-3212.)

10. Dr. Satwicz opined that it was a violation of standard of care not to have in a report of a particular visit at which prescriptions were received, the details about each prescription, and for what purpose particular medications were being used and in the dose levels prescribed. In his view, this meant that any other medical caregiver would not have enough information to learn about the patient's care needs and treatment progress from reading the visit report. For Dr. Satwicz, having to review the patient's chart to locate the copy of the prescription written at any particular visit was too cumbersome. (Testimony of Dr. Satwicz, Vol. X, 1955; Vol. XII, 2203, 2363-2366.)

11. Pt. H was seen at Dr. Ogoke's office on September 1, 2006. He had seen the VA's thoracic surgeon, and reported that surgery was being planned. He reported having pain relief from the Lidoderm Patch on the site of his neuroma. He continued to decline cervical facet joint injections in favor of a TPI to the neuroma site. He sought a renewal of his medications. A UDS

was done and the results were available by September 6, 2006.⁷⁶ Pt. H was counseled concerning the importance of being compliant in taking of his medications just as prescribed. He was also counseled about satisfying the terms of his narcotics agreement. He agreed to follow the planned treatments. By the time of this visit, the results of the cervical CT scan had not yet been received by Dr. Ogoke's office. The TPI was to be done as soon as possible. Pt. H was prescribed Oxycontin 20 mg. (60), Valium 10 mg. (30), Neurontin 600 mg. (60), Elavil 25 mg. (60), Percocet 7.5/325 mg. (120), and Lidoderm Patch #60-2 boxes.⁷⁷ (Ex. 43; 119-120/2544-2546 & 130-132/2555-2557.)

12. Pt. H was seen at Dr. Ogoke's office on September 25, 2006. He reported pain in the left clavicular area radiating down the left upper extremity. Although a TPI to his left clavicular neuroma was scheduled for that day, he declined to have it. He was getting care at the West Haven VA Hospital, including visits with the thoracic surgeon about surgery to remove shrapnel from his left brachial plexis, left clavicle area, and left chest wall. At this visit he had a physical examination. He was asked to and did produce, a handwritten note saying: "I ... do not wish to have the TPI treatment due to the fact I have not received TPI's since 5/18/06. I feel that my body is doing just as well with my on-going treatment." A treatment plan was reached that he would have his medications renewed. He reported wanting a possible decrease in his medications at a later time. He was told this had to be discussed with Dr. Ogoke. He was scheduled for a follow-up visit in two weeks. Pt. H indicated that he might transfer his care to his thoracic surgeon, or to the West Haven VA Hospital, within the next month or two. A

⁷⁶ I could not decipher sufficiently whether the UDS result from September 6, 2006 showed Pt. H was not in violation of his medication regimen. (Ex. 43, 121/2546.)

⁷⁷ I could not locate or decipher in Pt. H's medical records (Exhibit 43) the results of the UDS done at the August 11, 2006 office visit.

discussion occurred about the importance of being compliant at this time with his full treatment plan, and he agreed. Reference was made in the report of this visit to a review Pt. H's chart for additional evaluation information and management details. A prescription was written for Percocet 7.5/325 mg. (120).⁷⁸ (Ex. 43: 106-107/2531-2532; 117-118/ 2542-2543 & 129/2554.)

13. Pt. H was seen at Dr. Ogoke's office on October 13, 2006. He continued to decline having a cervical facet joint injection, but wanted to have a TPI at his left clavicle neuroma site. He mentioned that he wanted to decrease his medications if his pain lessened in the future. A UDS was done.⁷⁹ He was prescribed Oxycontin 20 mg. (60), Lidoderm Patch #60-2 boxes, Percocet 7.5/325 mg. (120), Valium 10 mg. (30), and Neurontin 600 mg. (60). On October 25, 2006, Dr. Ogoke gave Pt. H the first in a planned series of cervical epidural steroid injections (ESI). At this visit, Pt. H reported a 7/10 pain level in his left shoulder. The injection was to the C7-T1 level with fluoroscopy. He had completed the brief pain inventory form indicating that his medications were helping to relieve his pain by about 60-70%, but the pain increased with his activity level. He received a prescription for Percocet 7.5/325 mg. (120). Pt. H was seen on November 21, 2006 at Dr. Ogoke's office. He complained of pain at a 7/10 level in his left shoulder. A physical examination was performed. Another UDS was done.⁸⁰ He was prescribed his ongoing medications of Oxycontin 20 mg. (60), Lidoderm Patch #60-2 boxes, Valium 10 mg. (30), Percocet 7.5/325 mg. (120), and Neurontin 600 mg. (60). The worth of continuing to do the series of injection treatments as soon as possible was discussed with Pt. H. (Ex. 9. Ex. 43: 33-35/2458-2460; 39/2464; 41-44/2466-2469; 46-51/2471-2476; 102-104/2527-2529; 108/2533 & 128/2553.)

⁷⁸ I did not locate or decipher any other prescriptions written on September 25, 2006 within Pt. H's medical records (Exhibit 43).

⁷⁹ I could not locate or decipher the results of this UDS test within Pt. H's medical records (Exhibit 43).

⁸⁰ I could not locate or decipher the results of this UDS test within Pt. H's medical records (Exhibit 43).

14. On December 7, 2006, Dr. Ogoke gave Pt. H a cervical ESI with fluoroscopy at the C7-T1 level. Pt. H arrived reporting a 6/10 pain level in his left shoulder, neck and chest. He received a prescription for Percocet 7.5/325 mg. (120). On December 19, 2006, Pt. H was seen at Dr. Ogoke's office. He reported a pain level of 7/10 in his left shoulder and left upper extremity. He claimed "no significant improvement" in pain relief as a result of the second cervical ESI at the C7-T1 level. He reported numbness and sensitivity to cold, and he was going to see a neurologist. He completed the brief pain inventory form, reporting no changed conditions or complaints. A physical examination was performed. The treatment plan was to schedule another cervical ESI at the C7-T1 level as soon as possible. Pt. H asked to receive an early renewal of his Percocet medication "due to his holiday travel plans ... [he] will not be in the area [when he would have expected a renewed prescription]." Pt. H received this early renewal of Percocet 7.5/325 mg. (120), and a UDS was done.⁸¹ He wrote out a handwritten note to acknowledge receipt of the early renewal of the Percocet prescription, and wrote out his need for this - "due to my absence in the area until New Years, I will not fill the prescription until after due 12/27." Having Pt. H write this note was to ensure that he appreciated that early renewals of prescriptions were not something he could count on receiving, and that such renewals would be only for good cause, such as him being out of the area due to the holiday time period and therefore, being unable to pick up medication renewals. He was prescribed Percocet 7.5/325 mg. (120). To Dr. Trescot, this showed a good line of communication between Dr. Ogoke and Pt. H. At this visit Pt. H was also prescribed Lidoderm Patch #60-2 boxes, Valium 10 mg. (30), Neurontin 600 mg. (60), and Oxycontin 20 mg. (60). (Ex. 9. Ex. 43: 20-21/2445-2446; 23-31/ 2448-2456; 94-96/2519-2521 & 99-101/ 2524-2526. Dr. Trescot, Vol. XV, 2871-2872.)

⁸¹ I could not locate or decipher the results of this UDS in Pt. H's medical records (Exhibit 43).

15. Pt. H was seen at Dr. Ogoke's office on January 19, 2007. He reported a pain level of 6/10 in his left clavical area. A physical examination was performed. A UDS was done with a result that was positive for Oxycodone. Pt. H agreed to have another cervical ESI as soon as possible. He had his medications renewed of Valium 10 mg. (30), Oxycontin 20 mg. (60), Neurontin 600 mg. (60), Lidoderm Patch #60-2 boxes, and Percocet 7.5/325 mg. (120). On February 7, 2007, Dr. Ogoke gave Pt. H his third cervical ESI procedure at level C7-T1 with fluoroscopy. He also had a UDS done.⁸² He received renewals of his prescriptions of Lidoderm Patch #60-2 boxes, Valium 10 mg. (30), Oxycontin 20 mg. (60), Percocet 7.5/325 mg. (120), and Neurontin 600 mg. (60). On February 26, 2007, Pt. H had been scheduled for another injection procedure, but he came with no driver to take him home. The procedure could not be done. He reported shoulder discomfort and cervical area pain. He reported that he had experienced about two weeks of a 50% pain reduction following his last ESI procedure. The report of this visit noted that Pt. H was not following a schedule in regard to receiving the injections that he reported had helped relieve his pain, with his last injection having been on a rescheduled date. The concern was an issue about compliance with the treatment plan to alter the "pain generator." Pt. H was given a physical examination. A UDS was done⁸³ with intermittent UDSs planned to ensure compliance in the use of his medications. Despite a concern with medication compliance, Pt. H received renewals of his medications "10 days early." He was instructed that he had to return for his cervical ESI and have his condition reviewed. He was told how he needed to keep to a schedule for the injection procedures to give him "maximum benefit." He wrote a note dated February 26, 2007 that said, "I have no driver today." The prescriptions renewed were Lidoderm Patch #60-2 boxes, Valium 10 mg. (30), Oxycontin 20 mg. (60), and Percocet 7.5/325

⁸² I could not locate or decipher the results of this UDS within Pt. H's medical records (Exhibit 43).

⁸³ I could not locate or decipher the results of this UDS within Pt. H's medical records (Exhibit 43).

mg. (120). (Ex. 43: 69-72/2494-2497; 77-79/2502-2504; 83-92/2508-2517 & 172-174/2597-2599.)

16. Dr. Ogoke recognized, that the additional request by Pt. H for another early refill of prescriptions at the February 26, 2007 visit, was a red flag whether he was being compliant in taking his medications as prescribed or was violating the narcotics agreement. In the report of the February 26, 2007 visit, Dr. Ogoke wrote the following about the ten day early renewal of Pt. H's current medications:

We will, however, provide him with his [current] medication[s] today which will be 10 days early, and he will be required to return for his epidural steroid injection at the cervical spine level and be reviewed accordingly.

I will monitor his overall use of those medications.

We will continue during his visit to select days when we can do intermittent monitoring of compliance to his narcotics contract, as well as his opioid medications.

(Ex. 43, 172-173/2597-2598.)

17. Dr. Trescot thought this request for another early renewal of Pt. H's opioid medications was a red flag situation calling for an increase in monitoring to detect any non-compliance in his use of medications. She opined, that this additional monitoring and notation about it within Pt. H's medical records to address his need to be compliant in the use of prescribed medications, was adequate and proper practicing by Dr. Ogoke. Dr. Trescot, Vol. XV, 2873-2875; Vol. XVI, 3211-3212.)

18. To Dr. Satwicz, Dr. Ogoke acted reasonably in providing to Pt. H an early refill of his prescriptions during the holiday time period December 2006-January 2007, given Pt. H's explanation for why he needed the early refills. Dr. Satwicz became concerned when on February 26, 2007, Pt. H sought a ten day early refill of prescriptions. Although recognizing that

Dr. Ogoke's report of this visit discussed a need to do more monitoring of Pt. H to ensure he was compliant in taking his medications as prescribed, Dr. Satwicz thought the discussion in the visit report about this red flag situation was inadequate in addressing this violation of the narcotics agreement. Dr. Satwicz opined that Dr. Ogoke should have addressed in his visit report the possibility that Pt. H was demonstrating pseudo-addiction behavior and taking his prescribed medications too frequently. For Dr. Satwicz, the plan to do more UDS tests along with telling Pt. H to be compliant in taking his medications was insufficient to ensure Pt. H was not engaging in a narcotics agreement violation that should have led Dr. Ogoke to stop prescribing opioids until the issue was resolved. From what Dr. Satwicz saw in the February 26, 2007 report, Dr. Ogoke did not adequately address Pt. H's aberrant behavior of showing up for an injection procedure knowing he could not have it because he had no one to take him home, and at the same time seeking another early refill on his medications. To Dr. Satwicz, Dr. Ogoke's way of addressing this matter was in violation of the standard of care in practicing pain management medicine. (Testimony of Dr. Satwicz, Vol. X, 1951-1965; Vol. XIII, 2556-2616.)

19. On March 6, 2007, Dr. Ogoke gave Pt. H his fourth cervical ESI at the C6-7 level with fluoroscopy. He also had a UDS done. The results showed Pt. H was compliant in taking his prescribed medications. More monitoring of his use of medications was planned with more UDS tests. On March 16, 2007, Dr. Ogoke gave Pt. H an intercostal nerve block for Chostochrondritis at the T1-T2 level on the left side and a sternaclavicular joint injection on the left side. He came with a pain level of 7/10. (Ex. 43; 53-55/2478-2480; 66-68/2491-2493 & 166-171/2591-2596.)

20. On April 4, 2007, Pt. H had a follow-up visit with Dr. Ogoke. He reported his left shoulder pain had about a 40% improvement for about two weeks after the last injection, and

was now still better than his baseline pain. Pt. H reported pain at a 9/10 level in his left AC (acromioclavicular) joint region. He was scheduled for another injection procedure but came with the flu so the procedure was not done. He was given a physical examination. The treatment plan was to continue the current medication regimen. He was prescribed Percocet 7.5/325 mg. (120), and Lidoderm Patch #60-2 boxes.⁸⁴ Another UDS was done. The results of this UDS showed Pt. H was compliant in taking his medications. An opioid renewal screen form was completed. It listed that no changes to Pt. H's medications had been made. No prior narcotics agreement violations were noted. On April 19, 2007, Pt. H was seen in follow-up by Dr. Ogoke. Pt. H reported a pain level of 8/10 in his left shoulder. In four days he was scheduled to have an AC joint injection. He came because he had run out of "MS Contin" medication. He was given a physical examination. The treatment plan was to continue him on his current medications and to do the planned injection procedure. An opioid renewal screen form was completed showing he was last prescribed medications on April 4, 2007, had no prior narcotics agreement violations, the last UDS was normal, and that no changes to his medications were made. He received a prescription for "MS Contin 30 mg. (60), p.o. every 12 hours."⁸⁵ None of his other medications were renewed at this visit. (Ex. 9. Ex. 43: 56-58/2481-2483; 60-61/2485-2486; 64/2489; 156-164/2581-2589. Testimony of Pt. H's mother, Vol. I, 105-106.)

21. Dr. Satwicz opined that a patient taking Oxycontin medication while also taking Percocet and then adding in MS Contin is not usually done. It is taking two long-acting opioid medications together. Pt. H had been prescribed Oxycontin 20 mg. (60) on January 19, 2007,

⁸⁴ I could not locate or decipher further prescriptions written on April 4, 2007 in Pt. H's medical records (Exhibit 43).

⁸⁵ I could not locate a prescription written previously for MS Contin for Pt. H by Dr. Ogoke or by his physician assistants. The reference in the April 19, 2007 visit report is to Pt. H running out of his MS Contin prescription. In the opioid renewal form for April 19, 2007, there is a reference to Pt. H not receiving a prescription on March 16, 2007 for MS Contin.

February 7, 2007, and February 26, 2007. He was not prescribed Oxycontin again. (Ex. 43: 69/2494; 78/2503 & 84/2510. Testimony of Dr. Satwicz, Vol. X, 1958-1959.)

22. At times during the injection procedures Dr. Ogoke administered, Pt. H complained that they were very painful and that he asked during such procedures that they stop. Pt. H's mother knew her son found the injection procedures sometimes to hurt when given. She learned this from talking to her son once he had the injection procedures. She understood from him, and it was her own observation, that he had not received significant pain relief with the injections not working as well as he had hoped. His mother understood that her son continued to have the injection procedures so that he could continue to get the medications that gave him pain relief. She understood the importance of her son continuing to take his medications for pain relief in the way they were prescribed. She understood that he had hurt his whole body and particularly his chest and shoulder area from his war injuries. (Testimony of Pt. H's mother, Vol. I, 93, 107-109, 121.)

23. While her son was being seen at Dr. Ogoke's office, Pt. H's mother would be in the waiting area. He would typically be seen for fifteen to twenty-five minutes, but there would always be a long wait before her son was seen, sometimes forty-five minutes to one and one-half hours. Often the wait area would be "extremely crowded" despite as many as twelve to fifteen chairs to sit in. (Testimony of Pt. H's mother, Vol. I, 99, 101.)

24. Pt. H ended his care with Dr. Ogoke in April 2007 to treat instead with the West Haven, CT VA Hospital. He sought a copy of his medical records from Dr. Ogoke to provide to the caregivers at this Hospital so that he could begin full treatments there. He waited a long time for them and did not receive them. He then secured the services of an attorney in and around July 2007 to help him get his medicals records from Dr. Ogoke's office. Attorney Thomas

O'Grady, sent an August 1, 2007 letter to Dr. Ogoke's office to the attention to his medical records department, seeking a copy of Pt. H's full medical records. He included a signed authorization by Pt. H for Dr. Ogoke's records. No response was received. The letter was not returned as undeliverable. Attorney O'Grady then had his staff call Dr. Ogoke's office a few times in September 2007 to learn why the medical records had not been produced and sent. Attorney O'Grady never learned there was any reason why the records had not been sent, and his staff reported how they had been told during their telephone calls to expect receipt of the medical records soon. Attorney O'Grady sent a second letter of request for Pt. H's medical records dated September 25, 2007 to Dr. Ogoke's office to the attention of his medical records department. The letter was sent by fax. The letter referenced information Attorney O'Grady's staff told him that they had received during a September 14, 2007 call to Dr. Ogoke's office, explaining that the medical records were being copied and should be received around September 19, 2007. When this date had come and gone with no medical records received, Attorney O'Grady again had his staff call to find out when the records would be received. From the information he learned from his staff, Attorney O'Grady understood the records had been mailed out on September 17, 2007. By the time of the September 25, 2007 letter, the records had not been received. Attorney O'Grady warned in the letter that the HIPPA laws required compliance with a proper request for medical records with a time period of "14-21 days ... [as] a reasonable response time" according to the BORM. Attorney O'Grady further warned that non-compliance within the next "48 hours" would result in "legal action to compel you to produce ... [the] records ... not ... limited to, filing a complaint ... with the Office of Civil Rights, US Department of Health and Human Services as well as with the Board of Registration in Medicine." In this letter Attorney O'Grady copied the Office of Civil Rights and the BORM via

their fax numbers. (Exs. 1 & 2. Exs. 43, 2534-2536/109-111. Testimony of Atty. O'Grady, Vol. I, 70-76.)

25. On January 22, 2008, Attorney O'Grady filed a complaint form with the BORM that Pt. H signed, claiming Dr. Ogoke had failed to provide the long sought medical records. Once this complaint was made known to Dr. Ogoke, Pt. H's medical records were received by Attorney O'Grady on or about January 30, 2008, with a second set received in February 2008. Later, by letter of October 22, 2009, the US Department of Health & Human Services responded to both Attorney O'Grady and Dr. Ogoke, explaining that since the matter had been resolved by "voluntary compliance with the medical records provided to Pt. H, that the case was being closed by the Department. (Exs. 3, 4 & 83. Testimony of Atty. O'Grady, Vol. I, 70-76.)

Conclusion

The Statement of Allegations charged Dr. Ogoke with: failing to identify the doses of the opioids he prescribed for Pt. H within his visit reports; renewing some opioid prescriptions early without good cause shown in his visit reports; and, failing to timely send Pt. H his medical records after he requested them. The last charge was proven. The charge concerning failing to identify doses of the opioids prescribed in visit reports was not proven to be a standard of care violation. The charge about renewing opioid prescriptions early without sufficient reasons included in the visit reports was not proven.

Dr. Ogoke is responsible for Pt. H not timely receiving his medical records after ending care with Dr. Ogoke and requesting them. The testimony of Attorney O'Grady was clear and persuasive and supported by the letters he sent to Dr. Ogoke's office about the long delay. Pt. H had to have his medical records to have his pain management treatments continue at the VA Hospital in West Haven. He did not receive his medical records from Dr. Ogoke in a reasonable

passage of time. This was a clear violation of the standard of care pursuant to 243 C.M.R. 2.07(13)(b). I did not find any mitigating factors to excuse Dr. Ogoke's violation of this required conduct to timely produce the medical records. Even if Dr. Ogoke did not realize Pt. H was suffering this long delay because his office staff did not inform him about the request, he was responsible for ensuring former patients can receive their medical records in a timely manner.

I found no violation of standard of care with Dr. Ogoke's failure to identify the details about the opioids prescribed to Pt. H within the visit reports when the prescriptions were written. I was able to line-up the copies of the prescriptions written almost always, even in the out of order medical records that were presented to me in Exhibit 43. Even if I could not locate all the copies of Pt. H's prescriptions, I was able to line up the prescriptions in chronological order by reading the visit report to sufficiently understand whether on-going prescriptions were being renewed. This failure to include such detail in the visit reports was not required by any statute, regulation or guidelines at the time Dr. Ogoke treated Pt. H based on the guidelines in evidence and the pertinent statutes and regulations. There was insufficient proof that Dr. Ogoke maintained Pt. H's medical records in no order or in a very scattered way within Pt. H's medical records so the copies of the prescriptions were not reasonably accessible. I conclude this charge was not proven.

The BORM did not prove that Dr. Ogoke failed to engage in standard of care conduct when he permitted early renewals of opioid prescriptions for Pt. H. The first request was made in December 2006 in connection with the holidays and Pt. H being away and unable to receive his prescription renewals at the scheduled time. Dr. Satwicz did not have an issue with Dr. Ogoke permitting that early renewal. The second early renewal request came at the end of

February 2007. No specific reason to allow this was included in the visit report when the early renewal was given to Pt. H. Dr. Satiwcz found a violation of the standard of care by Dr. Ogoke not adequately discussing the seriousness of this red flag conduct. He wanted a discussion by Dr. Ogoke about why this behavior did not signal a narcotics agreement violation by Pt. H accelerating his use of his opioid medication. Although the specifics of what this red flag conduct by Pt. H may have represented to Dr. Ogoke was not described in the visit report, As a result of this request, Dr. Ogoke took actions. Pt. H was subjected after getting this second early refill request to an increase in UDS testing. Pt. H received counseling about the importance of not taking his prescribed medications improperly. Dr. Ogoke acknowledged this second early refill request was a red flag conduct by Pt. H. Why I conclude this additional action by Dr. Ogoke was adequate included the fact that Dr. Ogoke had UDS results at the time of this second refill request that did not show a violation of the narcotics agreement. And, after this second early renewal of opioid medication, no narcotics agreement violations were later shown by the UDS results.

Pt. H's mother testified that she was able to monitor her son's pain relief from taking his prescribed medication, and how he felt after having injection procedures. She did not testify that she observed her son taking his opioid medication more frequently than his medication regimen permitted. She did not testify, that she asked Dr. Ogoke or his physician assistants who treated her son, to talk to him about how he was taking too much of his opioid medication at one time. Pt. H never reported to Dr. Ogoke or his physician assistants that he was taking his opioid medication more frequently than he was supposed to. The BORM presented insufficient proof on this charge to show misconduct by Dr. Ogoke in not putting more information into his visit reports about why Pt. H received early refills of prescribed medication on February 26, 2007.

An April 19, 2007 visit by Pt. H occurred toward the conclusion of his care with Dr. Ogoke. At this visit, Pt. H reported to Dr. Ogoke that he had run out of his MS Contin medication and needed another prescription for it. Until that date, I had not found any visit report referencing a prescription for MS Contin, and I had not located a copy of a prescription for MS Contin. He had been taking Oxycontin 20 mg. (60) for a long time as a slow-acting opioid with a prescription for Percocet for break-through pain. There was an opioid renewal form from April 4, 2007 that listed the previous time Pt. H had received prescriptions was February 26, 2007, and that no changes to his medications were made at his April 4, 2007 visit. Pt. H had been seen by Dr. Ogoke on March 6 and 16, 2007 when he received injection procedures. There are hard to decipher handwritten short notes for each of these dates, but I could not read either of them as showing a prescription was written for MS Contin. I did not locate in Pt. H's medical records copies of prescriptions for MS Contin or for Oxycontin written on either March 6 or March 16, 2007. I found no March 6 or 16, 2007 opioid renewal forms that might have addressed if there was a change in Pt. H's medications made on either date. The April 19, 2007 opioid renewal form listed prescriptions last written on April 4, 2007 and that no changes in Pt. H's medications were being made on April 19, 2007. There was a notation on that opioid renewal form that stated MS Contin had not been prescribed on March 16, 2007. Despite no information about when this prescription for "MS Contin 30 mg. (60), p.o. Q12H," commenced with Dr. Ogoke, Pt. H received a prescription for it in response to his request.

Since MS Contin is a slow release opiate like Oxycontin, I conclude that the MS Contin was initially prescribed on April 19, 2007 and that it was a substitute prescription for the Oxycontin Pt. H had been taking. I conclude it was not an additional long-term opiate that Pt. H was taking in addition to the Oxycontin. I conclude it was not prescribed at some point as an

opiate to use along with the Percocet Pt. H was prescribed for break-through pain. I conclude a review of the medical records showing Pt. H's course of care with Dr. Ogoke support my conclusion. Given that the last time Pt. H would have received a prescription for Oxycontin 20 mg. (60) was on February 26, 2007, he would have run out of that medication by April 19, 2007. This explained why there was no discussion in the visit report of April 19, 2007 that this request for MS Contin that Pt. H said he had run out of, was not another request for an early renewal of an opioid medication. For these reason, the BORM has not proven the charge against Dr. Ogoke that he provided an early refill to Pt. H of an opioid medication without justification provided in the visit report when the MS Contin prescription was written on April 19, 2007.

The testimony of Pt. H's mother concerning her son's account of painful procedures, about the long waits to see Dr. Ogoke for scheduled appointments, and the crowds in the waiting area, was considered when determining whether the charges contained in the Statement of Allegations #s 2-8 were proven. I found that she did accompany her son to many of his appointments and made many observations of him while at Dr. Ogoke's office to make her testimony relevant and material to consider on these charges.

Patient I

Summary

Patient (Pt.) I testified.

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Inappropriately prescribed opioids to Pt. I when she was also receiving medication through a morphine intrathecal pump in her spine.
- Offered spinal injections to Pt. I despite an increased risk to Pt. I due to the intrathecal pump in her back.
- Discharged Pt. I only because she refused to receive injection procedures.

The facts the BORM alleged to support its allegations include the following:

- Prior to receiving care at Dr. Ogoke's office, Pt. I had an intrathecal morphine pump placed in her back.
- At her initial visit at Dr. Ogoke's office, Pt. I completed a questionnaire. She listed that she did not want any injection treatments.
- Having an intrathecal morphine pump in the spine places the patient at a greater risk for infection when receiving spinal injection treatments.
- Pt. I was under the care of Dr. Herard in Dr. Ogoke's office between September 13, 2007 and May 1, 2008, and received one spinal injection under Dr. Herard's care.
- Dr. Ogoke and Dr. Herard treated Pt. I with pain medication including Oxycodone and Soma.
- When Dr. Ogoke took over care of Pt. I from Dr. Herard on May 1, 2008, Pt. I told Dr. Ogoke she did not want injection treatments. Dr. Ogoke insisted that receipt of spinal injection treatments on a regular basis was part of her treatment plan.
- Because Pt. I refused to have injection treatments, Dr. Ogoke terminated Pt. I from his care on May 1, 2008.
- Dr. Ogoke did not document in Pt. I's medical records why Pt. I received prescriptions for opioids when she was receiving morphine through the intrathecal pump.

Findings of Fact

1. Pt. I was born in 1944. She came to Dr. Ogoke's office on September 4, 2007 to

begin care with his office. She was looking for a pain management specialist who had experience treating patients with an intrathecal pump in their lumbar spine. She understood Dr. Ogoke had experience treating such patients. She completed a number of new patient forms that day, including the Narcotics Prescription Policy & Agreement (narcotics agreement) and a release of her existing medical records to Dr. Ogoke's office. She answered a questionnaire on her medical history and current complaints. She provided a list of medications she was taking and a list of dates of surgeries. She provided her work, medical, and social history. She listed that she had worked as a police department matron and had been injured while strip-searching a prisoner. She listed that she had later been further injured by an automatic door hitting her. At the time she came to Dr. Ogoke's office, she was on a number of medications, including Oxycodone 30 mg. Pt. I answered on the questionnaire that she experienced worse pain with some of the treatments she had received, including injection procedures. Pt. I signed the information and consent forms regarding epidural steroid injections (ESI). She had a primary care physician (PCP). (Ex. 43; 52-57/2657-2662 & 143-157/2748-2762. Testimony of Pt. I, Vol. II, 351, 357, 359.)

2. Within Pt. I's medical records released to Dr. Ogoke's office was a medical evaluation from December 10, 2002, with the impression reached after a physical examination of, a failed back syndrome, chronic low back pain, chronic lumbar radiculitis, and possible chronic arachnoiditis. Pt. I had back surgery at the L2-L3 level in 1993. She had hardware in her lower back from surgery that she wanted removed, but removal ran a risk of infection. In the past she had treated with Dr. Marc Linson, and she was going to discuss with him the removal of the hardware. Pt. I had her lumbar surgery hardware removed in 2002. After Pt. I had been hit by a door in October 2002, her overall pain level increased to 7/10. The door incident occurred after

she had her last lumbar MRI scan, and she was to have another one. At this September 4, 2007 visit to Dr. Ogoke's office, Pt. I was using a crutch to walk. On physical examination she had range of motion limitations in her lumbar spine. Her spine was rigid. She was on medications, and Topomax 25 mg. was added for her neuropathic pain. Pt. I had a lumbar MRI on September 14, 2003 that revealed:

Posterior spinal fusion at L2-3 disc with instrumentation producing some artifact at L1-2 and L2-3 disc levels on the right. There is no underlying disc bulge or herniation at L1-2 or L2-3 disc levels ... There is a broad-based diffuse bulge at L3-4 and mild diffuse bulge at L4-5 and L5-S1 disc levels. There is a combination of disc herniation and spurring on left moderately narrowing the left neural foramina at L5-S1 disc level. This remains unchanged to previous MRI 6/21/02. There are no new findings at this time.

Pt. I had an intrathecal pump placed in her lumbar spine on June 3, 2004, so that she could receive morphine in her spinal fluid. This device is typically used to administer opioid medication to reach a pain center as a last-ditch effort to provide pain relief to a patient. By 2005, Pt. I had increased low back pain and pain in her hips, legs, knees, and ankles. While in care at a multi-disciplinary chronic pain treatment center in Pittsfield, Massachusetts, Pt. I was seen on November 12, 2006 by Dr. Gordon N. Kumar. By this time, despite her "history of multiple prior lumbar spine surgeries," she had been struggling "with considerable back and intermittent lower extremity pain." The door hitting her brought back pain issues and included "thoracolumbar spine trauma." Dr. Kumar found "much of her analgesic medication" was being "delivered via a programmable intrafcal infusion system ... delivering in a continuous manner a moderate amount of Dilaudid and Fentanyl on a 24/7 basis." Pt. I was also being prescribed "some oral opiate and non-opiate analgesic medication for additional respite in her pain." Overall, Pt. I was found to have "significant limitations with respect to strength, endurance and range of motion." Her physical limitations and pain had interfered with her social and marital

life. Dr. Kumar opined that Pt. I had a “fragile condition made worse with the discrete well chronicled more recent injury ... She requires a considerable amount of pain medication.” (Ex. 43: 48-51/2653-2656; 88-90/2693-2695 & 132-133/2737-2738. Testimony of Dr. Trescot, Vol. XV, 2879.)

3. At or before this first visit at Dr. Ogoke’s office, Pt. I met Dr. Ogoke and mentioned that she did not want to have injection treatments. Dr. Ogoke was not able to discuss this with her because he was not at the time having an appointment with her, but told her that this issue would be discussed. Pt. I understood that Dr. Ogoke had the skill to treat her pain even though she had a thecal pump. Dr. Ogoke did not take Pt. I on as his patient. Instead, she began care on September 18, 2007 with Pierre R. Herard, M.D./ FAAPMR, an interventional pain management specialist working at Dr. Ogoke’s office. Dr. Herard did a comprehensive initial evaluation. Pt. I complained to Dr. Herard of left leg pain, lower back pain that involved her entire back and reached into her legs, and right shoulder pain. Pt. I came to the evaluation in a wheelchair because it was hard for her to walk. She reported being “hit by a prisoner ... [while] searching a prisoner ... [for] illicit drugs under her breasts and ... attempting to remove the drugs.” She reported becoming disabled after that, and later being hit by a closing automatic door that further injured her. She reported a problem of falling “due to numbness” symptoms. She reported having “had a number of treatments such as injections,” and told Dr. Herard that she began feeling “worse in 2005 experiencing low back pain, hip pain, knees, and ankle and leg pain.” She reported “that the injections ... did not help,” and that she “had a pump after she had a lumbar surgery which did not help either.” Pt. I reported,

sleeplessness ... gaining weight ... having problems with her back, several painful spasms going to the left leg ... weakness ... headaches ... problems walking ... unable to pass her urine ... taking medication for that ... [and] abdominal pain associated with the pump insertion.

(Ex. 24. Ex. 43; 48-57/2653-2662 & 134-157/2739-2762. Testimony of Pt. I, Vol. II, 351-352, 358-359.)

4. From his physical examination of Pt. I on September 18, 2007, Dr. Herard found, [her gait to be] very poor ... ambulates with help ... cannot ambulate for any distance ... has to use a walker or a cane or the wheelchair ... several painful spasms along the entire lumbar spine both sides ... pain in both the SI joints going down to the legs ... weakness of the legs ... pump can be palpated in the ... lower abdomen ... flexibility of the lumbar spine is severely decreased ... impingement in the right shoulder.

Dr. Herard's impression was:

Status-post laminectomy syndrome with lumbar degenerative disk disease and lumbar radiculopathy and cervical radiculopathy ... Status-post fusion of the lumbar spine ... Cervical sprain ... Scoliosis ... Arachnoiditis with complications ... Myofascial pain syndrome.

He developed a treatment plan that included doing,

a CT scan of the lumbar spine, L1-L4 ... an SI joint injection to ... improve her pain in the lumbar spine ... C-spine CT scan ... nerve conduction test ... epidural steroid injection ... renew her medication for her pain syndrome.

Dr. Herard opined that Pt. I had a guarded prognosis, with a treatment plan to "try to help her pain." She was given prescriptions for Soma 350 mg. (120), Topamax 100 mg. (60), Provigil 200 mg. (30), Ativan (30), and Oxycodone 30 mg. (120).⁸⁶ Pt. I had signed a consent form to have epidural steroid injections (ESI) done. Pt. I told Dr. Herard that she did not want injection procedures, and that other doctors she had seen told her not to have them due to her atrophied back. Dr. Herard ordered sensory nerve conduction threshold testing, cervical and lumbar spine x-rays, and a CT scan of the lumbar spine. (Exs. 24, 25 & 42. Ex. 43: 48-53/2653-2658; 134-

⁸⁶ Pt. I's medical records show another set of medications prescribed on September 18, 2007, by Dr. Ogoke. The kinds of medications prescribed and that Dr. Ogoke is listed as prescribing them and not Dr. Herard, has made me conclude that the prescriptions were erroneously included in Pt. I's medical records. The prescriptions were; Naprosyn 500 mg. (60), Elavil 25 mg. (60), Robaxin 500 mg. (120), and Percocet 7.5/325 mg. (120). These medications did not appear in any later prescriptions written for Pt. I. (Ex. 25. Ex. 43, 142/2747. Testimony of Pt. I, Vol. II, 486-488.)

135/2739-2740 & 139-143/2744-2748. Testimony of Pt. I, Vol. II, 357, 360-361.)

5. The sensory nerve conduction threshold testing was done on September 19, 2007 to investigate Pt. I's lumbar radiculopathy. The results showed some very severe hypoesthetic conditions. (Ex. 43; 44-47/2649-2652 & 139/2744.)

6. The lumbar spine CT scan was done on September 27, 2007. The results showed:

A neurostimulator device ... enters the central spinal canal posteriorly at the L3-L4 level with the tip extending superiorly and terminating at the mid L2 level within the right anterolateral aspect of the central spinal canal. Evidence of previous L2-L3 posterior surgical fusion ... with sequela related to previous surgical metallic hardware.

...

Mild to moderate lumbar leyeoscoliosis and evidence of previous L2-L3 posterior surgical fusion with advanced multilevel lumbar spine degenerative disease which has progressed when compared to 9/14/2003 resulting in central spinal canal stenosis, most pronounced at the L3-L4 level, and neural foramina stenosis most pronounced on the right at the L3-L4 level, and most pronounced on the left at the L5-S1 levels; clinical correlation is requested.

(Ex. 43; 130-131/2735-2736 & 130-133/2735-2738.)

7. Pt. I was seen in follow-up by Dr. Herard on October 8, 2007. She was scheduled to have a bilateral sacroiliac joint (SI) injection, but she refused to have it. She agreed to reschedule it. She explained that her pump was delivering a low dosage of morphine, 95 mg. per day, and that the pump was last set/regulated on September 7, 2007. Pt. I thought it was not working well and her pump was to be discussed with her doctor later in October. Dr. Herard's treatment plan was to do the SI injection with fluoroscopy to reach the area where she had the most pain. He discussed with Pt. I the need to be "safe" when using both oral medication and medication from her pump. He explained a need to coordinate with her doctor, who would be giving her medication through the pump. Dr. Herard ordered pelvic x-rays for Pt. I. (Ex. 26. Ex. 43; 42-43/2647-2648 & 125/2730.)

8. It was risky to perform interventional treatments/injections on a patient who has the kind of pump that Pt. I had when she was scheduled to have an SI injection on October 8, 2007 with Dr. Herard. Nevertheless, he was going to be doing the injection using the fluoroscopy. Use of the fluoroscopy allows for viewing where the pump and its tubing are located to avoid touching the pump and the tubing with the injection needle. An injection can be given around the pump and still be an effective interventional treatment. Doing an SI injection involves injecting safely away from where the pump's catheter goes into the spinal fluid. It is considered a clean procedure. (Testimony of Dr. Trescot, Vol. XV, 2879-2880.)

9. For Dr. Satwicz, the information in Pt. I's medical records did not explain who was treating Pt. I with the intrathecal pump. He would have expected to see a discussion about the pump and why there was a need to also prescribe further pain medication. (Testimony of Dr. Satwicz, Vol. X, 1979-1982.)

10. Pt. I secured a report from her urologist, Dr. Jonathan S. Starkman dated October 12, 2007. Dr. Starkman referred to Pt. I as having "a neurogenic bladder," with management that included "a number of muscarinic receptor blockers for questionable overactive bladder and urgency incontinence." Dr. Starkman understood:

[H]er main problem is difficulty initiating urination with incomplete bladder emptying ... feels she needs to urinate all the time ... urinates in very small amounts with dribbling and an intermittent stream ... has mild occasional incontinence but does not use protection for this ... has occasional urgency and leakage with urgency incontinence that sounds more like overflow incontinence ... when ... unable to urinate, her bladder becomes quite distended ... assume[s] abnormal positions and push[es] on her lower abdomen and lean[s] forward to facilitate urination.

Dr. Starkman opined:

[Pt. I] may be having an atonic bladder with urinary retention and overflow incontinence versus detrusor sphincter dyssynergia as a cause for her intermittency and difficulties initiating urination with a dyscoordinated external

urethral sphincter and bladder neck ... prudent to perform sophisticated urodynamics in this patient with a complex CMG, electromyography, and pressure flow studies ... patient may in the long-term be best managed on an intermittent self-catheterization regimen ... will defer this ... until we characterize her bladder storage and emptying function with a complete urodynamics evaluation ... scheduled ... [in the] next few weeks.

Pt. I had difficulty providing urine specimens. (Ex. 29. Ex. 43, 115/2720.)

11. Pt. I was seen in follow-up by Dr. Herard on October 18, 2007. She was using her wheelchair. She complained of back pain. She completed a brief pain inventory form. Pt. I gave Dr. Herard the letter from Dr. Starkman. She had been scheduled to have an SI injection, which was not done because she said she had a tooth infection. She agreed to reschedule the SI injection. Dr. Herard discussed with Pt. I the findings of the various x-rays she had on October 17, 2007. Her cervical spine x-rays showed: "Diffuse degenerative changes without evidence of fracture or subluxation." Her lumbar spine x-rays showed: "Diffuse degenerative changes throughout the lumbar spine with limited range of motion. No evidence of significant compression fracture or subluxation." Her pelvis x-rays showed: "Fracture through the left superior and inferior pubic rami with some displacement of the superior ramis inferiorly. Underlying lytic lesion cannot be entirely excluded. CT scan of the pelvis is recommended for further evaluation." Dr. Herard summarized the findings as revealing: "[S]ome osteopenia and bone density ... increased in some areas ... some sclerotic changes ... multiple degenerative changes with pelvic tilt and some lumbar scoliosis." Dr. Herard's treatment plan was discussed with Pt. I. He increased her Oxycodone from 15 mg. to 30 mg. (120) because Pt. I reported her pain had not been well controlled. She was continued on Topamax 100 mg. (60), Soma 350 mg. (120) a muscle relaxant, Provigil 200 mg. (30) for the narcolepsy, and Ativan 1 mg. (30) for anxiety.⁸⁷ Dr. Ogoke had an office policy on doing urine drug screens (UDS) required of

⁸⁷ There is in Pt. I's medical records at Ex. 43,142/2747, prescriptions written on September 18, 2007 by Dr. Ogoke for medications that do not match the kinds of medications that Pt. I was prescribed by Dr.

patients like Pt. I who were taking opioids. Dr. Herard was going to “consult with Dr. Ogoke ... [on] how best to approach this” in light of the information from Pt. I’s urologist. (Exs. 27 & 28. Ex. 43: 25/2630; 39-41/2644-2646; 78-79/2683-2684; 102-104/2707-2709 & 121-123/2726-2728.)

12. Pt. I was seen in follow-up by Dr. Herard on November 16, 2007. He gave her a physical examination. He opined she was currently suffering from,

sacroiliitis and low back pain ... has a medical condition characterized by urinary retention and possible arachnoiditis ... is wheelchair-bound and cannot move independently ... is following up with her urologist ... was scheduled for sacroiliac joint injection today ... feels sick with incontinence ... has a pump and this is apparently not functioning well.

Dr. Herard’s treatment plan for Pt. I was to renew her medications of Oxycodone 30 mg. to take every six hours, Soma 250 mg. (120) to take four times a day, Ativan 1 mg. to take once a day, and Provigil 200 mg. (30). She was to take Amoxicillin 500 mg. “to control her possible underlying infection.” Based on Dr. Starkman’s information, Dr. Herard concluded that Pt. I “will not be able to provide urine for routine screening,” but she was able to provide some urine for a UDS at this visit. As a precaution, Dr. Herard was going to do blood work on Pt. I to rule out any infection before proceeding to injection treatments. The UDS result from the November 16, 2007 specimen was abnormal for Creatinine because none was detected, although it is a metabolic substance secreted in urine. The result was also positive for a medication she was not prescribed, Buprenorphine. To Dr. Satwicz, this UDS result was problematic and needed to be

Herard on the same date, and are not medications that her medical records show she was subsequently prescribed by Dr. Herard. The medications Dr. Ogoke wrote on that date are not mentioned in any of Pt. I’s medical record reports for that date. I conclude there is insufficient proof that they are prescriptions for Pt. I, and could be prescriptions written for another patient whose name was redacted. This is because Dr. Herard and not Dr. Ogoke was treating Pt. I on October 18, 2007. This issue was not discussed at the hearing or in the parties’ briefs. The medications were for EC-Naprosyn 500 mg. (60), Elavil 25 mg. (60), Robaxin 500 mg. (120), and Percocet 7.5/325 mg. (120).

addressed. Buprenorphine is used to treat opioid addiction like Methadone is used.⁸⁸ (Exs. 30, 31 & 32. Ex. 43: 34-38/2639-2643; 113-114/2718-2719 & 117-120/2722-2725. Testimony of Dr. Satwicz, Vol. X, 1968, 1972-1976.)

13. After Dr. Herard had the blood work results on Pt. I, he concluded that she could have the SI injection. He gave Pt. I a bilateral SI joint injection with fluoroscopy on December 14, 2007. Pt. I completed a brief pain inventory form at this visit, and was prescribed Provigil 200 mg. (30), Soma 350 mg. (120), Oxycodone 30 mg. (120), and Rozerem 8 mg. (30). Pt. I gave a UDS specimen on December 19, 2007. The next day results showed she was positive for opiates and for Oxycodone, was normal for Creatinine, and had an abnormal PH. Dr. Herard prescribed Ambien 5 mg. (30) on December 20, 2007. (Exs. 33 & 34. Ex. 43: 85/2690; 99-101/2704-2706; 105-107/2710-2712 & 109-112/2714-2717.)

14. Pt. I had a follow-up visit with Dr. Herard on January 10, 2008. Pt. I reported that her pain level had increased with some swelling after her December 14, 2007 bilateral SI joint injection. She also reported having "a bad reaction to Ambien ... felt some confusion." Overall, Pt. I reported that since she was hurt by the door in 2002, she has not been able to get her pain to subside and has had a poor quality of life. She provided to Dr. Herard the report about the incident by the physician who cared for her at that time, and who had referred her to Dr. Linson, the orthopedic surgeon. She also showed Dr. Herard the report of Dr. Kuhar from November 12, 2006. Dr. Herard gave her a physical examination. He renewed her prescriptions and planned to "do some titration for the medication causing Pt. I some problems." She was prescribed Oxycodone 30 mg. to take every six hours (180), given to her to help "control her pain syndrome and improve her quality of life." He prescribed Rozerem 8 mg. at night, Soma 350 mg. (120),

⁸⁸ This may have been a urine specimen that was not used for Pt. I. The BORM has not relied on this UDS result to prove the Statement of Allegations. If this specimen was from Pt. I from November 16, 2007, this was a time when Pt. I was under the care of only Dr. Herard.

and Provigil 200 mg. to take once a day. Dr. Herard gave Pt. I a guarded prognosis. On January 12, 2008, Humana, Pt. I's insurer, denied cost coverage of the Provigil 200 mg. as an ongoing prescription for her. She was sent a letter to that effect that she provided to Dr. Herard. She wrote to Humana that her leg pain "gets worse at night ... this pill has prevented [falling asleep throughout the day] and has improved her quality of life, with an ability to do "some cleaning/cooking, etc." She sought reconsideration of this denial. On February 8, 2008, Pt. I was seen in follow-up by Dr. Herard. He gave her some Provigil samples, and renewed her Soma 350 mg. (120) and Oxycodone 30 mg. (180). She also completed a brief pain inventory form, and an opioid renewal screen form was completed showing a prior normal UDS and no narcotic agreement violations. (Exs. 35 & 37. Ex. 43: 26-30/2631-2635; 74-75/2679-2680; 83-84/2688-2689 & 92-95/2697-2700.)

15. Pt. I was seen in follow-up by Dr. Ogoke on March 7, 2008. No explanation was provided in the report of this visit or in Dr. Ogoke's testimony about why he was seeing Pt. I at this time. Pt. I reported a pain level of 7/10 in her lower extremities and pelvic area and had neck area discomfort. Although she had "difficulty with ambulation ... she ... [reported] being able to ambulate around her home without support ... for short distances." Pt. I reported having a "history of arachnoiditis ... [with] a recent comprehensive metabolic testing for electrolytes, liver function, as well as renal function ... all normal." Dr. Ogoke understood Pt. I had a lumbar spine CT scan on September 27, 2007 showing "disk herniations and multilevel lumbar facet arthropathy as well as multilevel spinal canal stenosis." He discussed these findings with Pt. I, including the findings from her sensory nerve conduction threshold study done on September 19, 2007. Dr. Ogoke gave her a physical examination. He listed her conditions as: lumbar disk herniation; lumbar facet arthropathy at multiple levels; lumbar spinal canal stenosis at multiple

levels; sacroiliitis; lumbar radiculopathy; cervical strain; history of arachnoiditis status post surgery; and, post-lumbar spine laminectomy syndrome. His treatment plan was to schedule Pt. I "for epidural steroid injection series at the lumbar level," and then re-evaluate her condition for a possible "transforaminal approach" interventional treatment. His treatment plan also included scheduling her for SI injections, and to consider doing "diagnostic lumbar facet blocks." She was to have random UDSs "to show the patient's compliance to the opiate prescriptions as well as the narcotic contract." An opiate renewal form was done listing Pt. I's last UDS as normal and listing no narcotic agreement violations. Dr. Ogoke renewed her medications of Soma 350 mg. (120) and Oxycodone 30 mg. (180). He also prescribed Lyrica 75 mg. (14) and 75 mg. (60). He ordered an EMG of her lower extremities to investigate a possible sciatica condition. This test was performed on March 10, 2008. The results were consistent with mild bilateral radiculopathy at L5 and S-1 levels possibly caused by lumbar spinal stenosis. (Ex. 38. Ex. 43: 7-9/2612-2614; 18-19/2623-2624; 21-24/2626-2629 & 80-82/2685-2687.)

16. Dr. Herard saw Pt. I in follow-up on April 4, 2008. Pt. I came to the evaluation in a wheelchair. Pt. I completed a brief pain inventory form. An opioid renewal form was completed. She had been able to do a UDS on March 7, 2008, but the results from it were still pending. Up to this time, no narcotic agreement violations were noted on the opioid renewal screen form. Another UDS was done at this visit. Dr. Herard gave her a physical examination. He assessed a possible lytic lesion of the superior and inferior pubic rami on the left side with some displacement, narcolepsy associated with myasthenia gravis, and a chronic pain syndrome. Dr. Herard opined that x-rays of the lumbar spine showed "degenerative changes with a questionable fracture around the ileopubic area ... has a pump placed there." He further opined, that without the Provigil her condition has been worsening ... has baseline myasthenia gravis and ... is developing narcolepsy ... quality of life has

deteriorated ... since she has not been provided with the Provigil by the insurance company ... has a neurostimulator device at L2-L3.

His treatment plan was to do a pelvis CT scan, and x-rays of the lumbar spine and pelvis "to rule out any underlying process and to assess the origin of the fracture." He gave Pt. I some Provigil samples, and prioritized obtaining "formal authorization from the insurance" for her getting this medication at 200 mg. to take once a day. He also prescribed "Oxycodone 30 mg. every six hours, #180, and Soma 350 mg. four times a day." After the CT scan, the treatment plan was to re-evaluate Pt. I's condition and perhaps refer her for an orthopedic consultation. If "any lytic lesion," was detected, she would be referred to an oncologist. Dr. Herard discussed all this with Pt. I. Dr. Ogoke signed the report of this visit. On April 11, 2008, Pt. I underwent a CT scan of her abdomen and pelvis. The results showed fractures at the "left superior and inferior pubic rami, consistent with findings of 10/17/07 radiograph but with exact age uncertain ... remains unhealed." The implanted neurostimulator in the spinal canal was seen "with a control in the lower left anterior abdominal wall." Degenerative changes were seen in the lumbar spine. Pt. I saw Dr. Herard on April 11, 2008 to discuss the CT scan findings. He referred her to an orthopedic surgeon. After discussion with Pt. I, Dr. Herard did not know how she sustained the fractures. He provided her with a Provigil 200 mg. (30) prescription that her insurer approved. Dr. Ogoke signed the report of this visit. (Exs. 39 & 40. Ex. 43: 4-6/2609-2611; 14-17/2619-2622; 69-73/2673-2678 & 76-77/2681-2682.)

17. By the time of Pt. I's scheduled May 1, 2008 follow-up visit, Dr. Herard was no longer working in Dr. Ogoke's office. Pt. I was instead seen by Dr. Ogoke. Upon her arrival, she saw Dr. Herard. He spoke with her about leaving Dr. Ogoke's office, and that she could now become a patient of Dr. Ogoke. Pt. I arrived at this visit not realizing she would not be seeing Dr. Herard, but she agreed to see Dr. Ogoke. An opioid renewal form was done showing normal

UDS results and no narcotic agreement violations. Pt. I completed a brief pain inventory form. She came to the appointment in her wheelchair. She complained to Dr. Ogoke of a pain level of 8/10 in her low back and hip areas. Dr. Ogoke gave Pt. I a physical examination, although a limited one. He detected continuing "tenderness in the lumbar spine area as well as the sacroiliac notch areas with guarding as well with radicular pain in both lower extremities." He noted that the results from Pt. I's March 10, 2008 EMG testing showed "bilateral L5 and S1 radiculopathy" in the two lumbar spine levels tested. Pt. I had already been evaluated on March 7, 2008 by Dr. Ogoke who devised a treatment plan for her to have interventional pain management procedures "to help her lumbar herniation and facet arthropathy as well as her spinal canal stenosis." But today, Pt. I informed Dr. Ogoke that she was refusing interventional treatments, including "a transforaminal epidural steroid injection" that had been scheduled for this visit. Dr. Ogoke also wanted Pt. I to have a UDS done but she refused to give a specimen. After a discussion with Pt. I, Dr. Ogoke concluded that Pt. I would not comply with her treatment plan. As a result Dr. Ogoke decided to terminate care with Pt. I. He would not just treat her with pain medications. In his report of this visit, Dr. Ogoke explained:

[Pt. I] declined all interventional pain procedures regarding her care at this point and is not willing to be compliant with our treatment plan. Will allow the patient a medication supply for the next 30 days and allow her to get another physician or follow up with her primary care physician ... may also come into the clinic over the next 30 days for any emergency care ... related to treatment we have provided.

Upon leaving the office, Pt. I received prescriptions for Soma 350 mg. (120) and for Oxycodone 30 mg. (180), her regular doses and quantities. Pt. I was provided with a termination of care letter explaining that care with his office ended as of May 1, 2008, but that Pt. I had the next 30 days to come back to the office for care for emergencies. The letter listed two facilities in the area where Pt. I could seek continued pain management care - pain management clinics at

Baystate Medical Center and Mercy Medical Center. She was shown this letter and asked to sign it, but she refused. The letter was also sent to her by certified mail. Before leaving the office, Pt. I signed a physician release from liability form in regard to her refusal to undergo interventional pain management procedures, but did not sign a similar form in regard to her refusal to do random UDS testing. Pt. I did not inform Dr. Ogoke or any of his staff upon being terminated from Dr. Ogoke's care, that she wanted to be weaned off her narcotic medications. What she wanted was to continue with Dr. Ogoke's care receiving pain medications, but not to have to have injections or to provide urine specimens. During this thirty day time period following her termination and when she was still using the prescribed pain medication, Pt. I did not transfer her pain management care to a clinic or to another physician. She approached Baystate Medical Center's Pain Clinic for continuing care with pain medications, but understood that they would not treat her because the clinic had treated her in the past. After the thirty day supply of her pain medications had ended, in July 2008, Pt. I experienced some withdrawal symptoms of feeling "miserable" with hot and cold sweats, and shaking. She was seen at a hospital emergency room. Pt. I did secure pain management care at some point after this. (Exs. 21 & 41. Ex. 43; 10-13/2615-2618 & 60-67/2665-2672. Ex. 83. Testimony of Pt. I., Vol. II, 368-375, 377-378, 478, 480-482.)

18. According to Dr. Trescot, Dr. Ogoke did not violate any standard of care in terminating his care of Pt. I in the manner he did. The pain management specialist who is terminating care with a patient who will not follow her treatment plan because it includes injection treatments but does want to continue to receive her pain medication, does not have an obligation to wean the patient off her pain medication unless she has some known issue with taking her prescribed medications improperly. Dr. Ogoke was not aware that Pt. I had such

issues, and on May 1, 2008, she did not inform him of any issues. She also did not ask to be weaned off her narcotic medications. At this point, her UDS testing had not shown any narcotic agreement violations, and there was no other red flag issue at the time concerning her behavior. (Testimony of Dr. Trescot, Vol. XV, 2881-2887.)

19. Dr. Ogoke's treatment plan by May 1, 2008 for Pt. I, following his and the prior evaluations made by Dr. Herard, was to do interventional injection treatments, including SI injections and to try lumbar ESI injections. He would also prescribe her medication for pain, including opiates. He would not just prescribe pain medication without Pt. I also having interventional treatments. Dr. Ogoke understood that what he developed for Pt. I's treatment plan was continuing Dr. Herard's plan for Pt. I of having interventional procedures and not just pain medication. Dr. Ogoke understood Pt. I had been having interventional treatments as part of Dr. Herard's treatment plan. He was upset, as observed by Pt. I, that she had not been having all the planned injection treatments. The visit reports Dr. Herard produced never included an assessment that Pt. I would not be expected to undergo interventional procedures as a condition to continuing her pain management care with him. (Ex. 43, Pt. I's visit reports with Dr. Herard (already set forth in prior findings of fact). Ex: 43; 10-13/2615-2618 & 67/2672. Testimony of Pt. I, Vol. II, 368-370.)

20. Pt. I complained to the BORM about her care with Dr. Ogoke. She reported completing a background document at her initial visit to Dr. Ogoke's office. She claimed that one question asked if there was any treatment she would not have and that she wrote no injections to her back. Pt. I claimed that when Dr. Ogoke saw her answer, he told her that they would talk more about this. That talk never happened. Instead, Pt. I began care with Dr. Herard who performed the initial evaluation. Dr. Herard performed only one injection treatment, a

bilateral SI injection with fluoroscopy, after the procedure was postponed by Pt. I. Pt. I believed she had been able to get Dr. Herard to agree to not give her further injection procedures, but to continue to treat her with pain medications. Pt. I also addressed in her complaint her inability to provide urine specimens due to her underlying condition, as explained in a letter from her urologist that she provided to Dr. Herard. Pt. I emphasized that she was not refusing to do UDS testing. She wrote in her complaint form that on May 1, 2008, she found Dr. Ogoke to be "very agitated ... yelling," although not at her but at his staff. Her husband was having open heart surgery the following day and she felt unable to undergo the injection procedure scheduled for this visit with Dr. Ogoke. Pt. I also complained that she was terminated from care with no weaning off her medications that included Oxycodone. In addition, Pt. I complained to the BORM that she experienced at times long waits for her appointments, some as long as six hours. She understood someone waited twelve hours. She had also found the office to be often very messy. She commented that Dr. Ogoke will prescribe any medication you want as long as you have injections. (Ex. 83. Testimony of Pt. I, Vol. 2, 381-383.)

21. In her complaint form to the BORM, Pt. I included a letter dated "May 8" addressed to Dr. Ogoke, claiming her termination from care was unfair.

May 1st at my appt., I believe you terminated me unfairly. You didn't speak to me at all, nor did you let me finish when I said "I can't have shots in my back." My husband was at Bay State preparing for open heart surgery the next day. I couldn't even think when I was there. I have a broken pelvic and can't get on my stomach. If you can allow me time to have these shots, I will try to reconsider. When I had my 1st appt with you I had written no shots and explained it all to you. You had told me it was okay, before turning me over to Dr. Herard.

The Drs. say my husband won't be all well for 3 mo. I can't take the chance on shots till he is well.

I've had them all before so I once told you. In any case, if you won't have me back after approving me last Sept., will you please wean me off my meds. I would appreciate your answer as my meds will be due by May 30th.

I wish you well.

Sincerely,
Pt. I⁸⁹

Pt. I and Dr. Ogoke never discussed this letter. She did not seek another appointment with Dr. Ogoke after writing this letter. (Ex. 83. Testimony of Pt. I, Vol. II, 478.)

Conclusion and Recommendation

Dr. Ogoke is charged in the Statement of Allegations with having: inappropriately prescribed opioid medication to Pt. I while she was receiving morphine through an intrathecal pump in her back; offering her injection procedures to her back despite an increased risk with such injections due to the pump in her back; and, discharging Pt. I from his care only because she would not have injection procedures. The BORM has not proven these charges.

The findings show Pt. I's condition and the course of care she received from September 18, 2007 through May 1, 2008. The findings also show the care she received and for what conditions before this time period. This prior time period involved back surgery, injection treatments, and use of narcotic medications. Most of the findings address the care and prescriptions Pt. I received while being treated by Dr. Herard from September 2007 to May 2008. Pt. I never had any kind of an office visit with a physical examination and evaluation with Dr. Ogoke until March 7, 2008. Following that visit, she was seen again by Dr. Herard in April 2008. Dr. Ogoke saw Pt. I again on May 1, 2008 when Dr. Herard was no longer treating patients at Dr. Ogoke's office. Dr. Ogoke and Dr. Herard both had treatment plans for Pt. I that included not just giving her narcotic pain medications but also giving her interventional procedures. Pt. I was aware of her ongoing treatment plan when she had her May 1, 2008 visit with Dr. Ogoke. At this meeting, Pt. I made it clear that she would not have injection treatments

⁸⁹ This letter was not found in Pt. I's medical records (Exhibit 43).

and only wanted pain medications. She also refused to have UDS tests. As a result, Dr. Ogoke terminated her from his care. He basically did not take Pt. I on as his patient.

Dr. Herard did the pain medication prescribing for Pt. I while she was in care at Dr. Ogoke's office between September 18, 2007 and May 1, 2008, with Dr. Ogoke only prescribing medications for her on March 7, 2008 and May 1, 2008. Pt. I may have filled out a form on September 4, 2007 that she did not want lumbar epidural injections, but that was a form that Dr. Herard had to review. Over time, Dr. Herard's visit reports showed he discussed with Pt. I doing interventional procedures, and she had one with him, an SI injection. An SI injection did not involve a needle entering the spinal canal and would not have involved risks of hitting her intrathecal pump. Another physician implanted the pump in her lumbar spine and it delivered morphine into her spinal fluid. Dr. Satwicz and Dr. Trescot both acknowledged that even without injection treatments, having such a pump can lead to infections and that doing ESIs to the lumbar spine near the tubing can be risky if the injection reaches into the pump. Both agreed that doing an SI injection would not involve that kind of risk because the injection would not be into the spinal fluid. Moreover, Dr. Trescot explained well why the risk of doing ESIs could be addressed with use of the fluoroscopy to avoid the harm of the needle reaching the pump or the pump's tubing. This device allows the physician to view just where the injection is reaching in the spine and to see the pump and its tubing. Dr. Satwicz never opined that doing ESIs when there is an intrathecal pump is practicing medicine below the standard of care when the fluoroscopy is used, as was the case when Dr. Herard administered the SI injection to Pt. I. Dr. Ogoke always did ESIs and SI joint injections using the fluoroscopy. The fact that Dr. Ogoke's treatment plan for Pt. I was to do interventional procedures beyond just SI injections does not show he was breaching the standard of care.

Dr. Satwicz observed that Pt. I's medical records did not contain any explanation about what physician was attending to Pt. I's intrathecal pump during the time she was in care at Dr. Ogoke's office. Her medical records showed that Dr. Herard was aware of the need to be coordinating Pt. I's care with that other physician. Since Dr. Ogoke never took Pt. I on as his patient, there is no evidence to show one way or the other if he would have discussed the pump with the physician administering this device for Pt. I. Dr. Herard prescribed ongoing opioid medications to Pt. I during the time period he treated her. Dr. Ogoke maintained Pt. I's pain medications when he evaluated her on March 7, 2008. He also renewed her pain medications for thirty days on May 1, 2008 when he terminated her care, or refused to take her on as his patient. Nothing in the medical records or in Pt. I's testimony showed Pt. I had the intrathecal pump not still in her spine. Although Pt. I's pump was delivering morphine to her spinal fluid, and Dr. Ogoke prescribed opioids to her on the two dates in 2008, there is insufficient proof that his doing so violated a standard of care. No expert testimony specifically found these particular prescriptions Dr. Ogoke wrote for Pt. I were violating a standard of care. Dr. Ogoke added prescriptions for Lyrica, but that is not an opioid medication.

The BORM charged Dr. Ogoke with violating the standard of care in the way he terminated Pt. I from care in his office. This occurred on May 1, 2008. This was a date when Dr. Ogoke expected to be providing an ESI to Pt. I pursuant to the established treatment plan. Pt. I came to her visit with Dr. Ogoke on May 1, 2008 after Dr. Herard explained that he would be leaving the area and would no longer be treating Pt. I. Pt. I had liked her care under Dr. Herard. When Dr. Herard was leaving, Pt. I's care was transferred to Dr. Ogoke. At this May 1, 2008 visit, it was up to Pt. I whether or not she wanted to continue in care with Dr. Ogoke. Dr. Ogoke made it clear that he would be requiring interventional procedures and not just prescribing Pt. I

pain medications. When she decided she would not want any injection procedures, and that she would not give urine specimens, she was effectively deciding to not treat with Dr. Ogoke. It was her choice to do so. There is no support in the record for Pt. I being surprised or blind-sided by Dr. Ogoke not agreeing to alter her treatment plan to include only pain medications.

Pt. I claimed that she never had the opportunity to tell Dr. Ogoke why she would be refusing all injections in her back and would not be providing urine specimens for UDS testing. This is argued as demonstrating that Dr. Ogoke violated the standard of care in terminating his care of Pt. I on May 1, 2008. Pt. I had only one injection procedure during her care with Dr. Herard due to her postponing or outright refusal to have scheduled injection procedures that were to be done in furtherance of Dr. Herard's treatment plan for her. Although she had difficulty providing a urine specimen, she had done so with Dr. Herard. In order for Dr. Ogoke to provide her with narcotic pain medications, she had to sign onto the narcotics agreement. She had signed this agreement. If she was offering to Dr. Ogoke an amendment to that agreement that would eliminate one of the important monitoring tools for Dr. Ogoke to be able to check whether she was being compliant in taking her opioid medications as prescribed, for him to refuse her proposed amendment was practicing his pain management practice properly.

Pt. I testified that Dr. Ogoke was angry at his staff, not her, on May 1, 2008. She claimed to have heard him yelling and screaming at his staff. It is unclear just when she supposedly heard this outburst or the circumstances surrounding it. She seemed to tie this outburst to Dr. Ogoke learning that Dr. Herard had not done the injection procedures his treatment plan included. I did not find sufficient proof that this occurred by only Pt. I's testimony and her Exhibit 83 complaint information.

When Dr. Ogoke terminated his care of Pt. I, he informed her about the options she had

to continue with her pain management needs. She was told about two other area pain clinics at Baystate Medical Center and at Mercy Hospital Medical Center. She was told she could also continue to obtain pain management, including pain medications, by consulting with her PCP. Pt. I acknowledged that Dr. Ogoke told her all this. She was provided with a termination letter telling her this information as well. She was asked to sign the letter to acknowledge her receipt of it, and she refused to sign it. The letter was also mailed to her by certified mail.

At the time Dr. Ogoke terminated Pt. I's care, Pt. I was compliant in taking her prescribed medications. Dr. Trescot persuasively explained that Dr. Ogoke had no reason to taper Pt. I off her pain medications upon terminating her care. Pt. I also did not ask Dr. Ogoke to help her wean off her narcotic medications. To the contrary, she wanted to continue to receive her opioid pain medications. Dr. Ogoke's expectation at the May 1, 2008 visit was that Pt. I would be transferring her care to another pain management center or to another physician. Against this background, it is not clear why Dr. Ogoke had an obligation to engage in a tapering-off of Pt. I's opioid medications before terminating his care with her.

Dr. Ogoke gave her a thirty day supply of her on-going pain medications while she established her new pain management care. He also offered to address any emergency care she needed during the thirty day period. During that thirty day period, Pt. I's medical records do not show that she received further care from Dr. Ogoke. It is unclear from her testimony if she sought ongoing care with another physician or with the pain management clinic at Mercy Hospital. She testified that she was not able to return to receive pain management care at Baystate Hospital's clinic where she had been treated before, but that does not appear to be a likely reason why a pain clinic would refuse to treat a patient with chronic pain. If Pt. I was rejected from further care at these area pain management facilities or by another physician, the

BORM failed to prove that occurred, or that Dr. Ogoke bears responsibility for withdrawal symptoms Pt. I experienced.

The May 8, 2008 handwritten letter to Dr. Ogoke in Pt. I's complaint to the BORM, is troubling if it was seen by Dr. Ogoke and not responded to. It presumably came to Dr. Ogoke's office, if mailed at and around that date, during the thirty day time period when his termination letter allowed Pt. I to return for emergency care. The letter seemed to be seeking help to taper Pt. I off her opioid medications. In addition, Pt. I wrote that she was willing to now discuss having injection treatments with Dr. Ogoke. No further meeting occurred. Pt. I testified that she never returned to Dr. Ogoke's office after May 1, 2008, and there is no medical record showing she did. Nothing in her letter described any issue she had with taking her routinely prescribed opioid medication she received on May 1, 2008. Nothing in her letter discussed withdrawal symptoms, or that she was refused further pain management care from other pain management resources in the area. Even considering this letter as possibly received by Dr. Ogoke, the BORM has failed to show he violated a standard of care by dismissing her from his care on May 1, 2008 under the circumstances already described. There is insufficient proof Dr. Ogoke received the letter. This letter did not signal her need to have any emergency treatment by Dr. Ogoke.

In summary, if Pt. I had been inappropriately prescribed opioid medication while she was also receiving morphine through an intrathecal pump in her spine, that wrong would have involved Dr. Herard who did this prescribing for so long a time with Pt. I. The BORM also has not proven such prescribing was inappropriate. The information received from Dr. Ogoke and Dr. Trescot about the use of the fluoroscopy when doing injection treatments to the lumbar spine, even where the thecal pump was located, was persuasive that doing such injection treatments would not be a violation of standard of care. Dr. Satwicz did not provide such a sweeping

opinion that injections should never have been considered on a patient with this intrathecal pump. Pt. I only had the SI injection that none of the three physicians opined would have involved the spinal fluid. The BORM has not proven that offering injection procedures when Pt. I had the thecal pump was a violation of standard of care. Pt. I was not improperly or dangerously terminated from care by Dr. Ogoke. Pt. I was being treated by Dr. Herard. When he left, he transferred her care over to Dr. Ogoke. Dr. Ogoke discussed with Pt. I, his treatment plan for her. That plan like Dr. Herard's included having injection procedures. When Pt. I refused to have them and told Dr. Ogoke she would not participate in his monitoring tool to check on her proper use of her opioid medications by refusing to give urine specimens for UDS testing, he told her he could not treat her. The BORM has not proven that Dr. Ogoke refusing to just treat Pt. I with narcotic medication was a violation of the standard of care.

Patient J

Summary

Patient (Pt.) J testified.

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Failed to identify in his progress notes for Pt. J, the doses or adjustments of the opioids he prescribed.
- Continued to prescribe opioids to Pt. J despite repeated urine drug screen tests that were positive for illegal substances.

The facts the BORM alleged to support its allegations include the following:

- Pt. J was treated by Dr. Ogoke with a combination of pain medications that included Oxycodone, Methadone, and a Duragesic Patch.
- Dr. Ogoke gave Pt. J multiple injection treatments that included multi-level facet, epidural, and sacroiliac joint injections.
- In the follow-up reports of Pt. J's visits at Dr. Ogoke's office, the reports do not identify the doses or the adjustments of the opioids she was being prescribed at the visits.
- Pt. J received pain management care at Dr. Ogoke's office covering about seven years. Frequently, the results of Pt. J's urinary drug screen tests were positive for Marijuana. Such testing was also positive for Cocaine. These constituted violations of Dr. Ogoke's narcotics agreement that Pt. J signed.
- Pt. J continued to receive opioid prescriptions as part of her ongoing care despite these narcotics agreement violations.

Findings of Fact

1. Pt. J, born in 1953, saw Dr. Ogoke for a pain management assessment and examination on October 4, 2001 on referral from her treating physician. She completed various forms, including a form to explain her complaints and conditions. In his report of this initial evaluation, Dr. Ogoke described her as disabled with headaches from 1997, and she had two neuro-surgeries in 1997 to her brain for relief. She told Dr. Ogoke she thought she had "an aneurysm of the basilar artery." She reported her headaches returned with time and were "dull

and aching.” Pt. J reported having “constant pain” at levels from 4/10 up to 10/10. She was using a Duragesic Patch 100 mcg. for pain relief, but had break-through pain not being helped. She was also taking Diovan 80 mg. and Synthroid 0.5 mg. Pt. J reported having been on pain medication regimens in the past that had included Oxycontin that she reported had helped her pain the way the Duregesic Patch was helping it. Pt. J had hypertension and hypothyroidism. She reported having had a CT scan about two months ago, but did not have the results of it. She had ulnar nerve surgery bilaterally in 1997 and 2000. She had a gastric bypass procedure in 1996. She had a carpal tunnel release bilaterally in 1982. In or around 1996, she had been hurt in a motor vehicle accident. She was a smoker, reported only having two alcoholic drinks a year, reported trouble sleeping, and denied any history of mental health problems. Dr. Ogoke did a review of systems and gave Pt. J a comprehensive physical examination. In the report of the evaluation he listed her conditions as: headache syndrome, rule out cervicogenic headaches; occipital neuralgia; and, myofascial pain syndrome involving cervical paravertebral muscles. His treatment plan was to do: further evaluation of her headaches; a cervical spine CT scan at C2-C7 to rule out herniated nucleus pulposus versus spondylosis; prescribe tricyclic anti-depressants and anti-convulsive medication with titrating as needed; and, defer physical therapy for now. She was to return for a follow-up visit in two weeks. He prescribed Zonegran 100 mg. (60) and Pamelor 25 mg. (30). (Ex. 18. Ex. 43, 7-14/2770-2777 & 24-31/2787-2794. Testimony of Pt. J, Vol. I, 139-144.)

2. For Dr. Trescot, the background Pt. J had of having undergone gastric bypass surgery meant that she might have had an absorption deficit regarding long-acting medications because;

[They] require an intact gastro-intestinal system for complete absorption. The gastric bypass patients have a great deal of difficulty absorbing most of the formulating long-acting medications; in other words, the ones that are short acting that have been made into a long-acting oral formulation.

Dr. Trescot also found significant in Pt. J's medical history that she had been a tobacco abuser, smoker of two to three packs of cigarettes per day. She opined:

[N]icotine dramatically decreases blood flow to the nerves leading to ischemia of the nerves to the disc, leading to degenerative disc disease and to the bones heading to osteoporosis and poor bone healing.

(Testimony of Dr. Trescot, Vol. XV, 2888-2889.)

3. Pt. J's next visit with Dr. Ogoke occurred on March 13, 2003⁹⁰ when he performed another initial comprehensive evaluation. She was seeing him again for pain management on referral from her treating physician. She complained of hip and low back pain that radiated into her lower extremities. She also complained of significant foot pain. She had undergone a bunionectomy in November 2002, and explained to Dr. Ogoke her difficulties on the bottoms of both feet. She told Dr. Ogoke that she felt she was walking on "bones and a hammer toe." She felt she might need further foot surgery. She described the pain as varying in intensity. She described the pain that developed over the summer of 2002 as "burning, sharp, dull, aching, sore, shooting and sensitive." She reported difficulty climbing stairs. Pt. J reported having tried Vicodin, Vioxx, Celebrex, and Ibuprofen without any lasting pain relief. She had undergone a bone and joint whole body bone scan on January 16, 2003 that showed focal intense uptake of the left first metatarsal consistent with an x-ray report of findings of a fracture in this region. She was taking Neurontin, Levoxyl, Prozac and Bronkaid at the time of this evaluation. She denied any drug or alcohol abuse. Pt. J reported her pain caused difficulties with sleep, and that stress from the pain interfered with her family life and with social activities. She continued to be a smoker, smoking two to three packs of cigarettes a day. Dr. Ogoke gave a comprehensive physical examination. He assessed her conditions as: lumbar sprain and radiculopathy, rule out

⁹⁰ The medical records, Exhibit 43, contained no office visits at Dr. Ogoke's office between the initial 2001 evaluation and this March 2003 evaluation.

herniation; sacroiliitis; myofascial pain syndrome; and, sympathetic maintained pain in the foot post-surgery, possible foot neuroma. His treatment plan was to order a lumbar spine CT scan, and to start her on high dose nonsteroidal anti-inflammatory drugs (NSAID), muscle relaxants, tricyclic anti-depressants, and an anti-convulsant. He prescribed Norflex 100 mg. (60), Elavil 25 mg. (60), EC Naprosyn 375 mg. (90), and Zonegran 100 mg. (45). The treatment plan also included a physical therapy evaluation to be done as soon as possible to include Bioelectric treatments for her low back. Under consideration was giving Pt. J epidural steroid injections (ESI) and sacroiliac joint (SI) injections. In connection with this evaluation, Pt. J completed the new patient forms again, including signing the Narcotics Prescription Policy & Agreement (narcotics agreement). (Exs. 11 & 18. Ex. 43; 61-70/2824-2833 & 258-270/3021-3033. Testimony of Pt. J, Vol. I, 204-206.)

4. On May 30, 2003, Pt. J received prescriptions from Dr. Ogoke's office of Celebrex 200 mg. (60), Skelaxin 400 mg., Elavil 25 mg., and Percocet 5/325 (90).⁹¹ (Ex. 18. Ex. 43; 254/3017 & 256-257/3019-3020.)

5. On May 31, 2003, Pt. J had a cervical spine CT scan showing:

Mild cervical spondylosis at C4-5 and C5-6 ... with bilateral neural foraminal narrowing ... slightly worse on right at C5-6 ... mild left neural foraminal narrowing at C3-4 ... from uncovertebral hypertrophic change.

Pt. J also had a lumbar spine CT scan showing:

Bilateral pars defect at L5 vertebra resulting in grade I anterolisthesis of L5 over S1 ... moderate to severe bilateral facet joint hypertrophy and mild bilateral neural foraminal narrowing ... vacuum disc phenomena at L5-S1 ... L3-4 and L4-5 ... appear unremarkable.

(Ex. 43, 252-254/3015-3017.)

6. Pt. J was seen by Dr. Ogoke on June 24, 2003 complaining of low back radiating pain

⁹¹ I could not read the numbers of Skelaxin and Elavil on the copies of these two prescriptions. (Ex. 43, 256-257/3019-3020.) I could not locate or decipher any visit report for this date.

at a 9/10 level. Pt. J had a physical examination. Dr. Ogoke made the following assessments: cervical spondylosis at C4-5 and C5-6; bilateral pars defect at L5 vertebra resulting in grade 1 anterolisthesis of L5 over S1; lumbar facet arthropathy; lumbar strain; lumbar radiculopathy; sacroiliitis; myofascial pain syndrome; and, sympathetic maintained pain of the foot post-surgery with possible foot neuroma. Dr. Ogoke's treatment plan was to schedule Pt. J for a lumbar ESI series as soon as possible; a sacroiliac joint (SI) injection after the first lumbar ESI; an epidurogram; if Pt. J still had no pain relief, to consider a lysis of adhesion procedure; and, continue her current medications and physical therapy treatments. On July 3, 2003, Dr. Ogoke gave Pt. J the first in her series of lumbar ESI procedures with fluoroscopy at the L4-5 level. On July 16, 2003, Dr. Ogoke gave Pt. J a bilateral SI injection with fluoroscopy. On July 30, 2003, Dr. Ogoke gave Pt. J the second lumbar ESI procedure with fluoroscopy at the L5-S1 level. At this visit, she reported low back pain radiating to her lower extremities at a 6/10 level, and neck pain at a 4/10 level. Pt. J was given a physical examination. Added to the assessments made from the June 24, 2003 evaluation were costochondritis and thoracic strain with a need to rule out a herniation. The treatment plan included: Pt. J having a thoracic spine CT scan; continuing her physical therapy; discontinuing her Ultram medication⁹²; adding a calcium supplement; doing lab testing on Pt. J's vitamin B12 and thyroid levels; and, renewing her other prescriptions. At this visit, she was prescribed Percocet 5/235 (90), Celebrex 200 mg. (90), and Duragesic Patch 50 mcg. (10). Dr. Ogoke gave Pt. J her third lumbar ESI procedure with fluoroscopy at the L5-S1 level on August 12, 2003. At this visit, she was prescribed Norflex 100 mg. (60). On August 25, 2003, Pt. J was seen at Dr. Ogoke's office. She reported a pain level of 8/10 in her back and hips. She reported some short-lasting pain relief from the last lumbar ESI. She was given a physical examination. No changes were made to her ongoing assessments. The

⁹² I could not locate or decipher an Ultram prescription up to this point within Pt. J's medical records (Exhibit 43).

treatment plan was to defer the thoracic spine CT scan, continue her physical therapy treatments, follow-up with her primary care physician (PCP) for the blood work not yet done, and schedule a lumbar facet joint injection as soon as possible. At this visit, Pt. J was prescribed Percocet 5/325 (90), Duragesic Patch 25 mcg. (10), and Celebrex 200 mg. (90). (Ex. 18. Ex. 43: 5-6/2768-2769; 41-58/2804-2821; 237-240/3000-3003; 242-245/3005-3008; 247-250/3010-3013; 294-297/3057-3060; 299-300/3062-3063 & 302/3065.)

7. Pt. J's September 5, 2003 appointment was cancelled because she was in the hospital. Pt. J was seen at Dr. Ogoke's office on September 16, 2003. She complained of hip and low back pain at a 9/10 level. She reported having recently been hospitalized for binge alcohol drinking. She explained that this happened about one or two times a year, and she would be hospitalized to be monitored for seizures. Pt. J also reported that her current doses of medications were not as effective as they had been; that having taken narcotics for so long, she felt that she had "built up a tolerance to them." She acknowledged that she took her Percocet more frequently than prescribed to help her stronger pain. Pt. J was given a physical examination. No changes to her assessments were made. Her medications were renewed, including Percocet 5/325 mg. (90) and Celebrex 200 mg. (14). She was also prescribed Ativan 2 mg. (2) for interventional procedures. The treatment plan was to defer doing the thoracic spine CT scan, and for Pt. J to comply with her physical therapy regimen. Pt. J was counseled with a long discussion about the importance of being compliant in taking her prescribed medications and to follow-through with her other treatments, including having the injections, to gain control of her pain. The report of this visit noted that Pt. J understood this need to be compliant with her treatment plan. On September 24, 2003, Dr. Ogoke gave Pt. J her first in a series of bilateral lumbar facet joint injections with fluoroscopy at the L3-4, L4-5 and L5-S1 levels. At this visit,

Pt. J complained of foot pain and was given a referral to a podiatrist. (Ex. 18. Ex. 43: 35-40/2798-2803; 90/2853; 276-277/3039-3040 & 289-293/3052-3056.)

8. Pt. J was seen on October 1, 2003 at Dr. Ogoke's office. She reported a pain level of 8/10 in her low back, hips and legs. She acknowledged that she had not been to physical therapy. She reported that the last injection had given her some relief, but the pain returned. The treatment plan was to stop the Percocet and start MS Contin 15 mg. (60) and MSIR 15 mg. (90). She was also prescribed Ativan 2 mg. (2) for procedures. Her need to stay in compliance with her treatment plan was again discussed, and Pt. J agreed to follow it. Pt. J was seen on October 2, 2003 by Dr. Tatoian, a podiatrist. A bunionectomy was scheduled as a result of this evaluation. Dr. Tatoian's report on this evaluation was sent to Dr. Ogoke. Pt. J was seen on October 27, 2003 at Dr. Ogoke's office. Pt. J was prescribed MS Contin 30 mg. (60) to fill on November 1, 2003, and MSIR 15 mg. (90). At this visit, Pt. J signed the narcotics agreement again, to ensure she would be compliant with the treatment plan in terms of taking her prescribed medications properly. Pt. J was seen at Dr. Ogoke's office on November 20, 2003. She reported low back pain that radiated into her lower extremities. She received a physical examination and a urine drug screen (UDS) test was done.⁹³ The MS Contin and MSIR medications were discontinued, and she was prescribed Neurontin. Another lumbar facet joint injection was to be scheduled. Pt. J was seen on December 8, 2003 at Dr. Ogoke's office. She reported sharp low back pain that radiated into her legs. She wanted medication renewals. Pt. J was given a physical examination. The treatment plan was to have her undergo another lumbar facet joint injection as soon as possible and to schedule physical therapy. By this time Pt. J was taking

⁹³ I could not decipher or locate the results for the November 20, 2003 UDS test within Pt. J's medical records (Exhibit 43), or find a specific reference to the results in a visit report, although the handwritten follow-up visit reports were often hard to decipher.

Methadone.⁹⁴ On December 9, 2003, Pt. J had the bunionectomy. Pt. J was seen on December 23, 2003 at Dr. Ogoke's office. She reported the same low back pain radiating into her lower extremities. She was given a physical examination. Her Methadone dose was increased, and she was given Vioxx medication samples. She was to continue home physical therapy treatments. (Ex. 18. Ex. 43: 85-87/2848-2849; 89/ 2852; 282-286/3045-3049 & 329-332/3092-3095.)

9. Pt. J was seen at Dr. Ogoke's office on January 2, 2004. She reported a 9/10 pain level in her low back and 8/10 in terms of headaches. She had no Methadone to take since December 28, 2003 due to an issue with her pharmacy. She blamed that lack of medicine for her increased pain levels. Dr. Ogoke's office straightened out the problem with the pharmacy to make her Methadone available for her. At the time of this visit, Pt. J was taking Neurontin, Prozac, Levoxyl, and Diovan. She was status-post right foot surgery on December 9, 2003. She was given a physical examination. There were no changes in the assessments made, other than to note that the Costochondritis had resolved. The treatment plan was to continue her Methadone and Celebrex prescriptions, have Pt. J keep her physical therapy appointments, follow-up with her podiatrist, and schedule a lumbar facet joint injection in a month.⁹⁵ On January 9, 2004, Pt. J had a UDS done and received prescriptions for Ambien 10 mg. (10), EC Naprosyn 375 mg. (60), Oxycodone 30 mg. (90), and Methadone 40 mg. (90).⁹⁶ (Ex. 18. Ex. 43; 82-84/2845-2857 & 423-424/3186-3187.)

⁹⁴ I could not locate in Pt. J's medical records, Exhibits 18 or 43, the prescriptions for December 8, 2003. I could not locate a Methadone prescription that Pt. J was taking by December 8, 2003.

⁹⁵ I could not locate in Pt. J's medical records (Exhibits 18 or 43) the prescriptions written on January 2, 2004, if any. Pt. J was likely able to secure her Methadone prescription from her pharmacy and she may have received a Celebrex sample at this visit based on my reading of the handwritten visit report. (Ex. 43, 84/2847.)

⁹⁶ I deciphered the date on the documents in Exhibit 43; 423-424/3186-3187 to be 1/9/04 and not 1/9/06. I could not decipher or locate within Pt. J's medical records (Exhibit 43) the results of the January 9, 2004 UDS test.

10. Pt. J did not return to Dr. Ogoke's office until March 26, 2004, when Dr. Ogoke gave her a lumbar bilateral facet joint injection with fluoroscopy at the L3-4, L4-5 and L5-S1 levels. At this visit, Pt. J reported a pain level of 10/10 in her low back. She reported having headaches that she felt were caused by her running out of her Methadone medication. She reported not being on any pain medications and being followed by her primary care physician (PCP) who recommended that she use a specialist to treat her severe pain. She was taking at this time Diovan, Naltrexone, Levoxyl, Neurontin, and some vitamins. She also reported: "She has not been up here [at Dr. Ogoke's office] for the past three months; she had a bad experience with personnel in our office ... not finding that as being the case now." Pt. J was given a physical examination. She was prescribed Methadone 10 mg. (90), Roxicet (Percocet) 5/325 mg. (90) for breakthrough pain, and Gabitril 4 mg. for neuropathic pain (20 samples). She had blood work done, including to check for rheumtoid arthritis. (Ex. 18. Ex. 43: 77-81/2840-2844; 278-280/3041-3043 & 351-352/3114-3115.)

11. On April 5, 2004, Dr. Ogoke's office received a telephone call from Pt. J's sister explaining that Pt. J had been taken to the hospital with an apparent drug overdose. Pt. J's sister asked that Pt. J not be prescribed any more narcotics. On April 9, 2004, Pt. J did not show for her scheduled appointment. (Ex. 43; 175/2938 & 274/3037.)

12. On May 17, Pt. J was seen at Dr. Ogoke's office. She reported having relief from her last injection procedure, but that the pain had returned. She was given a physical examination. She was prescribed Methadone 10 mg. (90) and Roxicet 5/325 mg. (90). A UDS was done. On May 18, 2004, Pt. J called Dr. Ogoke's office to say that her sister had stolen her prescriptions and that she needed her medications. She said she would complete a police report about this theft. Dated May 18, 2004, Pt. J's sister wrote a "To Whom It May Concern" letter that was

placed in Pt. J's medical records. Pt. J's sister expressed her concern that her sister was abusing drugs and alcohol. She wrote:

She [Pt. J] has been an inpatient at many local rehabilitation centers ... Back in April she was treated by Dr. Ogokie (sic) for back pain with injections and a prescription for pain ... Within a few days ... [Pt. J] began slurring her words and falling sleep in upright positions and falling down. I intervened and demanded that she give me the pain pills. She could only produce 33 pills. I asked her where the rest were since it had only been a few days since she filled the prescription and she said she sold them and denied abuse. The following Sunday morning ... April 25th I awoke to find her unconscious and unresponsive on my living room floor. I called ... [for an ambulance] and she was transported ... [to the hospital]. She was intubated and treated for a drug OD. The tox reports came back negative but the ER Doc. said the Narcan may have impacted the results ... They extubated her two days later and within hours she went into full respiratory arrest ... [Pt. J] remained in very critical condition for days and was diagnosed with ARDS and acute respiratory arrest ... She later ... underwent ... surgery to drain puss pockets from her lungs. She suffered a recurrence of a collapsed lung two weeks ago and was re-hospitalized with a chest tube ... My sister is very angry at me and her family; we love her and want to support her so she can live a sober life, but for some reason she doesn't seem to be able to stop the drug and alcohol abuse ... I am writing to implore you not to give her anymore narcotic pain medication.

On May 19, 2004, Pt. J came to Dr. Ogoke's office to get new prescriptions based on her claim that her sister stole her prescriptions. She reported a pain level of 9/10 in the low back and legs. The UDS results from the May 17, 2004 specimen were negative for the Oxycodone screen, negative for opiates, and positive for Methadone. Pt. J explained that she had not been seen at Dr. Ogoke's office for two months because she had been hospitalized for pneumothorax with complications. She reported she was doing well now. She reported 100 percent relief lasting ten days from the lumbar facet joint injections done on March 26, 2004. Pt. J was given a physical examination. She was prescribed two weeks' worth of Methadone 10 mg. (45) and Roxicet 5/325 mg. (60). She was to see her cardiologist about her high blood pressure reading. She was to return for follow-up in two weeks. A lumbar ESI was to be scheduled for her. Within the report of Pt. J's May 19, 2004 visit, there was no reference to receipt of her sister's letter

regarding suspected substance abuse, and no indication in the report of this visit that Pt. J was counseled about a need to be compliant in taking her medications. There was no reference to a narcotics agreement violation. (Ex. 18. Ex. 43; 170-174/2933-2937; 273/3036; 347/3110 & 390-397/3156-3160.)

13. Pt. J was seen at Dr. Ogoke's office on December 21, 2004.⁹⁷ She had been suffering from a pulmonary embolism. She reported pain in her low back, hips and thighs at a 9/10 level. She was given a physical examination. The treatment plan was to schedule her for a lumbar ESI with discontinuance of her taking Coumadin (for the pulmonary embolism) for a few days prior to the procedure. Under consideration was doing a lumbar transforaminal procedure and a cervical injection procedure. Pt. J was prescribed MS Contin 15 mg. (30) and MSIR 15 mg. (60). (Ex. 18. Ex. 43; 169/2932 & 387/3150.)

14. Pt. J was seen on January 21, 2005 when Dr. Ogoke gave Pt. J the first in a planned series of lumbar transforaminal ESIs with fluoroscopy to levels L2, L3 and L4 on the left side. She came to this visit with a pain complaint of 10/10 in her low back, hips and legs. She asked to use a Lidoderm Patch instead of taking MS Contin. She also asked for other medications. She was prescribed a Duregesic Patch 25 mcg. (5). A UDS was done. Pt. J was seen on January 31, 2005 at Dr. Ogoke's office. She reported that the injection procedure had lessened her pain but that the pain was now returning. She was prescribed MS Contin 60 mg. (60) and MSIR 15 mg. (90). (Ex. 18. Ex. 43; 165-168/2928-2931; 379-381/3142-3144 & 383-386/3146-3149.)

15. Pt. J was seen on February 14, 2005 at Dr. Ogoke's office. She reported getting relief from the lumbar transforaminal ESI injection received on January 21, 2005, but reported that the pain returned be to at a 9/10 level. She reported having to use her pain medication more

⁹⁷ Pt. J's medical records (Exhibit 43) did not show she had returned to Dr. Ogoke's office since May 19, 2004.

frequently than prescribed because she was not having adequate pain relief. Pt. J was given a physical examination. She was confronted with the UDS results from her January 21, 2005 urine specimen that showed she was negative for Oxycodone and positive for Marijuana and Cocaine.⁹⁸ Pt. J denied she used Cocaine. She wrote a note saying that, and that she had never used any street drugs. Pt. J was referred to Dr. Punymurtula Kishore, an addiction specialist, for evaluation and treatment. In the February 14, 2005 referral form, Dr. Kishore was informed about Pt. J's diagnoses and the conditions for which she was receiving treatments by Dr. Ogoke, including what medications she was being prescribed. Reference was made to the recent UDS result showing she was positive for Cocaine. At the February 14, 2005 visit, Pt. J was prescribed medications.⁹⁹ The treatment plan for Pt. J was to do another lumbar transforaminal ESI once she was cleared for further care with Dr. Ogoke by Dr. Kishore. On February 15, 2005, Dr. Kishore received results from a UDS done February 14, 2005 on Pt. J. Marijuana was detected. Methadone, Cocaine and opiates were not detected. The Creatinine was found to be adulterated so the UDS was going to be repeated. A further UDS test result was issued for February 17, 2005, and another UDS was done on February 22, 2005 with the UDS results in by February 24, 2005. The results were negative for Cocaine with Methadone and opiates detected, but again, the Creatinine urine was adulterated, so another UDS test was needed. On February 21, 2005, Dr. Ogoke's office prescribed MSIR 15 mg. (60) and Methadone 10 mg. (70) for Pt. J. (Ex. 18. Ex. 43: 164/2927, 335-337/3098-3100, 356/3119, 372-376/3135-3139 & 378/3141.)

16. Dr. Trescot opined that Dr. Ogoke was within the standard of care in resuming to

⁹⁸ Exhibit 43, 378/3141, are the results from Labgenix for the January 21, 2005 urine specimen for UDS testing.

⁹⁹ I found copies of two prescriptions from February 14, 2005, Ex. 43, 376/3139, and Ex. 18, but the copies of the original prescriptions are too faint to read.

prescribe opioids to Pt. J for her pain control in light of clearance from Dr. Kishore to do this with increased monitoring of her proper use of her prescribed medications and for detection of any further use of illicit drugs. The reports from Dr. Kishore, the addictionologist, about Pt. J were in the medical record and provided for Dr. Trescot sufficient support as to why Dr. Ogoke continued to treat Pt. J with opioid prescriptions albeit with more monitoring.¹⁰⁰

The specialist felt that she was a reasonable patient to try and monitor closely ... [The specialist] apparently accepted her history of not taking the medicines that were found in her urine. Subsequent urines were clean ... So, Dr. Ogoke ... met absolutely the standard of care in the management of this patient.

(Testimony of Dr. Trescot, Vol. XV, 2890-2896.)

17. Dr. Satwicz saw insufficient information within visit reports as to the reasons Dr. Ogoke prescribed further opioid medications to Pt. J following her narcotics agreement violation by using of Cocaine and later Marijuana. Dr. Satwicz opined that Dr. Ogoke violated the standard of care due to this lack of explanation. (Testimony of Dr. Satwicz, Vol. X, 2006, 20010-2012.)

18. On February 27, 2005, Pt. J had a lumbar spine MRI as ordered by Dr. Ogoke. The results showed mild disc herniations and degenerative changes,

at L1-2 causing right lateral recess stenosis abutting and possibly encroaching upon the right L2 nerve root and causing moderate foraminal stenosis on the right ... at L2-3 without nerve root compression ... at L3-4 causing moderate right sided foraminal stenosis ... at L4-5 causing mild flattening of the dural sac and moderate bilateral foraminal stenosis, left greater than right underlying spondylolysis with superimposed moderate broad based disc herniation causing lateral recess stenosis abutting but not definitely displacing the S1 nerve roots and causing marked bilateral foraminal stenosis with encroachment upon the L5 nerve roots, left greater than right.

¹⁰⁰ Other than doing a number of UDS tests on Pt. J, I did not locate within Pt. J's medical records a report of Dr. Kishore explaining why Pt. J would be cleared to continue to receive opioid medication. There are mostly handwritten reports that are very faint copies to read and some not able to be read that may or may not contain such information directly from Dr. Kishore.

(Ex. 43: 353-355/3116-3118; 363-365/3126-3128 & 369-370/3132-3133.)

19. On March 1, 2005, Pt. J was seen at Dr. Ogoke's office. She reported a 10/10 pain level in her low back, left hip, legs, and feet. Most of her pain was on her left side. She reported that her pain medication was not always working sufficiently at controlling her pain. The recent lumbar spine MRI results were summarized in the report of this visit as showing disc herniations at multiple levels and facet arthropathy. Pt. J was counseled on the need to keep to a schedule of interventional treatments to address the conditions shown in the MRI to gain better pain control. Pt. J indicated she understood this and agreed to this treatment plan. A physical examination was given. A list of her ongoing diagnoses was included in the report of this visit. The treatment plan was to schedule the next lumbar ESI injection as soon as possible with the following one in the series to be given two weeks later. These injections were on the left side, and after that, the same injection series were to be scheduled for the right side. She was to stop taking Methadone and to start MS Contin. She was to continue with her other medications. Under consideration was a percutaneous disc decompression after ruling out discogenic low back pain if there is no improvement in this current treatment plan. At this visit, she was prescribed MSIR 30 mg. (60) and MS Contin 100 mg. (30). On March 9, 2005, Dr. Ogoke gave Pt. J a lumbar ESI injection on the left side with fluoroscopy at levels L2, L3, L4, L5 and S1. At this visit, she was prescribed MS Contin 30 mg. (30), MS Contin 100 mg. (30), and MSIR 30 mg. (60). A UDS was done. The UDS results of March 15, 2005 were positive for Oxycodone. (Ex. 18. Ex. 43: 156-162/2919-2925; 346/3109; 358/3121; 361-362/3124-3125 & 368/3131.)

20. On April 5, 2005, Pt. J was seen at Dr. Ogoke's office seeking stronger pain medication. She complained of a pain level of 9/10 in her low back, buttocks and legs. She was given a physical examination. She was prescribed MSIR 30 mg. (90) and MS Contin 100 mg.

(60). Dr. Ogoke gave Pt. J a lumbar discogram on May 23, 2005 to levels L2-3, L3-4, L4-5 and L5-S1, with L2-3 as the control. The report of this visit discussed the interventional treatments that Pt. J had undergone - ESIs, SIs and transforaminal blocks - and acknowledged their limited benefit in controlling Pt. J's chronic low back pain. She was assessed with retrograde displacement of the vertebra of the L5-S1 disk resulting in retrolisthesis, grade 2. At this visit, she was prescribed MS Contin 100 mg. (30), MSIR 30 mg. (90), and Levaquin 500 mg. p.o. daily for 3 days. The discogram was negative for diskogenic low back pain. (Ex. 18. Ex. 43: 150-155/2913-2918; 341/3104 & 343-345/3106-3108.)

21. Pt. J was seen at Dr. Ogoke's office on June 13, 2005. She reported a pain level of 10/10 for bilateral leg pain. She complained of low back and mid-back pain that was "constant, achy, moderate, in intensity ... does radiate constantly into the buttocks posteriorly to the knee level." Pt. J was given a physical examination. Pt. J's course of care was addressed in this report:

Treatment has been sporadic with short-term relief of pain only. Treatment options were discussed ... The patient does have a disk herniation at the L5-S1 level, which is causing marked bilateral foraminal stenosis and encroachment upon the L5 nerve root, the left side greater than right. These findings do match the patient's symptomatology, and at this time it is prudent to have the patient undergo a percutaneous disk compression procedure at L5-S1 for definitive treatment. The patient does agree with this plan.

No information was included in the report about Pt. J's behaviors in taking her medications, using illicit drugs as UDS results had shown, or about any possible drug abuse occurring. At this visit, Pt. J was prescribed an increase strength of her long acting pain medication. She was prescribed MSIR 30 mg. (120), Baclofen 10 mg. (90), MS Contin 100 mg. (30) and MS Contin 60 mg. (30). The list of assessments reached for Pt. J at this point were the following: cervical strain; cervical spondylosis C4 through C6; cervical facet arthropathy; cervicogenic headache;

thoracic strain rule out disk herniation versus facet arthropathy; lumbar sprain; lumbar radiculopathy L5-S1 pattern; disk herniation L1 through S1; lumbar anterior spondylolisthesis multi-levels; lumbar facet arthropathy; lumbar degenerative disk disease multi-levels; negative discogenic low back pain confirmed on diskogram May 23, 2005; myofascial pain of the trapezius and axial spine paravertebrals; costochondritis (resolved); and, sacroiliitis. On June 17, 2005, Pt. J had lumbar spine x-rays to rule out instability. The films showed grade 1.3.4 mm anterior spondylolisthesis of L4 relative to L5, and grade 1.5.8 mm anterior spondylolisthesis of L5 relative to S1, both of which were stable with flexion and extension. The films also showed degenerative disk disease at L4-5 and L5-S1 levels and mild levoscoliosis. On June 30, 2005, Pt. J received prescriptions for MSIR 30 mg. (120), Baclofen 10 mg. (90), MS Contin 100 mg. (60) and MS Contin 60 mg. (60). (Ex. 18. Ex. 43: 147-149/2910-2912; 334/3097 & 338-340/3101-3103.)

22. On July 8, 2005, Pt. J was seen at Dr. Ogoke's office. She complained of a pain level of 9/10 in her back, hip and legs. She described the back pain as achy, intermittently sharp, constant, and radiating into her lower extremities. She reported that Baclofen medication helped cramping symptoms in her legs. Pt. J was given a physical examination. She was prescribed MS Contin 100 mg. (60) at this visit. On July 11, 2005, Pt. J returned for another visit at Dr. Ogoke's office. The treatment plan was to schedule Pt. J for a percutaneous disk decompression and to continue her on her current medications. On July 22, 2005, Dr. Ogoke gave Pt. J a bilateral SI injection with fluoroscopy. A UDS was done. Her MS Contin and MSIR were discontinued and she was prescribed Oxycodone 15 mg. (90) and Methadone 40 mg. (45). The results from the UDS done on July 22, 2005 were positive for Marijuana, negative for Cocaine, positive for opiates (morphine), and positive for Oxycodone. On August 11, 2005, Pt. J had a

visit with Dr. Ogoke in preparation for the percutaneous disc decompression operation scheduled for the next day. He discussed the benefits and the risks of the procedure. He gave a physical examination. He prescribed Levaquin 500 mg. p.o. daily for 5 days following the procedure. He also prescribed Methadone 40 mg. (45) and Oxycodone 15 mg. (90). Dr. Ogoke performed the procedure on August 12, 2005 at Noble Hospital. Part of the procedure at L5-S1 had to be discontinued because of severe osteophyte and disk narrowing found. Pt. J did have the procedure at L2-3 and L4-5. She was prescribed Oxycodone 30 mg. (90) on August 22, 2005¹⁰¹, and Methadone 40 mg. (45) on August 26, 2005. There was no indication in the report of Pt. J's visits of August 11 and 22, 2005 about her positive for Marijuana UDS result from July 25, 2005. (Ex. 18. Ex. 43: 19-22/2782-2785; 135-136/2898-2899; 139-141/2902-2907; 312-319/3075-3082; 321-322/3084-3085; 324-328/3087-3092; 333/3096; 440-441/3203-3204 & 447-448/3210-3211.)

23. Pt. J was seen at Dr. Ogoke's office on September 7, 2005. She had a UDS done that was negative for Cocaine and opiates, and positive for Methadone. She complained of a pain level in her back and hips of 9/10. Pt. J was given a physical examination. She was prescribed Methadone 40 mg. (45) and Oxycodone 30 mg. (90) to fill September 13, 2005. On September 28, 2005, reporting a pain level of 9/10, Dr. Ogoke gave Pt. J had a bilateral SI injection with fluoroscopy. She requested medication refills. She was prescribed Ambien 10 mg. (10), Methadone 40 mg. (90), and Oxycodone 30 mg. (90). On October 18, 2005, the gastroenterology specialist Pt. J was referred to by Dr. Ogoke, wrote to Dr. Ogoke that Pt. J never appeared for her scheduled evaluation. On October 28, 2005, Pt. J appeared at Dr. Ogoke's office claiming she was to have a bilateral SI injection. This did not occur. At this

¹⁰¹ Pt. J was prescribed another medication by Dr. Ogoke on August 22, 2005, but I could not read what it was. It was for 60 mg. (30). (Ex. 43, 448/3211.)

visit, she was prescribed Ambien 10 mg. (10), Oxycodone 30 mg. (90), and Methadone 40 mg. (90). On December 8, 2005, Dr. Ogoke gave Pt. J another bilateral SI injection with fluoroscopy. She reported a pain level of 10/10 at this visit. A UDS was done. She was prescribed EC Naprosyn 375 mg. (60), Methadone 40 mg. (90), Oxycodone 30 mg. (90), and Ambien 10 mg. (10). (Ex. 18. Ex. 43: 72-76/2835-2839; 134/2897; 137/2900; 426/3189; 429-431/3192-3194; 433-435/3196-3198 & 437-439/3200-3202.)

24. Pt. J was seen at Dr. Ogoke's office on January 9, 2006 complaining of a pain level of 10/10. A UDS was done. She was prescribed Ambien 10 mg. (10), Naprosyn 375 mg. (60), Methadone 40 mg. (90), and Oxycodone 30 mg. (90). On March 13, 2006, Dr. Ogoke's office prescribed Naprosyn 375 mg. (60), Oxycodone 30 mg. (90), Ambien 10 mg. (10), and Methadone 40 mg. (90). Pt. J was seen at Dr. Ogoke's office on April 14, 2006. She reported that she was running out of medications and feeling "withdrawal symptoms." She asked for another SI injection. She was given a physical examination. A UDS was done. The results of the UDS were positive for Methadone. The treatment plan was to do a lumbar facet joint injection as soon as possible. Her medications were renewed but she declined more Naproxen (Naprosyn) and Ambien because she still had enough of both medications. She was prescribed Oxycodone 30 mg. (90) and Methadone 40 mg. (90). Pt. J was seen at Dr. Ogoke's office on May 11, 2006 with a pain complaint of 10/10. She had recently fallen. She asked about being detoxed off the opiates she was taking. The report of this visit noted that her medications had not been changed for a long time period. She explained that the Methadone was now less effective for her pain control. Pt. J was told that decreasing her pain medication might result in higher pain levels, but she wanted to try this plan anyway. She was to have a discussion with Dr. Ogoke about this first. For now, her medications were renewed. She was unable to give a urine

specimen for a UDS. This inability was not explained in the report of the visit, and the prior UDS had not involved a specimen that was able to cover testing for the number of substances. The treatment plan was to still do the lumbar facet joint injection as soon as possible. On June 15, 2006, Pt. J was seen at Dr. Ogoke's office. She had cervical and lower extremities sensory nerve conduction threshold evaluations that did not show further evidence of radiculopathy. She was prescribed Oxycodone 30 mg. (90) and Methadone 40 mg. (90). A UDS was done.¹⁰² On June 23, 2006, Pt. J was seen at Dr. Ogoke's office. She reported a 10/10 pain level in her feet, buttock, hips, and legs. She reported episodes of incontinence. She asked for and was prescribed a Duragesic Patch 25 mcg. (10). On July 15, 2006, Dr. Ogoke gave Pt. J a bilateral SI injection with fluoroscopy. She came to this appointment with a pain complaint of 10/10. She was prescribed a Durageic Patch 25 mcg. (10), Oxycodone 30 mg. (120), and Methadone 40 mg. (90). On August 17, 2006, Dr. Ogoke gave Pt. J a bilateral cervical facet joint injection procedure with fluoroscopy at the C4-5, C5-6, C6-7, and C7-T1 levels for her cervical facet arthropathy. A UDS was done that was positive for Oxycodone. She was prescribed Oxycodone 30 mg. (120), a Duragesic Patch 25 mcg. (10), and Methadone 40 mg. (90). (Ex. 18, Ex. 43: 117-133/2880-2896; 178/2941; 398-406/3161-3169; 408/3171; 410-424/3173-3187; 491/3254 & 495/3258.)

25. Pt. J was seen at Dr. Ogoke's office on September 15, 2006. She reported a pain level "10+/10" in her low back and hips. She reported needing to use using more pain medication than was prescribed.¹⁰³ She explained that the August 2006 cervical facet joint

¹⁰² I could not locate the UDS results from the June 15, 2006 specimen, but it may have been in Pt. J's medical records (Exhibit 43) and was not a legible document. I found a UDS result Ex. 43, 414/3177, that I could not read because the copy was too faint.

¹⁰³ By this time, Pt. J's request to taper off her narcotic medications, something she was to discuss with Dr. Ogoke, was either given up, or that talk never happened, or that talk occurred but was not recorded

injection provided moderate neck pain relief, but that pain had returned. She was told to discuss possible medication changes with Dr. Ogoke. She acknowledged having “increased social stressors,” and that she recently used Cocaine. She thought she was not yet addicted to the Cocaine. A discussion occurred about having a consultation with an addiction specialist, and she agreed to do this, writing this agreement in a note for inclusion within her medical record. She was provided with a list of addiction consultation facilities in the area. She was given a physical examination. She was advised to do follow-up with her PCP for high blood pressure. She was to discuss with Dr. Ogoke having changes made in her pain medications and received just renewals of her current medications for now. Further plans for her as recommended by Dr. Ogoke, included having a trigger point injection (TPI) for a trochanteric bursa, a facet cervical diagnostic block, and a bilateral SI joint injection. Pt. J agreed to this plan, and to start it as soon as possible. She was prescribed a Duregesic Patch 25 mcg. (10), Oxycodone 30 mg. (90), and Methadone 40 mg. (90).¹⁰⁴ She had a UDS done with results from September 18, 2006 that showed the Oxycodone screen was negative, but the results were positive for Cocaine, low for Marijuana, and positive for opiates and Methadone.¹⁰⁵ On October 16, 2006 Pt. J had a visit with Dr. Ogoke. She completed a pain inventory form and had a UDS done to test for the presence of Oxycodone. Pt. J reported being compliant in taking her prescribed medications. She complained of pain in one of her toes that often caused her to remove her shoes for some pain

within a medical record. At least I could not decipher or locate such a write-up within Pt. J’s medical records (Exhibit 43).

¹⁰⁴ No specific discussion was found in the visit report for September 16, 2006 concerning why, even if she agreed to counseling due to her revelation that she had used Cocaine, Pt. J would have been prescribed the opioids she was at this visit.

¹⁰⁵ I read Ex. 43, 490/3253 as showing UDS results from the September 15, 2006 specimen despite the document being very faint. The results of the UDS were not known at the time the September 15, 2006 visit report was produced.

relief. She noted that after the cervical facet joint injection from two months ago, that her neck pain was now at a 4-6/10 level and that headaches were associated with neck pain. The need for lower extremities central nerve conduction threshold studies was noted in the report of the visit due to the persistence of this pain with the etiology of it “unclear.” Due to the need for this data about her lower extremities, Dr. Ogoke put on-hold doing further interventional treatments. She had a physical examination. Her current medications were renewed of Duragesic Patch 25 mg. (10), Oxycodone 30 mg. (90), and Methadone 40 mg. (90). The UDS result showed she was negative for Oxycodone. The report of the October 16, 2006 visit does not discuss Pt. J’s acknowledged use of Cocaine or whether she had an evaluation with an addiction specialist, or had begun detoxification treatment for use of Cocaine.¹⁰⁶ This report did not address the UDS result from the September 15, 2006 specimen. (Ex. 18. Ex. 43: 113-115/2876-2877; 473/3236; 478/3241; 482-490/3245-3253; 492-494/3255-3257.)

26. Dr. Trescot opined that, given Pt. J’s admissions concerning use of Cocaine, her recognition of the dangers of it being addictive, and her willingness to have counseling with the addictionologist, and in light of her significantly high intractable pain levels, that continuing to prescribe opioid medications to her was not a violation of standard of care. (Testimony of Dr. Trescot, Vol. XV, 2897-2901.)

27. On November 10, 2006, Pt. J was prescribed Oxycodone 30 mg. (90), Methadone 40 mg. (90), and Duragesic Patch 25 mcg. (10). A UDS was done. The November 16, 2006 results of the UDS from the November 10, 2006 specimen were negative for Oxycodone and negative for Fentanyl. (Ex. 18. Ex. 43; 469-472/3232-3235 & 476-477/3239-3240.)¹⁰⁷

¹⁰⁶ I could not locate or decipher in Pt. J’s medical records (Exhibit 43) any write-up that Pt. J had in fact gone for counseling regarding her use of Cocaine.

¹⁰⁷ I could not locate or decipher a November 10, 2006 visit report in Pt. J’s medical records (Exhibit 43).

28. Pt. J became hospitalized in November 2006 at the Mercy Providence Behavioral Health Hospital. She was discharged on November 30, 2006 with a discharge plan to address her mental health and substance abuse issues for which she had been hospitalized. She received a discharge plan that had her seeking care for her issues with her psychiatric caregiver and with Dr. Ogoke regarding her pain control issues. A copy of her discharge instructions was provided to Dr. Ogoke at some point in time. (Ex. 43, 474-475/3237-3238.)

29. On December 5, 2006, Pt. J had a sensory nerve conduction threshold study for her pain complaints in her lower extremities. The results showed “L4-5 mild hypoesthetic condition.” Also on December 5, 2006, Pt. J had a UDS done. The December 8, 2006 results were negative for Oxycodone and positive for Fentanyl. At a December 12, 2006 visit at Dr. Ogoke’s office, Pt. J complained of a pain level of 8/10 in her low back and hips. She was given a physical examination. A UDS was done.¹⁰⁸ In terms of her efforts to address her drug use and referrals to addiction specialists, Pt. J reported:

[S]he tried to get treatment from the addiction medicine services ... given at the last office visit ... was unable to obtain services ... tried multiple numbers and has been unsuccessful, despite positive Cocaine urine drug screen on multiple occasions and self-report of Cocaine use in the past. She denies Cocaine use at the present time.

Pt. J wrote a note to go into her medical records at this visit that explained how she had “made an honest attempt to seek out the places listed on the sheet of paper I was given.” Pt. J wrote that she felt “ashamed. It won’t happen again.” At this visit, Pt. J was counseled about the need to be compliant in taking her prescribed medications and in following the treatment plan. She was counseled to treat this issue with the psychiatrist who she had used in the past. She was instructed to report back on this issue by the next office visit. At this visit, Pt. J was prescribed

¹⁰⁸ It may be that the results of the December 12, 2006 UDS testing is on Ex. 43, 461/3224, but I could not read it because the copy was so faint.

her current medications of Methadone 40 mg. (90), Oxycodone 30 mg. (90), and a Duragesic Patch 25 mcg. (10).¹⁰⁹ (Ex. 18. Ex. 43: 98/2861; 100-107/2863-2870; 459-466/3222-3229; 463-466/ 3226-3229 & 473/3236.)

30. On January 11, 2007, Pt. J was prescribed Duragesic Patch 25 mcg. (10), Methadone 40 mg. (90), an Oxycodone 30 mg. (90). On February 8, 2007, Dr. Ogoke gave Pt. J a bilateral SI injection. Pt. J came to Dr. Ogoke's office complaining of a pain level of 8/10 in her lower back into her hips and legs. A UDS was done that included an Oxycodone screen. An order was done for her to have physical therapy and to have nerve conduction studies. She was prescribed a Duragesic Patch 25 mcg. (10), Methadone 40 mg. (90), and Oxycodone 30 mg. (90).¹¹⁰ Pt. J was seen on March 7, 2007 by Dr. Ogoke. Pt. J had been treating with Valley Psychiatric for an "isolated use of Cocaine." The visit report noted that subsequent random urine drug screens, including one done on February 8, 2007, were negative for Cocaine. Pt. J had a sensory nerve conduction threshold study that did not reveal any carpal tunnel syndrome in either of her hands. Pt. J was given a physical examination. Another UDS was done. Her medications were renewed; Oxycodone 30 mg. (90), Methadone 40 mg. (90), and a Duragesic Patch 25 mcg. (10). The treatment plan was to schedule her for a diagnostic cervical facet joint injection "in the near future," and to consider further interventional treatments including another SI injection and lumbar ESI procedures. The March 14 and 15, 2007 results of the UDS done on March 7, 2007 were negative for Fentanyl (Duregesic Patch), and positive for Oxycodone and opiates. On

¹⁰⁹ Within this visit report, there was no discussion about why Pt. J would be prescribed her opioid prescription regimen before Dr. Ogoke had received the report from her treating psychiatrist concerning her use of Cocaine. Within this report, there was no discussion concerning the UDS test results that were showing non-compliance in taking medications as prescribed.

¹¹⁰ I could not locate or decipher any visit reports for January 11, 2007 or February 8, 2007 within Pt. J's medical records (Exhibit 43) addressing Pt. J's Cocaine positive UDS result.

March 19, 2007, Pt. J was hospitalized with Methicillin resistant *Staphylococcus Aureus* Pneumonia at Mercy Hospital. She had “left video-assisted thoracostomy with multiple lung biopsies.” Other diagnoses made at discharge were: fungal bronchitis; “[r]ecurrent pulmonary aspiration secondary to substance use;” alcoholism but with Pt. J’s claim of having been “sober for the last 3 months;” chronic back pain for which Pt. J was taking narcotic medication; and, “[e]xtensive chronic obstructive pulmonary disease.” She was given “broad spectrum antibiotic therapy.” The discharge summary instructions were for her to see her PCP, a thoracic surgeon, a pulmonologist, and Dr. Ogoke. She was given a prescription for Oxycodone 10 mg. (60). She reported that she had a week’s supply of Methadone at home. The discharge summary contained the following:

The patient has done extremely well during her hospitalization, and once her acute pain issues were resolved, she did not appear to be narcotic seeking and appeared to use p.r.n. non-narcotics appropriately.

(Exs. 10 & 18. Ex. 43: 91-97/2854-2860; 197-199/2960-2962; 425/3188; 442-445/3205-3208; 449-451/3212-3214; 453/3216; 455-458/3218-3221; 566-572/3329-3335.)

31. On April 10, 2007, Dr. Ogoke gave Pt. J a bilateral SI injection with fluoroscopy. She reported a pain level of 8/10 in her mid-back area. An opioid renewal screen form was completed listing her last UDS as normal but noting a prior narcotics agreement violation with care being received by Valley Psychiatric Service. Her medications were renewed¹¹¹ and another UDS was done. The results of the April 10, 2007 UDS showed she was negative for Oxycodone and Fentanyl. On May 15, 2007, Dr. Ogoke gave Pt. J a bilateral lumbar facet joint injection with fluoroscopy at L2-3, L3-4, L4-5 and L5-S1. She reported a pain level of 8/10 in her back.

¹¹¹ I could not locate prescriptions dated April 10, 2007 in Pt. J’s medical records (Exhibits 18 and 43).

An opioid renewal screen was completed listing her last UDS as normal,¹¹² and a prior narcotics agreement violation for which she was receiving help. Her medications were renewed; Oxycodone 30 mg. (90), a Duragesic Patch 25 mcg. (10), Methadone 40 mg. (90), and Robaxin 500 mg. (120). On June 16, 2007, Dr. Ogoke gave Pt. J a second bilateral lumbar facet joint injection with fluoroscopy at the L2-3, L3-4, L4-5 and L5-S1 levels. The results of her UDS from May 15, 2007 showed no Oxycodone was detected. She had another UDS done. Her opioid renewal form noted she had a narcotics agreement violation in her past for which she was seeking treatment. She was prescribed Oxycodone 30 mg. (90), Methadone 40 mg. (90), and Robaxin 500 mg. (120). (Ex. 18. Ex. 43: 182-195/2945-2958; 538-540/3301-3303; 542/ 3305; 549-557/3312-3320; 559-563/3322-3326 & 565/3328.)

32. On July 17, 2007, Pt. J came for a follow-up visit with Dr. Ogoke. She reported “60%” pain relief from the second bilateral lumbar multi-level facet joint injection procedure done June 16, 2007. She reported burning sensation in her right foot and toe. She had a physical examination and a UDS was done. She completed a brief pain inventory form. An opioid renewal form listed prior prescriptions as written on June 16, 2007, results from the UDS done on June 16, 2007 pending, and a prior narcotics agreement violation for which Pt. J was seeking treatment. A physical examination was done. The diagnoses made were: lumbar facet arthropathy; lumbar herniation; lumbar degenerative disc disease; sacroiliitis; cervicothoracic junction pain rule out facet versus degenerative disc disease versus herniation; myofascial pain syndrome involving subacromial muscle and trapezius; and, suprascapular neuralgia. The treatment plan was to have Pt. J undergo another bilateral lumbar multi-level facet joint injection as soon as possible, then a facet denervation procedure using radiofrequency lesioning generator.

¹¹² I do not know whether or not the May 15, 2007 opioid renewal screen form reflected review of the April 10, 2007 UDS results, whether they had arrived at Dr. Ogoke’s office by then, or whether I misread the results concerning being negative for Fentanyl and for Oxycodone on April 10, 2007.

Pt. J would have her neck pain monitored, and have a cervical epidural steroid injection, or a cervical facet joint injection. Her medications were to be reviewed in thirty days. Pt. J was prescribed Methadone 40 mg. (90), Oxycodone 30 mg. (120), Robaxin 500 mg. (120), a Duragesic Patch 25 mcg. (10), and Ativan 2 mg. (2) and Actiq 600 mcg. (2) for procedures. The July 17, 2007 UDS result was positive for Oxycodone. On August 17, 2007, Dr. Ogoke gave Pt. J a bilateral lumbar facet joint injection with fluoroscopy at the L2-3, L3-4, L4-5, and L5-S1 levels. Pt. J completed a brief pain inventory form. She was prescribed Robaxin 500 mg. (120), Oxycodone 30 mg. (120), Methadone 40 mg. (90), Ativan 2mg. (2) and Actiq 600 mcg. (2) for procedures, and a Duragesic Patch 25 mcg. (10). Another UDS was done. The results were negative for Cocaine, opiates, and Oxycodone, and positive for Methadone. Pt. J experienced pain at an 8/10 level at times when she received interventional procedures. (Ex. 18. Ex. 43: 179-181/2942-2943; 235/2998; 520/3283; 522-525/3285-3288; 528-531/3291-3294; 533/3296; 535-536/3298-3299 & 543-544/3306-3307. Testimony of Pt. J, Vol. I, 164, 166-167.)

33. By September 17, 2007 when Pt. J was seen at Dr. Ogoke's office, she was seen by Dr. Herard with Dr. Ogoke signing-off on Dr. Herard's visit report. Dr. Herard prescribed Oxycodone 30 mg. (120), Methadone 40 mg. (90), a Duragesic Patch 25 mcg. (10), and Ativan 2 mg. (2) and Actiq 600 mcg. (2) for procedures. She had another UDS done.¹¹³ On October 17, 2007, Dr. Herard prescribed a Duragesic Patch 25 mcg. (10), Methadone 40 mg. (90), and Oxycodone 30 mg. (120). She had another UDS done.¹¹⁴ On November 16, 2007, Dr. Herard prescribed Oxycodone 30 mg. (120) and Methadone 40 mg. (90). Pt. J had a UDS done that was

¹¹³ I could not locate or decipher in Pt. J's medical records (Exhibit 43) the results of the September 17, 2007 UDS testing.

¹¹⁴ I could not locate or decipher in Pt. J's medical records (Exhibit 43) the results of the October 17, 2007 UDS testing.

negative for alcohol, opiates, Cocaine, and Oxycodone, but positive for Methadone, Buprenorphine, and Marijuana. On December 14, 2007, Dr. Ogoke gave Pt. J a lumbar facet denervation procedure on the right side with fluoroscopy covering levels L1, L2, L3, L4, and L5 on the right. She had another UDS done that was negative for alcohol and Cocaine, but positive for Methadone, Oxycodone and Marijuana.¹¹⁵ (Ex. 18. Ex. 43: 234/2997; 499-502 /3262-3265 & 511-519/3274-3282.)

34. Pt. J was seen by Dr. Herard in follow-up on January 10, 2008. She reported having a 30% decrease in pain from the December 14, 2007 interventional treatment. An opioid renewal form was completed that listed her most recent UDS as positive for Marijuana. The form noted that Pt. J was cleared for further care by an addiction specialist, and that she had a prior narcotic agreement violation from November 16, 2007.

She carries a letter [of Dr. Leavitt of January 8, 2008] from Valley Psychiatric Service saying that the doctor there would like us to continue her medications, Methadone and Oxycodone, for pain. The doctor writes that adequate control of her pain has helped maintain her sobriety now for over a year. The patient nearly died in the past from this according to the doctor. We will take that into consideration and we will continue to treat the patient.

At this visit, Dr. Herard did a physical examination. He assessed Pt. J with lumbar facet joint dysfunction and chronic lumbar radiculitis. Dr. Herard wrote in his report of this visit that Pt. J agreed to follow the terms of the narcotics agreement and that she would not use illicit drugs. The plan was to follow her psychiatrist's advice. Dr. Herard prescribed a Duragesic Patch 75 mcg. every 72 hours (long-lasting), and Oxycodone 30 mg. every 6 hours (short-acting) (120). Further interventional treatments were planned. Dr. Ogoke signed this report. Pt. J was seen by Dr. Herard on January 17, 2008. Dr. Herard wrote in the report of this visit, that Pt. J's opioid

¹¹⁵ I could not locate prescriptions written on December 14, 2007 within Pt. J's medical records (Exhibits 18 and 43) other than a reference at Ex. 43, 232/2995 within the January 10, 2008 opioid renewal form a notation that prescriptions were last written on December 14, 2007.

medications were changed with discontinuance of her Methadone medication on January 10, 2008. He explained that this was done because of her complaint that she was not “feeling any results.” She reported that her medications were not controlling her pain, and that as a result, she experienced more stress. She continued to be treated by Valley Psychiatric Service for stress management to prevent further health risks to her. Dr. Herard’s report of this visit refers to the January 8, 2008 note of Dr. Leavitt of Valley Psychiatric Service agreeing to monitor Pt. J’s behavior and that Dr. Leavitt recommended continuing Pt. J on her narcotic pain medications to maintain her sobriety. Dr. Leavitt was treating Pt. J with “stress management and prevention of any harmful behavior.” Dr. Herard wrote in his report of this visit: “I spent a long time with the patient discussing the report” of Dr. Leavitt. Dr. Herard noted that Dr. Leavitt was “quite sure that ... Pt. J is not an addict.” Dr. Herard gave a physical examination and noted that Pt. J was “labile and crying because of pain,” but was not showing “any aberrant behavior.” Dr. Herard concluded that there was a “need to titrate pain medication with the goal of controlling Pt. J’s pain.” He assessed her with: chronic cervical and lumbar radiculitis; chronic cervical and lumbar facet joint dysfunction; fibromyalgia; and, history of depression, anxiety, and stress syndrome. He prescribed pain medication of: Hydromorphone 4 mg. every 8 hours for the next 15 days as a trial; a Duragesic Patch 75 mcg. to use every 72 hours as a long-acting medication; and, Oxycodone for short-acting relief. Dr. Herard reported:

I told her to be careful and to call her primary doctor with any signs of respiratory problems. She will come back in 15 days to see if we should continue to titrate her medications ... She still has the choice to go back to the Methadone. She appears to have good behavior and therefore we will continue her treatment. We will plan to do some therapeutic and diagnostic blocks at the next visit.

This report was also signed by Dr. Ogoke. On January 26, 2008, Dr. Ogoke gave Pt. J a lumbar facet joint injection with fluoroscopy on the left side at levels L2-3, L3-4, L4-5, and L5-S1. This

was for her lumbar facet arthropathy pain. She came to the visit complaining of a pain level of 8/10. She received prescriptions. On January 29, 2008, Pt. J was seen at Dr. Ogoke's office by Dr. Herard. An opioid renewal form was completed. Her last UDS was noted as positive for Marijuana. Also noted was a prior narcotics agreement violation, and that Pt. J had been seen by an addiction specialist. Pt. J's pharmacy would not cover the prescriptions from January 26, 2008, so they had not been filled. Pt. J told Dr. Herard that she believed she developed a "tolerance" to the medications she had taken for years and wanted to try different medications. She was given a physical examination that showed her to be in pain and lacking full mobility. Dr. Herard prescribed new medications of OxyContin 40 mg., 2 a day (long-acting) and OxyIR 5 mg., every 6 hours (120). He explained to Pt. J that these medications could be titrated if necessary. He wrote in his report of this visit:

We discussed the need to make an effort in this situation ... If she cannot give us a clean urine then we will have to contact the doctor who is sponsoring her in terms of pain management. This patient's situation may be so precarious that it would not be wise to discontinue the medications, and the risks outweigh the benefits. We will keep in contact with ... Valley Psychiatric Service.

Dr. Ogoke also signed this report. On January 29, 2008, Pt. J was sent by registered mail a termination of care letter by Dr. Ogoke's office. In the letter, Pt. J was offered emergency care for the next month and provided with names and contact information of substitute pain management practices in the area for further care. Despite this termination letter, Pt. J continued in routine pain management care with Dr. Ogoke's office. (Exs. 10, 12, 13 & 14. Ex. 43; 218-225/2981-2987 & 227-232/2990-2995. Testimony of Pt. J, Vol. I, 178-184.)

35. On February 4, 2008, Dr. Ogoke gave Pt. J a bilateral SI injection with fluoroscopy. She came to the visit complaining of a pain level of 8/10. An opioid renewal form was completed, noting Pt. J last received prescriptions on January 10 and 17, 2008 and not January

26 and 29, 2008. The form listed her last UDS as positive for Marijuana, that she had a prior narcotics agreement violation, and that she was cleared for treatment by an addiction specialist.

On February 6, 2008, Ann Howe, a psychotherapist and licensed medical social worker at Valley Psychiatric Service wrote to both Dr. Ogoke and Dr. Herard about Pt. J at Pt. J's request. The letter, received February 8, 2008, explained:

She is fearful that she will be asked to leave your clinic because Marijuana was discovered in her system. She told me today about smoking Marijuana before she came to our appointment. She needs pain medication that you provide to help keep her stable so she can enjoy a better quality of life. She has agreed not to smoke Marijuana again.

On February 18, 2008, Dr. Herard gave Pt. J a bilateral lumbar facet joint procedure with fluoroscopy at levels L2-3, L3-4, L4-5, and L5-S1. At this visit her last UDS was pending. Pt. J reported a pain level of 10/10. Dr. Herard prescribed Methadone 10 mg. (120) and Oxycodone 30 mg. (120).¹¹⁶ (Exs. 10, 15¹¹⁷ & 18. Ex. 43: 211-217/2974-2980; 503-504/3266-3267 & 506-510/3269-3273.)

36. On March 14, 2008, Pt. J was seen by Dr. Herard. He explained in his report of this visit that Pt. J had a chronic back pain condition with pain relief from facet joint injections and medial branch nerve blocks. At this visit, Pt. J reported 70% relief of pain from the last interventional procedure although the relief did not last. Pt. J reported a pain level at this visit of 10/10. She reported her pain was relieved by taking medication. Dr. Herard found the use of the medication stabilized her condition and provided her with a better quality of life. An opioid

¹¹⁶ At Ex. 43, 507-509/3270-3272, it appears that Dr. Ogoke gave Pt. J a lumbar facet denervation procedure with fluoroscopy on February 18, 2008. I am not sure that the date on the form that seems to indicate February 18, 2008 is correct because Dr. Herard on the same date gave Pt. J the lumbar bilateral facet joint procedure with fluoroscopy. (Ex. 43; 211-213/2974-2976 & 503-504/3266-3267.)

¹¹⁷ The psychotherapist's letter was not bated stamped; it was not found within Pt. J's medical records (Exhibit 43). There is a handwritten date on it of "2/18/08" with some initials that likely means the date of its receipt by Dr. Ogoke's office.

renewal form was completed listing Pt. J's last UDS as positive for Marijuana. The form also noted Pt. J had a prior narcotics agreement violation for which she was treated by an addiction specialist. Dr. Herard gave Pt. J a physical examination. Addressing with Pt. J the Marijuana found from her UDS results, Dr. Herard emphasized with her the importance of being compliant with the terms of her narcotics agreement. Pt. J wrote a note that she wanted to remain in this pain management practice. She promised to stop using illicit drugs. Dr. Herard was aware that she continued to treat with Valley Psychiatric Service where they wanted her to continue with her pain management regimen despite the Marijuana found in her UDS results. At this visit, Dr. Herard prescribed Methadone 10 mg., 4 every 12 hours (240) (long-acting) and Oxycodone 30 mg., every 6 hours (short-acting). He explained to Pt. J that these medications could be titrated if necessary. He wrote in his report that she would likely get an SI injection at her next month's visit. Dr. Ogoke also signed this report. (Exs. 16 & 18. Ex. 43; 207-209/2970-2972 & 498/3261.)

37. On March 28, 2008, Pt. J was seen by Dr. Herard. She was scheduled to have a bilateral SI injection with fluoroscopy with Dr. Herard, but this was not done. An opioid renewal form was completed, noting that the results from her last UDS were pending, but that she had a prior narcotic agreement violation, and had been cleared by an addiction specialist. She had been having UDS results that continued to show use of Marijuana. Dr. Herard gave a physical examination and diagnosed chronic lumbar facet joint dysfunction aggravated by her degenerative disc disease and radiculitis. Dr. Herard and Dr. Ogoke discussed whether Pt. J should continue to receive pain management care at Dr. Ogoke's office. They considered her underlying health conditions, including her anxiety and depression, and her violations of her narcotics agreement. They knew that Pt. J's Valley Psychiatric Service caregivers wanted her to

continue to receive pain medication. Dr. Ogoke and Dr. Herard agreed that all Pt. J would now be offered would be interventional procedures to help control her pain, and she would no longer receive pain medication from them. Dr. Herard told this to Pt. J. She became upset at this decision. She wanted to receive pain medication as well as the interventional treatments. Dr. Herard explained that to help her transition to another caregiver for pain management, she could receive thirty days of medication. She was upset and refused this solution. Dr. Herard gave her about ten minutes alone to calm down and to consider this development. When he returned to her, she had left the office. Dr. Herard wrote in his report of this visit:

[T]his patient would be better off at another clinic and having her pain management with softer medications that will protect her health. The patient was made aware of that and she opted to leave the clinic. I offered her medication for a month, but she declined. I gave her 10 minutes [alone] for anger management, but when I went back to the room, the patient had left. It is unfortunate that after so many years the relationship with this patient is terminated. She had received a number of treatments here and we wanted to give her the benefit of the doubt and give her the best treatment available. She may come back to get a one-month supply [of pain medication] ... and we will be glad to assist her with whatever treatment she needs in the future.

Dr. Ogoke signed the report. (Ex. 17. Ex. 43; 201-205/2964-2968 & 496-497/3259-3260.

Testimony of Pt. J, Vol. I, 184-185.)

38. On April 28, 2008, Dr. Ogoke's office received a request for Pt. J's medical records from Pioneer Spine & Sports Physicians. The records were mailed July 11, 2008 along with Pt. J's medical records release form signed April 28, 2008. (Ex. 43; 17-18/2780-2781 & 206/2969.)

39. Over the course of her care at Dr. Ogoke's office, Pt. J found the office to often be very crowded. She recalled a fish tank and candy left out in the wait area. She would use the bathroom off the wait area and found it often messy from frequent use. She found that the medical assistant staff changed fairly frequently over her years of care. Pt. J recalled a time when she heard someone who she believed was Dr. Ogoke "yelling," from either the procedure

or exam room. She recalled asking Dr. Ogoke about her diagnoses one time early in her care with him; she did not get what she considered direct answers and she was annoyed by this. She recalled not asking him again. She would be seen or treated in an examination room and in a procedure room. Many of the injection procedures caused her pain until the needle was removed. She would be positioned on her stomach to receive the injection procedures with a pillow under her that she sometimes used to bite into due to her experience of pain during a procedure. Some injection procedures did not last as long as others. She had periods of time when her medications seemed not to be effective at pain relief, and she thought they were not working because she was becoming tolerant to them. At such times, she would ask for a stronger dose or some change in her medications. When she was terminated from care, Pt. J did not line up another caregiver. After her medications ran out, she started feeling nauseous and sweaty. She experienced what she thought were withdrawal symptoms and she sought detoxification treatment. Pt. J understood that by signing Dr. Ogoke's narcotics agreement, she could be terminated from care if she used illicit drugs or stopped being compliant in taking her medication. She understood that the urine specimens she gave at Dr. Ogoke's office would be analyzed to see if she was in compliance with taking her prescribed medications and if she was using illicit drugs. Pt. J had not wanted to stop getting the pain medications she had been receiving when Dr. Ogoke and Dr. Herard terminated her care. (Testimony of Pt. J, Vol. I, 145-150, 154-155, 158-166.)

40. As a general practice, in his reports of visits with Pt. J, Dr. Ogoke did not list the specific dosages or names of the medications, including the opioids, he prescribed for Pt. J. His office practice was to keep a copy of the actual prescription within the patient's medical records. This is what he and his office staff followed with Pt. J. Almost every prescription written for Pt.

J was found within her medical records. Dr. Ogoke would not routinely explain within visit reports why Pt. J continued to be prescribed opioids and in the on-going doses, after she had a positive UDS result for an illicit drug or when she had a negative UDS result for a narcotic being prescribed. Instead, there would be references to Pt. J receiving counseling by an addictionologist or by a psychiatric service provider for her improper taking of her prescribed medications and her taking of illicit drugs. Within Pt. J's medical records were reports from these specialists viewed by Dr. Ogoke's practice as clearing her for continued opioid prescriptions, or in the case of Valley Psychiatric Service, requesting that Dr. Ogoke and Dr. Herard continue to prescribe Pt. J her ongoing narcotic pain medications due to a severe risk that she would engage in alcoholism that could result in her death. (Ex. 43.)¹¹⁸

41. Concerning his prescribing of opioids to Pt. J, Dr. Satwicz opined that Dr. Ogoke violated the standard of care in not listing in his reports of Pt. J's visits, the name and dosage of a medication, and a discussion explaining its intended use for pain management. Dr. Satwicz concluded that not doing this meant a subsequent medical caregiver could not, without a lot of work pouring through Pt. J's medical records, uncover copies of the prescriptions Dr. Ogoke and his physician assistant staff prescribed at a particular visit. Because the copies of the prescription sheets kept in Pt. J's medical records were not always sufficiently legible, Dr. Satwicz saw this as further support for his conclusion that Dr. Ogoke's recordkeeping violated the standard of care. Dr. Satwicz also opined that Dr. Ogoke violated the standard of care by continuing to prescribe opioids to Pt. J after she had UDS results positive for illicit drugs; that prescribing narcotics after such UDS results should not have continued as long as it did. Dr. Satwicz opined that visit reports did not adequately explain why continued prescribing of opioids in the face of

¹¹⁸ Her psychiatric services provider made this request on more than one occasion.

use of illicit drugs by Pt. J was allowed, and that doing so was violating the standard of care. (Testimony of Dr. Satwicz, Vol. X, 1995, 1999, 2004, 2006-2008; Vol. XIII, 2582-2583, 2586.)

42. Concerning his prescribing of opioids to Pt. J after she had UDS results positive for illicit drugs, Dr. Trescot concluded, on the particular course of events involved, that Dr. Ogoke did not violate the standard of care by not terminating care with Pt. J much sooner than he did. Dr. Trescot opined that Dr. Ogoke acted reasonably in referring Pt. J to care her psychiatric care providers and/or to detoxification centers, in order to get her back on track with compliance in the use of her prescribed medications and in avoiding any illicit drugs. Dr. Trescot noted that once Pt. J engaged in this care, Dr. Ogoke continued to prescribe her opioid medication for her severe on-going pain while also providing her with injection procedures to also address her pain. Dr. Trescot understood from Pt. J's medical records, that prior to the time of Pt. J's termination from care by Dr. Ogoke and Dr. Herard (who had begun treatment of Pt. J), she was in treatment for her use of Marijuana at Valley Psychiatric Service. The use of Marijuana was uncovered from a number of UDSs that she had, although her use of Cocaine had stopped being detected in the many UDSs she had. Pt. J showed Dr. Ogoke's office, a letter from Valley Psychiatric Service asking that Dr. Ogoke and Dr. Herard keep her on her pain management regimen, including the opioids, because doing so was keeping her pain under control so that she did not turn to alcoholism, a condition that a few years earlier had been life-threatening to her. She was also experiencing a better quality of life. Valley Psychiatric Service had been treating Pt. J for her mental health conditions. Dr. Trescot concluded that Dr. Ogoke's visit reports on Pt. J contained information showing that Dr. Ogoke and Dr. Herard were closely monitoring Pt. J's use of her prescribed pain medications and whether she was taking illicit drugs. They were also ensuring that Pt. J undergo the interventional procedures that were always a part of her agreed

upon treatment plan. When the ongoing UDSs were not showing compliance with staying away from the use of Marijuana, even after she agreed to not take Marijuana anymore, and even following a time period in reliance on the advice of Valley Psychiatric Service caretakers to continue her pain medications, Dr. Ogoke and Dr. Herard both agreed to terminate care of Pt. J and stop prescribing her narcotic pain medication. Pt. J could still seek interventional treatments at Dr. Ogoke's office. Pt. J would not agree to that, and wanted to continue with her opioid pain medications. Dr. Trescot opined Dr. Ogoke acted appropriately and within the standard of care in not terminating more abruptly his care of Pt. J. (Testimony of Dr. Trescot, Vol. XV, 2896-2914; Vol. X, 3222-3224.)

43. In her complaint against Dr. Ogoke that she filed with the BORM in April 2008, Pt. J wrote that she had just come out of detoxification care. From her perspective, problems began in December 2007 and continued until Dr. Ogoke terminated her care. She described Dr. Ogoke in this complaint as a "lunatic flying back [and] forth ... sweats profusely, and is extremely agitated." Pt. J asserted in her complaint that she does not have a Marijuana or Cocaine problem. She believed she was treated terribly when she was terminated from care by Dr. Ogoke. Pt. J maintained that she "did everything he [Dr. Ogoke] told me to [do] and he still threw me out." She wrote in her complaint: "I was told if I'd sign my own letter of termination, I would be given two months of medications, anything I wanted." Pt. J acknowledged in her complaint that Dr. Ogoke told her to "get notes from my therapist and my psychiatrist that it would be okay to treat me," if I wanted to resume care with him. Pt. J wrote in her complaint that she asked Dr. Ogoke to "detox me," and that did not happen. (Ex. 83.)

44. Pt. J never asked Dr. Ogoke or Dr. Herard to taper her off her opioid medications upon her termination of care with Dr. Ogoke and Dr. Herard. (Ex. 43)

Conclusion and Recommendation

The BORM charged Dr. Ogoke with failing to identify in his visit reports on Pt. J, the details of the prescriptions he wrote, and did not explain why he made certain medication adjustments. The BORM further charged Dr. Ogoke with continuing to prescribe opioid medications to Pt. J even after UDS results showed she had taken illicit drugs. I did not find the first charge was proven by the BORM. I did find Dr. Ogoke had violated the standard of care in not timely ending his care of Pt. J in light of her UDS results that were positive for Cocaine and her admission to taking Cocaine, and for her continued use of Marijuana.

Pt. J was subpoenaed to testify and was the BORM's witness. On cross examination, she was asked questions that dealt with whether or not she had used illicit drugs while under the care of Dr. Ogoke and Dr. Herard to which she pled the fifth amendment and did not answer these questions.¹¹⁹ As a result, I did not have testimony from her that she did or did not use Cocaine or Marijuana, the two illicit drugs her medical records indicate she had used. In making my findings of fact concerning whether Pt. J had used these illicit drugs while being treated by Dr. Ogoke's practice, I did not draw an adverse inference against her for refusing to answer these questions. My findings of fact showing that she did use these illicit drugs were sufficiently supported by her medical record information. These records contained: her written statements admitting her use of Cocaine; her statements to Dr. Ogoke's physician assistant admitting use of Cocaine; her statements to the addictionologist who evaluated her; her psychiatric caregivers asserting her use of Marijuana; her sister's written plea to Dr. Ogoke to not prescribe her narcotics due to her alcohol and addiction issues; and, the UDS results showing her use of these illicit drugs on multiple occasions. I also found that Pt. J was not a consistent historian

¹¹⁹ Pt. A had no attorney and did not want to postpone her testimony in order to consult with an attorney about this issue. She was given time off the record to talk to the BORM counsel about this issue. Both parties treated her pro se effort to assert her fifth amendment privilege with respect.

concerning her care at Dr. Ogoke office, and that her recollections about what happened with her care were not always found to be sufficiently reliable to support the claim she was making when contrasted against the information found within her medical records, or her claims were not at all or sufficiently corroborated by any other evidence. Instead, I more often than not, followed what her medical records revealed. Dr. Ogoke was not specifically asked all that much specifically about his care of Pt. J to demonstrate in any way that his care was inconsistent with the medical records kept on Pt. J.

In terms of my reliance on Pt. J's medical records information, I found more difficulty deciphering dates and legibility of handwritten visit reports for Pt. J than I had with other medical records of patients listed in the Statement of Allegations. That is why I have many footnote comments concerning my findings of fact about what happened to Pt. J on a number of the visits. Nevertheless, I was able to establish a course of events in the treatment of Pt. J with Dr. Ogoke, with his physician assistant staff, and with Dr. Herard, to be able to sufficiently address whether the facts supported the claims made concerning Dr. Ogoke violating the standards of care with Pt. J.

As with other of the patients listed in the Statement of Allegations, Dr. Ogoke's practice was not to routinely include the details of a patient's particular prescriptions within the report of an office visit. Nevertheless, there is insufficient proof that to do so was always a required practice for Massachusetts physicians during the time period he treated Pt. J. Dr. Ogoke's practice during this time was to add a copy into Pt. J's medical records of the actual prescription written at any particular visit. In my review of Pt. J's medical records, I almost always was able to locate a fully legible copy of the prescription written to connect to the date of a particular visit Pt. J had at Dr. Ogoke's office. No evidence established that Dr. Ogoke's practice was to attach

the copy of the prescription to the report of the office visit when the prescription was written, and there was no evidence that addressed whether Dr. Ogoke's practice was to have a patient's medical records kept in chronological order to aid in locating the particular copy of the prescription or other important documents, such as a test result discussed within a visit report. The presentation of the medical records for all the patients listed in the Statement of Allegations was sloppy and without any clear and reliable order demonstrating why any particular page followed a prior page. I did not find sufficient proof to conclude that Dr. Ogoke maintained inadequate or hard to follow full accounts of a patient's care at any particular visit: I just had medical records copied onto a disc (Exhibit 43) in no order and often with faint copies.

The drug prescribing guidelines in place while Dr. Ogoke treated Pt. J did not require that Dr. Ogoke include in visit reports the details of a prescription he or his physician assistants wrote at a particular office visit. When I reviewed the copies of the prescriptions, they contained the details that the BORM contends should have appeared within the office visit reports.

A few times I could not decipher a copy of a prescription I located within Pt. J's medical records. This appeared to be due to the copy being copied too faintly. And, a few times, the date of prescriptions was erased from what seemed to be due to redacting the patient's name on the prescription. This issue was found in Exhibits 18 and 43.

Dr. Satwicz's main reason why he found a violation of the standard of care with Dr. Ogoke's visit reports is that he could not, by examining a visit report, gain sufficient information about the current health status and current treatment situation for Pt. J, including the reasons for a chosen course of care or course of prescribing. A visit report would not routinely address the reaction to a specific event such as a UDS positive for the use of Cocaine or Marijuana, which mattered because often opioids continued to be prescribed. Dr. Satwicz wanted to have

combined within one visit report, all the underlying medical record documentation related to that visit along with a useful assessment of all the known data.

Dr. Satwicz opined that this lack of sufficient discussion and data within the visit reports was practicing below the standard of care. It is understandable why he reached that conclusion. Even when I was able to assemble all the medical information pertinent to a particular visit report, I concluded that UDS results showing Pt. J was not taking her prescribed medications and was at times found to have used Cocaine and Marijuana, were not adequately addressed within the visit reports in terms of explaining why Pt. J continued to be prescribed opioid medications. This happened too often during Pt. J's care. Dr. Ogoke explained how during the time period he treated Pt. J and gave her UDS tests, that he experienced long delays in his receipt of UDS results. I found that credible and took that into account. Nevertheless, these UDS results were received even if later than close in time to the specimen dates. In addition, Pt. J made admissions about her illicit drug use. She had hospitalizations showing poor impulse control over drug and alcohol use. Her sister highlighted her concerns that Pt. J was a drug abuser.

Even when all this was known, Pt. J was not tapered-off her opioid medications. For certain time periods, Pt. J was not compliant in having her timely interventional procedures, further complicating her pain control. Pt. J's psychiatric care providers wanted Dr. Ogoke and Dr. Herard to continue to give Pt. J pain control medication so that she would not turn to alcohol abuse that they feared would imperil her health. This was an issue toward the end of her care only. It was not an on-going immediate concern in the years prior when Pt. J was also using illicit drugs at times and not being compliant with her prescription regimen or with her injection treatment regimen. For these reasons, and in reliance on Dr. Satwicz's expert opinion, I conclude that Dr. Ogoke violated the standard of care in continuing to treat Pt. J with opioid

medications for a long time period despite her use of illicit drugs on more than one or two occasions.

Pt. J's care with Dr. Herard and Dr. Ogoke continued after it was clear that Pt. J had not ended her use of Marijuana. I suspect this happened because of Valley Psychiatric Service's request that Pt. J continue with her ongoing pain management opioid prescription medications, and Pt. J's agreement to not use illicit drugs and to follow properly her treatment plan. She was given another chance to avoid a termination of care. But, by the close of March 2008, Dr. Ogoke and Dr. Herard both agreed that the issue of her use of Marijuana had not stopped based on her UDS results. As a result, Pt. J was informed that she would be offered only interventional treatments and would need to secure her pain medication with another provider. She was provided with the opportunity to have a thirty day supply of her on-going medications and to seek emergency care with Dr. Ogoke's office. Pt. J's complaint holds Dr. Ogoke responsible for what she believed to be withdrawal symptoms that were obviously going to occur due to her termination of care. Although Dr. Ogoke should have terminated his care of Pt. J sooner than he did, the BORM did not prove Pt. J's claim that Dr. Ogoke's conduct was responsible for her withdrawal symptoms. Pt. J had been provided with lists of area detoxification centers prior to her termination of care after she acknowledged use of Cocaine. She was aware that she needed to seek new pain management care after her care with Dr. Ogoke ended. She had no interest in tapering-off her opioid pain medications.

Patient K

Summary

Patient (Pt.) K did not testify.¹²⁰

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Prescribing high doses of opioids at Pt. K's initial evaluation at Dr. Ogoke's office without first performing a full physical examination.

The facts the BORM alleged to support its allegations include the following:

- Pt. K treated with Dr. Ogoke from September 2006 to December 2007.
- Pt. K complained of back, hip and leg pain, and was diagnosed by Dr. Ogoke with lumbar radiculopathy, lumbar strain, sacroiliitis, coccydynia, and sacral contusion.
- At Pt. K's initial evaluation with Dr. Ogoke's office, she received prescriptions for Morphine (MS Contin) 60 mg. to take twice a day, and Percocet 10/325 mg. to take up to four a day which were excessive doses of opioids for Pt. K's clinical condition.
- The initial evaluation of Pt. K was reported as including a very detailed physical examination, but Dr. Ogoke never did that detailed physical examination at that time.
- Dr. Ogoke treated Pt. K with a combination of opioid pain medication that included Morphine and Oxycodone, and gave Pt. K multiple interventional treatments including sacroiliac joint injections and lumbar transforaminal epidural steroid injections.
- Pt. K's injections were painful and she would bite down on a towel when receiving them to stop her from screaming out.
- When Pt. K told Dr. Ogoke she no longer wanted to receive interventional treatments/injections, Dr. Ogoke informed her, in that case, she would not receive her pain medication from him.

Findings of Fact

1. Pt. K was forty-three years old when she began care with Dr. Ogoke on September

¹²⁰ In the Petitioner's brief, there are references to Pt. K's complaint to the BORM and to Exhibit 83, the complaints to the BORM of the patients listed in the Statement of Allegations. There is no Pt. K complaint. This was confirmed in a subsequent correspondence from the Petitioner filed after the brief was filed.

20, 2006. She was referred to Dr. Ogoke by her primary care physician (PCP) who had been treating her for injuries sustained during a slip and fall on ice in January 2006, hurting her tailbone and back. From that time, she had pain in her low back that radiated into her right leg. She had been taking only over-the-counter medication for her pain symptoms. She was a college art professor and studio art instructor who had to be on her feet for long periods of time while teaching and instructing. She had a past surgical history that included a left foot fracture, bilateral knee surgeries, removal of spinal and ovarian cysts, and removal of a pilonidal cyst. She had hypothyroidism, which can cause changes in metabolizing medications. She was a smoker. By September 20, 2006, Pt. K's pain complaints were of constant aching pain, intermittent shooting pain with spasms, and some sharp and cramping pain. She reported that the symptoms worsened when bending or standing. She had pain using stairs. Due to her pain, she had trouble sleeping. She was able to do light yoga stretches. She reported a pain level ranging from 5-6 to 9/10. She was not teaching during the fall 2006 semester as a result of her pain symptoms. She reported that the pain had negatively impacted all parts of her life. (Ex. 43, 22-29/3357-3364. Testimony of Dr. Trescot, XV, 2916-2918.)

2. Dr. Ogoke's office protocol required new patients to complete a number of forms including a long patient questionnaire to provide background information on the patient's medical and social history, pain complaints, medications taken, and prior treatments. At the initial visit, a patient received a comprehensive physical examination that included a review of systems. At this September 20, 2006 visit, Pt. K completed this questionnaire and Dr. Ogoke gave her a review of systems and comprehensive physical examination. Within the treatment plan section of this evaluation, was the following: "Patient is seen and evaluated by Dr. Ogoke ... Treatment plan developed by Dr. Ogoke ... PA-C dictating for Dr. Ogoke." Dr. Ogoke

signed this report. (Ex. 43: 22-29/3357-3364; 107/3442 & 109-119/3444-3454. Testimony of Dr. Ogoke, Vol. VII, 1433-14344 & Testimony of Dr. Trescot, Vol. XV, 2915-2920.)¹²¹

3. On her initial questionnaire form, Pt. K reported she was currently taking Levoxyl, Zyrtec, and Naprosyn medications. During the physical examination, Dr. Ogoke observed that Pt. K did a lot of guarding when the areas of her pain complaints were examined. The impressions Dr. Ogoke reached were: lumbar radiculopathy with a need to rule out any disc herniations; lumbar strain; sacroiliitis; coccydynia; and, sacral contusion. The treatment plan was to do neurometer lower extremity testing to investigate the radicular pain and to have a lumbar MRI. She was prescribed EC Naprosyn¹²² (60), Skelaxin 800mg. (90), Percocet 7.5/325 mg. (90), Elavil 25 mg. (60), and Ativan 2 mg. (2) to take prior to having a lumbar MRI in light of her experience of anxiety during a prior MRI.¹²³ The treatment plan included scheduling a bilateral sacroiliac joint (SI) injection as soon as possible, then scheduling lumbar transforaminal epidural steroid injections (ESI), followed by a review of her condition to determine the effectiveness of the injection procedures in providing her with pain relief. After that, the treatment plan was to consider doing facet joint injections, and physical therapy treatments. This initial evaluation included a discussion with Pt. K about the complications, benefits, and alterations of care under the treatment plan. Pt. K agreed to the plan. Among the forms she completed, reviewed and signed in undertaking pain management care with Dr. Ogoke was the Narcotics Prescription Policy & Agreement (narcotics agreement). (Ex. 43: 22-29/3357-3364;

¹²¹ In its brief, the BORM referred to Pt. K's complaint to the BORM that Dr. Ogoke never gave her an initial physical examination. But, as noted in footnote 1, I never received any such complaint. (Exhibit 83.)

¹²² I could not decipher the milligram strength of the EC-Naprosyn on the copy of the prescription. (Ex. 43, 100/3435.)

¹²³ Although the Statement of Allegations at #s 165 and 166 assumes that Dr. Ogoke, prescribed MS Contin 60 mg. to take twice a day on September 20, 2006, this did not occur.

100-104/3435-3439; 107/3442 & 109-119/3444-3454. Testimony of Dr. Ogoke, Vol. VII, 1428-1429, 1431, 1433-1434 & Dr. Trescot, Vol. XV, 2915-2920.)

4. Pt. K had a hypothyroid condition. Dr. Trescot opined that this “leads to changes in the metabolism of medications and increased risk of muscle pains from myofascial pain and propensity for weight gain.” (Testimony of Dr. Trescot, Vol. XV, 2916.)

5. After reviewing on September 20, 2006 Pt. K’s background questionnaire information and the results from her comprehensive initial evaluation, Dr. Ogoke decided that she should have a lumbar spine MRI and neurometer testing to provide more information about what was producing her pain symptoms. For Dr. Satwicz, prescribing so many medications to Pt. K at the first evaluation with Dr. Ogoke might have caused Pt. K to have adverse reactions in light of her hypothyroidism condition. He was concerned that Skelaxin was prescribed because Pt. K did not show evidence of intense muscle spasm that this medication is used to treat, and because Skelaxin can be abused as it is a sedative. Dr. Satwicz explained:

To start four different medications at one time is a problem ... [P]roviding Naprosyn which is a non-steroidal; Skelaxin, also a relaxant; Percocet, the combination of Oxycodone and Acetaminophen; and Elavil, a tricyclic anti-depressant, all at one time is in my view inappropriate because ... each one has its own side effect profile, each one can cause problems and when we put them altogether if the patient had an allergic reaction to something, had an untoward effect to something, we wouldn’t know which of them ... caused it ... So it’s adding a lot of medicine at one time when it would be proper care to start one at a time, see what we get out of that and then add another medication.

(Testimony of Dr. Satwicz Vol. X, 2014-2015, 2019-2021.)

6. Dr. Trescot opined that Dr. Ogoke had properly prescribed the medications he did for Pt. K at her first visit. Pt. K was in pain not relieved by using over-the-counter medication. Because of this, Dr. Trescot thought that prescribing these pain relief medications at the initial evaluation, was proper. (Dr. Trescot, Vol. XV, 2918.)

7. Pt. K had a lumbar MRI on September 28, 2006 that showed minimal anterolisthesis of L4 and L5, likely due to degenerative changes. No significant central canal or foraminal narrowing was detected. (Ex. 43, 91-92/3426-3427.)

8. Pt. K returned to Dr. Ogoke's office on September 29, 2006. She reported a pain level of 6/10 in her low back. She wanted an early refill of her Percocet prescription. She was taking extra Percocet 7.5/325 mg. tablets each day to better control her pain and not following her prescription. She reported an upset stomach with nausea when she took the Percocet and Skelaxin at the same time. The results from her lumbar MRI were not yet available. She had a physical examination. Because she had misused the Percocet and had the stomach upset from taking medication without food, she wrote this in a note that went into her medical records. In addition, she was counseled at length about the need not to violate the narcotics agreement that required her to take her medications only as prescribed. Pt. K explained that she only took the Percocet more frequently in order to get better control over her pain. As a result of her pain complaint relieved by taking more Percocet and her agreement to take the Percocet only as prescribed, her dose of Percocet was increased to 10/325 mg. She received only 45 tablets to keep her time for refilling the Percocet prescription the same as for refilling her other medications. She was advised to have food when taking her medications. The treatment plan was to consider prescribing a long-acting medication if Pt. K's pain did not improve. A UDS was done. The note Pt. K wrote on September 29, 2006 read:

When I started taking the medicine for my back I was experiencing upset stomach. I then called for an appointment. I have since been sure to eat with my medicine so I don't get sick. Also when I first started taking the Percocet, it didn't seem to be working, so I was taking two pills. It seems to be working now. I am able to be more active physically with minimal pain with the medicine.

On October 2, 2006, the results of the UDS were positive for Oxycodone (the Percocet).

prescribed). No non-prescribed or illicit drugs were detected. (Ex. 43; 18-21/3353-3356 & 93-99/3428-3434.

9. From his review of Dr. Ogoke's early treatment of Pt. K, Dr. Satwicz concluded that Pt. K had been overprescribed opioids and pain medications, especially because she had come to Dr. Ogoke's care without prior ongoing use of anything for pain other than over-the-counter medications. He was particularly concerned that she reached Percocet 10/325 mg. so soon for the kind of clinical pain complaints she had. He explained:

[S]tarting at the higher dose [of Percocet] is unusual for somebody who had not been on any pain medication at all ... an opioid naïve patient ... so to start with the stronger than baseline Percocet is not appropriate.¹²⁴

Unlike Dr. Satwicz, Dr. Trescot was aware that Dr. Ogoke initially prescribed the lower dose of Percocet 7.5/325 mg. for Pt. K. She opined that prescribing the higher dose of Percocet on September 29, 2006 was within the standard of care and was not overprescribing, based on the circumstances Pt. K presented at this follow-up visit. Dr. Trescot thought it acceptable that the effort was made to try to find an effective dosage of Percocet to lessen Pt. K's overall pain level, while carefully counseling her to use her medications only as prescribed and adding more monitoring of her use of medications, including having Pt. K write out a statement acknowledging her overuse of the initial Percocet prescription. (Testimony of Dr. Satwicz Vol. X, 2020 & Dr. Trescot Vol. XV, 2921-2923.)

10. While in Dr. Ogoke's care, Pt. K's treatment plan included undergoing interventional procedures along with receiving pain medications. The purpose of the interventional procedures was to direct medication through injections to the areas of her body that were triggers for her

¹²⁴ Dr. Satwicz provided this opinion not realizing at the time he answered the question asked of him, that Pt. K had been started on the lower Percocet dose of 7.5/325 mg. on September 20, 2006, with the increase to 10/325 mg. on September 29, 2006. The date of September 29, 2006 for the higher dose of Percocet is very clear. (Ex. 43, 99/3434.)

pain with a goal of securing more effective pain control with less dependence on pain medications. Pt. K, like all his patients having interventional procedures, would sign a form that described the procedure as well as a consent to have the procedure. (Ex. 84; Dr. Ogoke Interview, 12-14, 23, 36-38, 64-69, 77-82, 134-140, 144, 147-148, 150-151, 158-160 & 163.)

11. Pt. K had a neurometer test done on October 19, 2006. Also on this date, Dr. Ogoke gave Pt. K a bilateral SI injection with fluoroscopy. She reported a pain level at 6/10 at this visit. She was prescribed Percocet 10/325 mg. (90), Skelaxin 800 mg. (90), and EC Naprosyn 375 mg. (60). An order for blood work was made. (Ex. 43: 15-17/3350-3352; 86-90/3421-3425 & 150/3485.)

12. On October 30, 2006, Dr. Ogoke gave Pt. K a lumbar transforminal ESI with fluoroscopy at levels L4, L5 and S1 on the right side. This was for her lumbar radiculopathy. Pt. K came to this visit reporting radiating low back pain at a 4-5/10 level. She reported pain relief from the SI injection, but found the pain returned as she increased her activity level. Dr. Ogoke reviewed the lumbar MRI as showing "mild facet arthrosis at multiple levels from L1-2 down to L5-S1, as well as evidence of spondylolisthesis at L4 upon L5 with an anterior distribution (anterolisthesis) with uncovering of posterior margin of the disk ... associated with central canal stenosis with minimal narrowing." He concluded:

[This] pathology might require her to undergo flexion and extension films of the lumbosacral area to evaluate for instability of that spondylolisthesis ... [H]er pain has multiple origins, including sacroiliac joint mediated pain, facet mediated pain, and nerve root mediated pain.

Dr. Ogoke opined that Pt. K could benefit from lumbar transforaminal ESIs to the nerve root with a review of Pt. K's overall response after that to determine if repeating such procedures would be warranted, or whether to do a lumbar facet injection. Dr. Ogoke discussed these findings and proposed procedures with Pt. K. He performed a physical examination at this visit.

He diagnosed: lumbar radiculopathy; sacroiliitis; lumbar spondylolisthesis at L4-5; lumbar spinal canal stenosis at L4-5; lumbar facet arthropathy; and, coccydynia. The treatment plan was to do another SI injection as soon as possible. A UDS was done. Her prescriptions were renewed, including Percocet 10/325 mg. (90).¹²⁵ The need for her to be compliant in taking her medications as prescribed was again discussed with her. The result of the last UDS was positive for Oxycodone. (Ex. 43: 10-14/3345-3349; 81-85/3416-3420; 148/3483; 152/3487 & 154-155/3489-3490.)

13. On November 8, 2006, Pt. K was given a prescription for Ativan 2 mg. (2) to take in connection with an upcoming interventional procedure because she had a needle phobia. On November 10, 2006 Dr. Ogoke gave Pt. K a lumbar transforaminal ESI with fluoroscopy at the L4, L5 and S1 levels. On December 6, 2006, Pt. K had a follow-up visit with Dr. Ogoke. She reported a pain level of 6/10 in her lower back, right hip, and right leg. She reported having a 50% benefit in pain relief after having the lumbar transforaminal ESI. She wanted pre-medication for undergoing her next one. A physical examination was given. Another UDS was done. These UDSs were done to ensure Pt. K's continued compliance with the narcotics agreement to only take medications as prescribed and not to take any illicit drugs. She was prescribed Actiq 600 mcg. (2) and Ativan 2 mg. (2), both to get through the upcoming ESI procedure.¹²⁶ Upon subsequent evaluation, and if needed for pain control, a facet block diagnostic procedure was under consideration. (Ex. 43: 6-8/3341-3343; 138-139/3473-3474; 142-144/3477-3479 & 151/3486.)

14. Dr. Satwicz appreciates that using a pre-medication before having an interventional

¹²⁵ I could not locate within Pt. K's medical records (Exhibit 43) more than the prescription for Percocet on October 30, 2006.

¹²⁶ I could not locate a copy of the prescriptions for the Actiq or Ativan for December 6, 2002, but the precise dosages and amounts were listed within the visit report. (Ex. 43, 6-7/3341-3342.)

procedure can be appropriate, such as the limited use of Ativan for anxiety for a patient having trouble staying still during a procedure that will be lengthy. Dr. Satwicz opined that Actiq would relieve pain during a long procedure, but was not indicated for use with helping Pt. K during her interventional procedures because Actiq is a powerful fast-acting drug for cancer pain that Pt. K did not need for her clinical condition. Dr. Ogoke made limited use of Actiq limited to help only a patient, such as Pt. K, through an interventional procedure. Dr. Ogoke explained that “Actiq is a prophylactic measure which falls under “conscious sedation.” He prescribed Actiq in connection with interventional procedures “to reduce the pain or discomfort a patient will perceive because it’s an opioid and it’s delivered transmucosally ... [It reduces] the experience of pain,” and not necessarily because the injection procedures are inherently very painful. Using Actiq “allows the patient to have a higher pain threshold and [be] calm with the medication.” Dr. Trescot opined, that at the time Dr. Ogoke treated Pt. K, Actiq was being used by pain management specialists for non-cancer pain, and that this limited use of it for the interventional procedure was not outside the standard of care or irresponsible prescribing. Dr. Trescot opined that the Ativan was for Pt. J’s anxiety about needles and the Actiq was to help her if she felt pain during the procedure. (Ex. 84, 165-168. Testimony of Dr. Satwicz, Vol. X, 2017-2019, 2023-2026; Dr. Ogoke, Vol. VII, 1434-1435 & Dr. Trescot, Vol. XV, 2924-2927.)

15. Pt. K was seen at Dr. Ogoke’s office on December 20, 2006. Pt. K reported a pain level of 8/10, despite relief from her pain medications. Due to a funeral, “concern over discomfort related to injection,” and her son being hit by a car requiring her attention, she did not have her scheduled interventional procedures, missing three of them. Nevertheless, she had been compliant with the treatment plan, and she wished to proceed with the interventional procedures. At this visit, Pt. K explained that she had not been able to secure her full prescription amount of

Percocet from her pharmacy and was seeking a prescription to cover what she had not received. She had received only 72 Percocet tablets and not 90 as prescribed. She wrote a letter explaining this request. The December 20, 2006 Percocet prescription was written to receive (48). She was prescribed Ativan 2 mg. (2) for pre-procedure anxiety. Pt. K was also seeking an increased amount per month of Percocet to take due to the increase in her back pain. As a result of this evaluation, the decision was made to prescribe Pt. K an increase in Percocet 10/325 mg. from (90) to (120), although the increase was viewed as possibly only a temporary increase. The plan was to schedule these interventional procedures as soon as possible. A UDS was done.¹²⁷ (Ex. 43; 76-78/3411-3413 & 135-137/3470-3472.)

16. On January 5, 2007, Pt. K was seen by Dr. Ogoke complaining of an increased pain level of 9/10, despite being compliant in taking her medications. She was having poor pain control with her current medications. Dr. Ogoke gave a physical examination. Pt. K was not yet scheduled for the lumbar transforaminal ESI series or for the SI injection because of renovations at Dr. Ogoke's office. Pt. K had no "long-acting opioids," and Dr. Ogoke decided to prescribe her MS Contin 60 mg. to take every 12 hours. The MS Contin would provide Pt. K with long-acting pain relief covering most of her pain while the Percocet would be for short-acting pain relief for breakthrough pain. Her overall progress with pain management would be monitored with this new medication regimen. A UDS was done.¹²⁸ Dr. Ogoke wrote in his report on this visit about the need to do close monitoring of Pt. K's use of medications. She was also prescribed Actiq 600 mcg. (2) for upcoming interventional procedures. Other prescriptions

¹²⁷ I could not locate or decipher the UDS results from the December 20, 2006 urine specimen within Pt. K's medical records (Exhibit 43).

¹²⁸ I could not locate or decipher the UDS results from the January 5, 2007 urine specimen within Pt. K's medical records (Exhibit 43).

written on January 5, 2007 were for Skelaxin 800 mg. (90) and Elavil 25 mg. (60).¹²⁹ Pt. K was seen at Dr. Ogoke's office on February 1, 2007. She reported a pain level of 8/10. The interventional procedures had still not been scheduled. A physical examination was done. She was prescribed EC Naprosyn 375 mg. (60), Skelaxin 800 mg. (90), Elavil 25 mg. (60), Percocet 10/325 mg. (120), and MS Contin 60 mg. (60). A UDS was done. The UDS results from February 3, 2007 were positive for the opiates she was taking with no use of illicit drugs detected. (Ex. 43: 71/3406; 74-75/3409-3410; 127-130/3462-3465 & 133-134/3468-3469.)

17. Dr. Satwicz opined from his review of Pt. K's medical records, that Dr. Ogoke was starting out Pt. K with too high opioid doses and with no reason to be prescribing Actiq, even if for a procedure. He opined that this kind of prescribing was in violation of the standard of care; that Pt. K's clinical condition did not justify a need for such high opioid doses. Dr. Ogoke added the MS Contin for long-acting pain control with use of the Percocet for her breakthrough pain, because Pt. K was not experiencing good pain control and reported high pain levels. He was monitoring her use of these medications closely. Pt. K had been having normal UDS results at the time Dr. Ogoke prescribed the MS Contin, and not taking her prescribed medication improperly or using illicit drugs. Dr. Trescot opined that under these circumstances and the recognized need for close monitoring, that Dr. Ogoke had not violated the standard of care with this increase in opioid prescribing for Pt. K's pain. (Testimony of Dr. Satwicz, Vol. X 2014-2015, 2019-2020, 2026; Dr. Trescot, Vol. XV, 2927-2929 & Dr. Ogoke, Vol. VII, 1438.)

18. Pt. K was seen on March 2, 2007 by Dr. Ogoke. She reported a pain level of 5/10. She felt her radicular pain was 70% improved which she attributed to the lumbar transforaminal

¹²⁹ I could not locate in Pt. K's medical records (Exhibit 43) copies of the prescriptions written on January 5, 2007 for Percocet or for MS Contin.

ESI.¹³⁰

[She] reports that the radicular pain to the lower extremities has markedly improved by about 70 percent since her last procedure, which was a transforaminal epidural steroid injection ... has no coccyx area pain and describes pain that involves the right hip region, low back area and also the middle portion of the right thigh, laterally only. She no longer continues with radiculopathy. She feels that she is making progress. She is also compliant to her oral medications.

Unfortunately, Pt. K was having insurance issues regarding coverage of the interventional procedures. Dr. Ogoke gave a physical examination. The treatment plan was to do another SI injection and a lumbar transforaminal ESI as soon as possible once her insurance coverage issues were resolved. Pt. K did not have the funds to pay privately for more injection treatments. A UDS was done. Her medications were renewed: EC Naprosyn 375 mg. (60), Skelaxin 800 mg. (90), Elavil 25 mg. (60), Percocet 10/325 mg. (120), and MS Contin 60 mg. (60). At an April 2, 2007 visit with Dr. Ogoke, Pt. K complained of a pain level of 8/10 in her low back and right hip region. An opioid renewal screen form was completed showing Pt. K's last prescriptions were from March 2, 2007 with no prior narcotics agreement violation. No information was listed concerning the results of her March 2, 2007 UDS. A handwritten note, later put into the typed visit report, states that there were no UDS results since December 6, 2006. The results reached on March 7, 2007 from the March 2, 2007 UDS specimen from the outside laboratory, Ameritex, did not show narcotics agreement violations. At this April 2, 2007 visit, Pt. K completed a brief pain inventory form. In the report of this visit, Dr. Ogoke concluded that Pt. K's "pain pattern has not changed significantly." He gave a physical examination. The treatment plan was to do the interventional procedures. A UDS was done. Dr. Ogoke renewed her medications of Elavil 25 mg. (60), Skelaxin 800 mg. (90), MS Contin 60 mg. (60), EC Naprosyn 375 mg. (60), and

¹³⁰ I could not locate or decipher a date when a lumbar transforaminal ESI was done between January 5 and April 2, 2007. Some of the procedure medical records for Pt. K (Exhibit 43) had no date visible on the copy that might have been due to efforts at redacting Pt. K's name or due to the copying process.

Percocet 10/325 mg. (120). At an April 30, 2007 visit with Dr. Ogoke, Pt. K reported a pain level of 7-8/10. An opioid renewal screen form was completed listing her last prescriptions as written on April 2, 2007, and showing that her last UDS was normal.¹³¹ No previous narcotics agreement violation was listed. Her new insurance coverage was to start at the end of May 2007. Dr. Ogoke gave a physical examination. He found Pt. K's pain pattern was the same. Her diagnoses remained the same. She sought a prescription for Valium as a muscle relaxant medication for slowing down the spasm in her low back. She reported her current pain medications were helping to control her pain, but continued to agree to have the interventional procedures once her insurance would cover them. A UDS was done. She was prescribed her ongoing medications: Skelaxin 800 mg. (90), Percocet 10/325 mg. (120), MS Contin 60 mg. (60), Elavil 25 mg. (60), and EC Naprosyn 375 mg. (60). (Ex. 43: 61-70/3396-3405; 72-73/3407-3408; 121-126/3456-3461; 170-173/3505-3508; 175-176/3510-3511 & 178-180/3513-3515.)

19. At a June 21, 2007 visit with Dr. Ogoke, Pt. K's insurance had not been settled, so she still had not had the planned for interventional procedures. An opioid renewal screen form was completed showing her last prescriptions were from April 30, 2007, and that her last UDS was pending. She completed a brief pain inventory form. She reported a pain level of 8/10 and muscle spasms in her back. Dr. Ogoke gave her a physical examination. He made no changes to his diagnoses. The treatment plan was to renew Pt. K's medications for 30 days and to do the interventional procedures once the insurance issue was settled. Dr. Ogoke prescribed MS Contin 60 mg. (60), Percocet 10/325 mg. (120), Elavil 25 mg. (60), Naprosyn 375 mg. (60), and

¹³¹ It is not clear whether that normal UDS was from March 2, 2007 or from April 2, 2007. Some of Pt. K's medical records (Exhibit 43) seemed to show UDS results but the copies were so faint I could not decipher them. It is not clear when Dr. Ogoke's office received the March 7, 2007 results from the March 2, 2007 urine specimen.

Skelaxin 800 mg. (90). A UDS was done. By a July 20, 2007 visit with Dr. Ogoke, Pt. K's insurance had been settled and the interventional procedures were to be scheduled for her as soon as possible. An opioid renewal screen listed UDS results was pending, and stated that she had no prior narcotics agreement violations. Dr. Ogoke gave her a physical examination. He reported on her pain symptoms:

Her pain remains in the low back area with bulbs or muscle spasm overlying the sacroiliac notch area on both sides, which ... radiates into the lower extremity ... especially on the right side.

The diagnoses listed in the report were: lumbar radiculopathy; lumbar strain; sacroiliitis; coccydynia; and, sacral contusion. She was given renewals of all her ongoing prescriptions at the same doses: Elavit 25 mg. (60); EC-Naprosyn 375 mg. (60); Percocet 10/325 mg. (120); MS Contin 60 mg. (60); and, Skelaxin 800 mg. (90). She was also prescribed Ativan 2 mg. (2) and Actiq 600 mcg. (2) for the interventional procedures. Pt. K told Dr. Ogoke that use of these medications for the interventional procedures helped her. A UDS was done, and the July 23, 2007 results were positive for opiates, but the Oxycodone screen was cancelled. (Ex. 43: 56-60/3391-3395; 158-160/3493-3495; 162/3497; 164/3499 & 166-169/3501-3504.)

20. Pt. K had not had her interventional procedures by an August 20, 2007 visit with Dr. Ogoke. She reported a pain level of 9/10. Dr. Ogoke acknowledged that she had been maintained on her pain medications while waiting for her insurance coverage of the injection procedures since she could not afford to pay for them otherwise. The insurance was now available, so having the injection procedures was her next planned treatment. An opioid renewal screen form was completed listing her last prescriptions as written on July 20, 2007, and her last UDS as normal. No narcotics agreement violations were listed. Dr. Ogoke gave her a physical examination. The diagnoses and Pt. K's treatment plan remained the same. The interventional

procedures were to be scheduled as soon as possible, starting with an SI injection. She was prescribed Ativan 2 mg. (2) and Actiq 2 mcg. (2) for upcoming interventional procedures.¹³² She was also prescribed Elavil 25 mg. (60), Percocet 10/325 mg. (120), MS Contin 60 mg. (60), Skelaxin 800 mg. (90), and EC-Naprosyn 375 mg. (60). A UDS was done with an order for an Oxycodone screen. The August 21, 2007 UDS result was positive for Oxycodone. (Ex. 43: 52-55/3387-3390; 156-157/3491-3492; 195/3530 & 202-203/3537-3538.)

21. Pt. K was seen by Dr. Ogoke on August 23, 2007.¹³³ She reported a pain level of 8/10. He noted in the report of the visit that her pain,

has remained quite significant but unfortunately she was supposed to get an SI joint injection today and when the procedure was initiated she became extremely anxious even prior ... despite being given Ativan for pre-medication ... as well as Actiq 600 mcg.

Dr. Ogoke reported that she suffered a severe anxiety attack, and he reported:

[T]he decision was made to abort the procedure immediately after prepping the patient's skin and the patient will be followed up subsequently. She has enough medication at this time to last her until her next visit.

Her treatment plan was not changed. She was to re-schedule the interventional procedures. Dr. Ogoke noted in the report of this visit that her care would need to be re-evaluated. A UDS was done that was positive for opiates and for Oxycodone with no illicit drugs detected. (Ex. 43: 48-52/3383-3387; 196/3531 & 205-206/3540-3541.)

22. Pt. K was seen on September 14, 2007 by Dr. Pierre Herard who had not previously seen Pt. K. An opioid renewal screen form was completed listing her last prescriptions as written on August 20, 2007, listing no prior narcotics agreement violations, and that she had pending

¹³² Pt. K had been previously prescribed the Ativan and Actiq for use in connection with interventional procedures that had not occurred. It was not explained in her medical records (Exhibit 43) why, if she had filled those prescriptions, she would have needed new prescriptions for them.

¹³³ Pt. K was either seen on August 22 or 23, 2007. I concluded that she was only seen by Dr. Ogoke on one or the other date and not on both dates.

UDS results. She completed a brief pain inventory form. Pt. K reported a pain level of 9/10 and painful low back spasms making it hard to stand to do her teacher job. Dr. Herard was aware of the panic attack with needle phobia she had on August 23, 2007 that prevented her from having her scheduled SI injection. He discussed this with Pt. K. She was scheduled to have the SI injection at this visit. Dr. Herard gave her a physical examination and reached the impressions that she had painful sacroiliitis, painful myofascial pain syndrome in the lumbar spine, and possible lumbar discogenic pain with radiculitis. Dr. Herard gave her a “trigger point injection to the sacroiliac joints and sacroiliac muscles and the quadratus lumborum.” Pt. K tolerated the procedure well. Dr. Herard renewed Pt. K’s ongoing medications of Elavil 25 mg. (60), Percocet 10/325 mg. (120), MS Contin 60 mg. (60), EC Naprosyn 375 mg. (60), Skelaxin 800 mg. (90), and Ativan 2 mg. (2) and Actiq 600 mcg. (2) for her next procedures. A UDS was done. Dr. Ogoke signed Dr. Herard’s report of this visit. Pt. K had a visit with Dr. Herard on October 9, 2007. She reported having good relief from the injection procedure she received on September 14, 2007, allowing her to engage in more routine activities. But, she reported the back spasms were recurring and she wanted to have another injection procedure. An opioid renewal screen form was completed listing her last prescriptions from September 14, 2007, and that her last UDS was normal.¹³⁴ Pt. K completed a brief pain inventory form. Dr. Herard gave her a physical examination. He did not alter her diagnoses or treatment plan. She was to be scheduled for a bilateral SI injection with fluoroscopy. He renewed her prescriptions of Percocet 10/325 mg. (120), Elavil 25 mg. (60), and MS Contin 60 mg. (60). A UDS was done. She was instructed to take the MS Contin in the morning to prevent drowsiness. (Ex. 43: 34/3369; 40-47/3375-3382; 192-194/3527-3529; 197-201/3532-3536 & 204/3539.)

¹³⁴ It is not clear whether the reference to the normal UDS result was from August 20, 2007 or from September 14, 2006.

23. Pt. K was seen by Dr. Ogoke on November 6, 2007. An opioid renewal screen form was completed listing her last prescriptions as issued on October 9, 2007, her UDS results as pending, and no prior narcotics agreement violations. Pt. K completed a brief pain inventory form. She reported persistent low back area pain with radicular pain in the legs and buttocks at an 8/10 level. Dr. Ogoke gave her a bilateral SI injection with fluoroscopy. He noted that she had not been able to have lumbar transforaminal ESI procedures due to a long-standing insurance issue that was now resolved. He gave her a physical examination and assessed her with: sacroiliitis; lumbar radiculopathy; lumbar sprain and rule out facet-mediated pain; and, possible lumbar discogenic pain. Dr. Ogoke's treatment plan for Pt. K was to schedule a lumbar transforaminal ESI procedure to be followed by re-evaluation of her condition for a possible lumbar discogram as a diagnostic procedure if the transforaminal ESI injection did not resolve her pain. In connection with consideration of the lumbar discogram, Dr. Ogoke explained in his report of this visit:

She has been having difficulty with short periods of sitting and short periods of standing, changing positions frequently, as well as difficulty with sleep at night because of positional issues as well.

On this date, Dr. Herard wrote a prescription for Pt. K of Oxycodone 30 mg. (120).¹³⁵ A UDS was done with results that were positive for Oxycodone and opiates. (Ex. 43: 33/3368; 35: 39/3370-3374; 184-185/3519-3520 & 187-190/3522-3525.)

24. Pt. K had a follow-up visit on December 3, 2007 with Dr. Herard. She reported that the November 6, 2007 SI injection had provided pain relief. Dr. Herard gave her a physical examination and assessed her with bilateral sacroiliitis and chronic lumbar radiculitis. The

¹³⁵ I could not locate in Pt. K's medical records (Exhibit 43) other prescriptions written for Pt. K on November 6, 2007, although in the visit report, Dr. Ogoke noted that Pt. K's medications would be renewed for thirty days.

treatment plan was to renew her medications and to do a nerve block procedure the following week. He instructed Pt. K to bring in her Percocet the next day for counting toward ensuring compliance in taking this medication. At this visit, she was prescribed Percocet 10/325 mg. (120), Oxycodone 30 mg. (120), MS Contin 60 mg. (60), along with Ativan 2 mg. (2) and Actiq 60 mcg. (2) for the upcoming procedure. She was instructed to take the MS Contin every 12 hours and the Oxycodone every 6 hours.¹³⁶ (Ex. 43; 31-32/3366-3367 & 181-182/3516-3517.)

25. On December 5, 2007, Dr. Ogoke's office mailed a letter to Pt. K by certified mail. It was returned as not deliverable.¹³⁷ (Ex. 43, 79-80/3414-3415.)

Conclusion and Recommendation

The Statement of Allegations charges that Dr. Ogoke violated the standard of care in his treatment of Pt. K by prescribing high doses of opioid medications at her initial evaluation at his office, an initial evaluation that did not involve him first giving Pt. K a full physical examination. These charges were not proven.

Dr. Ogoke did give Pt. K a full physical examination and a full initial comprehensive evaluation on September 20, 2006 when she first saw him. He did not prescribe MS Contin to her at this visit as charged in the Statement of Allegations. He prescribed at this initial visit, a Percocet dose at 7.5/325 mg., and not a 10/325 mg. dose as charged in the Statement of

¹³⁶ There were no later medical records on Pt. K (Exhibit 43). No medical record or information in Dr. Herard's December 3, 2007 visit report showed that he ordered a UDS. I was not able to locate or decipher the results of the October 9, 2007 UDS that had been pending at the November 6, 2007 visit with Dr. Ogoke. No mention of the UDS results was within the December 3, 2007 visit report. I could not locate any medical record discussing the end of Pt. K's care with Dr. Ogoke and Dr. Herard. No testimony addressed why Pt. K's care with Dr. Ogoke ended. In its brief, the BORM refers to Pt. K's complaint to the BORM to support its contention that Pt. K told Dr. Ogoke she did not want to have further injection procedures, and in response, Dr. Ogoke told her she could no longer receive pain medications unless she also had injection procedures. The reference was to Exhibit 83, the complaints filed by the patients listed in the Statement of Allegations. There is no complaint filed by Pt. K in evidence or any information in her medical records that she was refusing further injection procedures.

¹³⁷ There is insufficient proof that the letter sent by certified mail to Pt. K on December 5, 2007 was a termination of care letter.

Allegations. Dr. Ogoke explained sufficiently in both his testimony and within his reports from the first visit into the next visit reports, that he was keeping Pt. K well monitored in her use of the Percocet she was receiving. Not until January 2007 did Dr. Ogoke prescribe MS Contin 60 mg. to Pt. K as a long-acting opioid medication along with maintaining the Percocet 10/325 mg. dose for break-through pain. The future reports and course of events that occurred with Pt. K and her pain complaints, showed that she did not become addicted to her opioid medication that remained quite stable for months, and that she did not use illicit drugs.

Pt. K signed Dr. Ogoke's narcotics agreement at her initial visit and evaluation with Dr. Ogoke. She revealed at her next visit at Dr. Ogoke's office on September 29, 2006, that she was taking more of the Percocet 7.5/325 mg. than the prescription called for. She explained that she did this to get better pain relief. This evidence supported what the medical records showed; no initial Percocet 10/325 mg. dose prescription had been written for Pt. K by Dr. Ogoke, or by any of his physician assistants, or by Dr. Herard. The medical records showed that Pt. K was prescribed Percocet at the increased dose of 10/325 mg. for the first time at this second visit. Dr. Satwicz opined that it was proper prescribing to start an opioid naïve patient on the lowest dose of Percocet and not on the highest Percocet dose of 10/325 mg.

At this second visit Pt. K was permitted to have her Percocet dose increased to the 10/325 mg. level only after she received considerable counseling about why she could not increase the frequency of taking her prescribed medications, and only after she had explained her actions in a written note that was placed into her medical records. No expert opinion evidence showed this particular course of care to be violating the standard of care, particularly with counseling given Pt. K on the need to be compliant in taking her pain medication as prescribed to avoid violating her narcotics agreement, and in light of giving her UDS tests to check on her compliance. Dr.

Trescot opined that Dr. Ogoke did not violate any standard of care when he initially prescribed opioids for Pt. K. Dr. Trescot found his course of care in prescribing pain medication to Pt. K to be understandable and reasonable, with Pt. K's need for pain relief explained sufficiently in her medical records.

For Dr. Satwicz, even if Pt. K's initial Percocet prescription was at 7.5/325 mg., she was receiving overall too much new medication when the Percocet and the other non-opioid medications were considered. Dr. Satwicz opined this was too much medication for someone who had only been using over-the-counter medication for pain. He explained that it would be difficult if Pt. K suffered side-effects from one of these new medications to determine which one was at fault. In addition, he found significant that she had a hypothyroid condition to complicate use of the new medications. On September 29, 2006, nine days after she received these new medications, Pt. K experienced feelings of nausea. Although this was apparently resolved by instructing Pt. K to have food when her taking her medications, having that symptom was the kind of side effect Dr. Satwicz opined should have been avoided by less medication being prescribed at Pt. K's initial visit. Nevertheless, the BORM charged Dr. Ogoke in the Statement of Allegations with prescribing "high dose opioids" to Pt. K at the initial visit, not with being prescribed too many medications. Only the Percocet she received was an opioid.

The course of care in terms of prescribing medications for Pt. K, showed that her prescriptions remained fairly unchanged once she received in January 2007 the long-acting MS Contin and to have more of the Percocet 10/325 mg. to take for break-through pain. The Statement of Allegations did not charge Dr. Ogoke with misconduct other than for his prescribing practices at Pt. K's initial visit.

The Statement of Allegations alleges that Dr. Ogoke never performed a full physical

examination at Pt. K's initial visit with Dr. Ogoke. This is incorrect as demonstrated by Dr. Ogoke's believable testimony, and by the visit report of his initial comprehensive physical examination given to Pt. K. That report explained that Dr. Ogoke gave the physical examination and his physician assistant dictated the results of it. The claim that Dr. Ogoke violated the standard of care at this initial visit of Pt. K by not performing a full physical examination before prescribing high doses of opioids, has not been proven. The source of this claim was the reference in the BORM's brief to a complaint filed by Pt. K with the BORM. No such complaint is in evidence.

Although it was not a medication that Dr. Ogoke prescribed at Pt. K's initial visit, I did not find sufficient proof that his prescribing of Actiq for Pt. K to take during interventional procedures fit within the charge that Dr. Ogoke initially prescribed too high opioid doses to Pt. K. Dr. Satwiz did not consider Actiq to ever be a proper prescription for non-cancer pain. Dr. Satwicz's opinion never tied the start of the Actiq prescriptions to the initial visit. I was persuaded by Dr. Trescot's opinion, that the limited use Pt. K was to make of the Actiq to address her pain during an interventional procedure, kept Dr. Ogoke's prescribing of it within the standard of care. Dr. Trescot also supported her opinion that Dr. Ogoke was not over-prescribing opioids through his Actiq prescriptions, due to the on-going UDS testing that Pt. K had throughout her care with Dr. Ogoke to uncover any improper use of her prescribed medications. Dr. Trescot was persuasive when she opined that this limited use of Actiq was being done at the time by other pain management specialists. No evidence showed that Dr. Ogoke was also prescribing Actiq for on-going breakthrough pain Pt. K was experiencing. Dr. Ogoke reasonably explained why he offered limited amounts of Actiq for use by some of his patients who had particular problems getting through their interventional procedures.

Dr. Ogoke credibly explained how a patient's perception of pain during injection procedures could be viewed by some patients as helped if they bit into a towel or pillow during a procedure. If that kept them able to receive the treatment, he would not prevent them from doing that. The BORM claimed that Pt. K had such painful interventional procedures and was given towels to bite into to keep her from screaming during procedures. Pt. K never testified, and no complaint filed by Pt. K with the BORM is in evidence, the source of this claim.

Pt. K's underlying condition, as described over time in her medical records, showed she had been helped by the interventional procedures that were part of her pain management treatment plan. The medical records showed that she agreed to having them as part of her treatment plan. Her pain complaints only grew when she could not have them due to Dr. Ogoke's office renovations delaying them and when her insurance stopped covering their costs. Only then did she receive the MS Contin 60 mg. for long-acting pain relief and the increase in the amount of Percocet 10/325 mg. tablets to take from (90) to (120). Pt. K's phobia of needles after she had a long wait until her insurance covered the interventional procedures, may have contributed to her having an anxiety attack before the start of an SI injection Dr. Ogoke was about to perform. She eventually was given the bilateral SI injection with fluoroscopy, but with the aid of taking Ativan and Actiq. This later narcotic prescribing was not proven to be connected to the initial opioid prescription Pt. K received from Dr. Ogoke.

It is not clear why Pt. K's care with Dr. Ogoke ended, or when it ended, or under what circumstances. There was nothing in the medical records or in Dr. Ogoke's testimony to explain the end of her care. Pt. K did not testify to explain what happened. The BORM claims that Dr. Ogoke ended care of Pt. K because she would not undergo further interventional procedures, and he would not continue to treat her with only pain medications. The BORM's brief sources this

claim based on a Pt. K complaint made to the BORM that is not in evidence. But, even if this is why Dr. Ogoke would have ended care with Pt. K, that determination would have been consistent with his protocol for treating patients, explained to the patient upon agreeing to have his pain management care. If he found having such interventional procedures was the treatment plan for the patient, then that patient could seek pain management care elsewhere in the area if she did not want such treatments. No evidence showed that if this is how Pt. K's care ended with Dr. Ogoke, he violated a standard of care. The Statement of Allegations did not include a charge of a violation of standard of care about how Dr. Ogoke ended his care of Pt. K.

Patient L

Summary

Patient (Pt.) L did not testify. No complaint by Pt. L to the Board of Registration in Medicine was presented. (Ex. 83.)

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Prescribing Oxycontin 40 mg., a high dose, to take twice a day to add to the Vicodin 10 mg. she was already taking upon coming to an initial evaluation with Dr. Ogoke in September 2002.

The facts the BORM alleged to support its allegations included the following:

- Pt. L treated with Dr. Ogoke in 1998 for low back pain. She returned for care with him and treated with him again in September 2002.¹³⁸
- Pt. L was treated by Dr. Ogoke starting on September 19, 2002 for; lumbar radiculopathy, lumbar strain, sacroiliitis, level T11-12 mild disc bulge, spur formation, and ligamentous hypertrophy at levels L4-5 and L5-S1.
- Dr. Ogoke treated Pt. L starting on September 19, 2002 with a combination of pain medications, including Vicodin and Oxycontin, and

¹³⁸ February 6, 2003 was the last medical record (Exhibit 43) involving a treatment of Pt. L by Dr. Ogoke or his staff, prescribing medications, but there is no medical record I could locate on the end date of care.

with interventional procedures, including epidural steroid injections and nerve blocks.

- When Pt. L returned to care with Dr. Ogoke in September 2002, she was already taking Vicodin 10 mg. for pain.
- Dr. Ogoke added to that a prescription for Pt. L of Oxycontin 40 mg. to take twice a day.

Findings of Fact

1. Pt. L is a female born in November 1968 who hurt her back during a car accident on March 17, 1998. She was the front seat passenger when the car was hit head-on at the driver's front side. She was wearing a seat belt and her airbag deployed. The car's speed was about 30-35 mph. She was taken to a hospital emergency room. She had a medical history that included a lumbar disc bulge found in 1990, and cervical spine x-rays from June 1, 1990 that were compared to the post-accident March 20, 1998 cervical spine x-rays. These latter x-rays showed "[n]o significant abnormality." The radiologist noted: "If there remains strong clinical suspicion of a cervical spine injury a follow-up examination may be of value." Pt. L was seen by Dr. Ogoke on March 25, 1998 upon referral by her primary care physician (PCP). She complained of pain at a 7/10 level in her lower back that radiated into her legs. She sometimes had sharp pains. She had headaches that would come and go, and trouble sleeping due to back pain. She was taking Naprosyn 500 mg. that she received from her emergency room visit that somewhat lessened her pain symptoms. Pt. L had a full time job as a dietary aide. Dr. Ogoke did a review of systems and gave a physical examination diagnosing: cerviogenic headaches; lumbar radiculopathy rule out herniation; sacroiliitis; and, cervical strain. He found a cause/effect connection of the pain symptoms to the car accident. Pt. L completed various forms as Dr. Ogoke's new patient.¹³⁹ He explained his treatment plan for her would involve taking high dose

¹³⁹ I could not find within Pt. L's medical records (Exhibit 43) that she signed a narcotics agreement on March 25, 1998.

NSAIDs (non-steroidal anti-inflammatory drugs) medication, muscle relaxants, and tricyclic anti-depressants. She was prescribed Norflex 100 mg. (30), Elavil 25 mg. (30), and EC-Naprosyn 375 mg. (30). He prescribed physical therapy treatments. She would be re-evaluated in one week. Dr. Ogoke wrote her a note to keep her out from work. When Dr. Ogoke saw Pt. L on April 3, 1998, she reported having bad headaches, but felt better overall. He gave a physical examination, and reached the same diagnoses as at the first examination, although he noted the lumbar radiculopathy symptoms had resolved. He prescribed EC-Naprosyn 375 mg. (30), and Norflex 100 mg. (30). (Ex. 43; 25-36/3567-3578 & 66-73/3608-3615.)

2. Dr. Ogoke saw Pt. L on April 17, 1998. Although she had been feeling better due to the medication and physical therapy treatments, Pt. L reported a 6/10 level of pain in her lower back that radiated into her left lower extremity. Dr. Ogoke gave her a physical examination. His impressions were: persistent lumbar radiculopathy; cervogenic headaches; sacroiliitis; cervical strain; and, poor progress with conservative management. Dr. Ogoke ordered a lumbar CT scan to determine if Pt. L had herniated discs, degenerative disc disease, or facet arthropathy. She was to continue on her medications, and he was adding a narcotic.¹⁴⁰ She would be re-evaluated following the outcome of the CT scan. Dr. Ogoke wrote her a note to continue to keep her out of work. Pt. L had the lumbar CT scan on April 23, 1998 that showed: "Mild broad-based central protrusion L5-S1 intervertebral discs. Mild generalized bulging L3-4 intervertebral discs." Pt. L was seen by Dr. Ogoke on May 5, 1998. Due to ongoing pain complaints in the low back and cervical areas, and after discussing with Pt. L what the test results showed, his treatment plan was to give Pt. L various interventional procedures. In preparation for having these, Pt. L signed forms explaining the injection procedures and consent forms to have various procedures. She

¹⁴⁰ I could not locate or decipher prescriptions written on April 17, 1998 in Pt. L's medical records (Exhibit 43) and the visit report did not contain the specifics about the prescriptions.

was prescribed 10 Percocet tablets.¹⁴¹ She had a lumbar epidural steroid injection (“ESI”) at the L4-L5 level on May 5, 1998, the first in a planned series. She was instructed to take her medications and to do home exercises. Pt. L was seen by Dr. Ogoke on May 19, 1998. She reported pain relief from the lumbar ESI #1 procedure, but with moderate activity the pain level increased to 8/10. Dr. Ogoke gave a physical examination. He opined that the medications and home exercises were not providing progress in controlling her pain in the low back and that she had plateaued. For her cervical pain, as planned, Dr. Ogoke gave her trigger point injections, including an occipital nerve block and a suprascapular nerve block. Pt. L was seen by Dr. Ogoke on June 2, 1998. She reported a diminished pain level of 2/10 in her low back area having had a good result from her ESI #1 treatment. She told Dr. Ogoke:

[The] trigger point injections and peripheral nerve blocks for treatment of her occipital neuralgia ... suprascapular neuralgia, myofascial pain syndrome of the trapezius ... resolved the pain ... headaches ... resolved ... occasional brief sore neck following these injections ... believes that she has essentially resolved her problem in the cervical spine area ... pleased with her overall progress.

Dr. Ogoke gave a physical examination. He gave her the lumbar ESI #2 procedure at the L-4 and L-5 levels. His treatment plan was to give her the lumbar ESI #3 procedure in four weeks. He renewed her medications.¹⁴² (Ex. 43: 4/3546; 9-24/3551-3566; 54-65/3596-3607 & 180/3722.)

3. On June 16, 1998, Pt. L was prescribed Elavil 25 mg. (30), EC-Naprosyn 375 mg. (30), and Norflex 100 mg. (30). Pt. L was seen by Dr. Ogoke on June 18, 1998. She reported a pain level of 1-2/10 in the neck area of the trapezius at the root of the neck and pain in the mid-

¹⁴¹ As best I could decipher the copy of the prescription, it was for 10 Percocet tablets with the dose undecipherable. (Ex. 43, 22/3564.) I could not locate further prescriptions written on May 5, 1998 in Pt. L's medical records (Exhibit 43).

¹⁴² I could not locate within Pt. L's medical records (Exhibit 43) copies of prescriptions written at this visit or a list of Pt. L's medications being renewed in the visit report.

thoracic area. She reported no lumbar radicular symptoms. She reported decreased pain in the lower back area following her lumbar ESI #2 injection procedure. She reported being compliant in taking her medications and with doing home exercises. Dr. Ogoke gave her a physical examination. His treatment plan was to continue the high dose NSAIDS and muscle relaxant medications, and to add a tricyclic anti-depressant medication (Elavil). The lumbar ESI #3 procedure was to be done. If there was an increase in her neck area pain a cervical MRI would be considered. Dr. Ogoke considered that Pt. L might have a cervical soft tissue injury in the cervical discs. Pt. L was seen by Dr. Ogoke on June 30, 1998. She reported neck area pain and headaches at a 3/10 level. She reported that her low back area pain had decreased. She was scheduled to have her lumbar ESI #3 procedure at this visit. Due to her progress with the low back area pain at a reported 0/10 level at this visit with sustained improvement after the lumbar ESI #2 procedure, no lumbar ESI #3 procedure was given. Dr. Ogoke gave her a physical examination. The diagnoses made were: thoracic strain; cervical strain; lumbar herniation at L5-S1 with multilevel generalized bulging of L3-4 and L4-5; sacroiliitis; suprascapular neuralgia; occipital neuralgia; and, myofascial pain syndrome involving the trapezius. To continue to treat the neck area pain that also now included upper thoracic area discomfort, Dr. Ogoke, with the written consent of Pt. L, ordered physical therapy bio-electric treatments. She reported no pain level change after having this first procedure. She was to have this 5 times a week for the next 2 weeks. Pt. L received a prescription for Elavil 10 mg. (50) at this visit. (Ex. 43: 6-8/3548-3550; 48-53/3590-3595 & 176/3718.)

4. On July 1, 1998, Pt. L underwent a physical therapy bioelectric treatment. On July 7, 1998, Pt. L was seen by Dr. Ogoke. She reported that the bioelectric treatment had helped. She reported her neck area pain as 0/10 and her lower back area pain as 4/10 level. By now she

had returned to work and that presented challenges to controlling her low back pain. She did not report any radiating pain. Dr. Ogoke gave her a physical examination. Pt. L was given the lumbar ESI #3 at the L4 and L5 levels because of her low back pain. She was given a renewal of her current medications of Norflex 100 mg. (30), Naprosyn 500 mg. (30), and Elavil 25 mg. (30). She was to be seen in follow-up in a few weeks. Pt. L was seen on August 7, 1998 by Dr. Ogoke. She reported having “resumed her normal level of function without significant discomfort.” She reported no pain and a good result from the lumbar ESI #3 procedure. She had resumed her normal activities. She reported taking no medications. Dr. Ogoke gave her a physical examination. Due to her lack of pain complaints, she was discharged as a patient. (Ex. 43; 5/3547 & 40-47/3582-3589.)

5. Pt. L returned to start new care with Dr. Ogoke on September 19, 2002, upon referral of Dr. George Reynolds, her primary care physician (PCP). She was unemployed. Pt. L completed a background questionnaire as she had when she first treated with Dr. Ogoke in 1998. She signed various forms required of new patients, including a Narcotics Prescription Policy & Agreement (narcotics agreement). She reported low back pain from moving and lifting furniture on August 28, 2002. The pain was sharp, shooting and constant. She was taking Vicodin 10 mg. (“IC hydrocodone + APAP 10/650 tablets.”¹⁴³) Medications helped to relieve the pain, but the pain would worsen with increased walking, sitting or lifting. She was having trouble sleeping. She reported a pain level of 9/10 with a better pain level only being 8/10, and a pain level that would reach 10/10. The pain radiated into her lower extremities. The pain was negatively impacting her social life, work, and interpersonal relationships. Prior to this visit, on August 12, 2002, Pt. L had CT scans of her abdomen and pelvis. These were done to investigate her right

¹⁴³ This is Vicodin 10 mg. (Testimony of Dr. Trescot, Vol. XV, 2930-31.)

flank and back pain complaints.¹⁴⁴ Dr. Ogoke had the results of the CT scans and addressed their findings with Pt. L along with findings from her April 23, 1998 CT scan of the lumbar spine.¹⁴⁵ Dr. Ogoke did a review of systems and performed a physical examination. He diagnosed: sacroiliitis; lumbar strain; and, lumbar radiculopathy with a need to rule out herniation. He prescribed NSAIDs medications, muscle relaxants and tricyclic antidepressants of Elavil 25 mg. (60), Skelaxin 400 mg. (120), Lavil 25 mg. (60) and Vioxx 25 mg. (30). He also prescribed Oxycontin 40 mg. (60) and Vicodin 10 mg. (90). He ordered a physical therapy evaluation. Dr. Ogoke opined that she needed a lumbar spine MRI and physical therapy bio-electric treatments. He scheduled her for a sacroiliac joint (SI) injection. He was considering a series of lumbar epidural steroid injections (ESI). He had Pt. L review and sign consent forms for interventional treatments. Dr. Ogoke secured Pt. L's medical release to obtain her Mt. Tom Mental Health Center records. (Ex. 43: 101-110/3643-3652; 172-176/3714-3718; 178-179/3720-3721 & 181-190/3723-3732. Testimony of Dr. Ogoke, Vol. VII, 1437, 1444. Dr. Trescot, Vol. XV, 2933.)

6. Pt. L had a lumbar MRI on September 24, 2002 that showed:

1. Mild disc bulge or herniation and spur formation T11-12 causing flattening of the dural sac abutting the anterior cord. There may be encroachment upon the right lateral recess as well. Images are somewhat degraded due to motion.
2. Mild ligamentous hypertrophy L4-5 and L5-S1. MRI of the lumbar spine is otherwise normal.

¹⁴⁴ The August 12, 2002 CT scans revealed:

No evidence of a right-sided urinary calculus. Slight inhomogeneity or slight decreased attenuation right lobe of liver probably representing slight geographic fatty infiltration. Ultrasound or contrast enhanced CT scan could be obtained if clinically indicated.

No evidence of right sided urinary calculus. Fluid containing structure to the left of uterus probably volume averaging of the bladder with a left ovarian cyst being much less likely.

(Ex. 43, 179/3721.)

¹⁴⁵ See Pt. L, Finding of Fact #2.

(Ex. 43: 113/3655; 159/3701; 171/3713 & 177/3719.)

7. Dr. Satwicz found the addition at Pt. L's September 19, 2002 initial visit with Dr. Ogoke of the Oxycontin at 40 mg. twice a day to add to the other medications she was taking to help her pain, including adding it to the opioid Vicodin 10 mg., to be an excessive high dose of this additional opioid without sufficient cause given the NSAIDs, other medications, and Vicodin she was taking. From his review of Pt. L's medical record, Dr. Satwicz could not justify this amount of opioid medication at these doses based on the clinical condition Pt. L presented at this first visit with "moderate pain ... butt hurts." Dr. Satwicz concluded that Dr. Ogoke violated the standard of care in his prescriptions for Pt. L at this first visit. He opined that to put a new patient on a long-acting opioid "for a relatively acute problem" is inappropriate; that this kind of prescription might only be appropriate after using a trial of short-acting opioids to see the response to their use. Dr. Satwicz noted that such a prescription of Oxycontin could have resulted in a "terrific" abuse of this drug by Pt. L, and it flew in the face of any reasonable prescribing habits in light of the other medications Pt. L was also taking and at a first patient visit. (Dr. Satwicz, Vol. X, 2026-2032, 2035-2036; Vol. XIII, 2593-2594.)

8. Dr. Trescot opined concerning this initial Oxycontin prescription by focusing on the medical profession's changing attitude toward the prescribing of Oxycontin. By 2011, the dose Dr. Ogoke prescribed in 2002 would have been at the high end of an Oxycontin prescription at an initial visit. Although a long-acting opioid, it was considered to be a very risky opioid to prescribe in a high dose only by about 2005 onward. By then, patients figured out how to remove the coating on the tablets so that the medication lacked its long-acting release properties. This made it a very risky opioid for addiction by the patient. It was also not until about 2005 that Oxycontin was known to have a high street value that would encourage diversion. Dr. Trescot

opined, that in 2002, Oxycontin was viewed by pain management specialists as a very effective pain control medication that was tolerated well by patients. She found Dr. Ogoke was within the standard of care for that time period in prescribing Oxycontin at the high dose of 40 mg. at this first visit because of the great pain Pt. L was experiencing. Dr. Trescot opined that she might have done the same as Dr. Ogoke did. Pt. L was complaining of a pain level as high as 8-10/10 all the time. She told Dr. Ogoke at this visit how those pain symptoms were negatively impacting her life. Dr. Trescot explained:

My practice has always been to start medicines low and work up when looking at patients who are in moderate pain. However, this is a patient who by report is in excruciating pain, and the only person who can make that decision of what dose to start with is the person who is facing, is face to face with the patient.

Dr. Trescott concluded from the review of Pt. L's medical records that Dr. Ogoke was engaging in on-going monitoring of Pt. L's condition from this point forward with a treatment plan that he needed her to agree with. She also had to agree to comply with the narcotics agreement and only take the medications as he prescribed them. Dr. Trescot concluded that Dr. Ogoke made Pt. L aware that the Oxycontin 40 mg. was for long-acting pain relief toward getting control of her high pain level, and that the Vicodin 10 mg. was for her break-through pain. (Dr. Trescott, Vol. XIV, 2672-73; Vol. XV, 2931-35 & Vol. XVI, 3228-3229.)

9. On September 27, 2002, Dr. Ogoke gave Pt. L a thoracic ESI #1 with fluoroscopy at the T12-L1 level. She reported a pain level of 10/10. On October 7, 2002, Dr. Ogoke gave Pt. L a thoracic ESI #2 with fluoroscopy at the T11-T12 level. She reported a pain level of 8/10 in her lower back and left leg. Pt. L received another prescription for Vicodin 10 mg. (90). On October 22, 2002, Dr. Ogoke gave Pt. L a thoracic ESI #3 with fluoroscopy at the T5-T6 level. Pt. L reported pain levels of 8/10 in her low and mid back. She was prescribed Oxycontin 40 mg. (60) and Vicodin 10 mg. (90). (Ex. 43: 92-100/3634-3642; 153-154/3695-3696; 157-

158/3699-3700; 160/3702; 163-166/3705-3708 & 169-170/3711-3712.)

10. On November 5, 2002, Pt. L was seen at Dr. Ogoke's office. She complained of a pain level of 7/10 in her lower back and in her shoulder. She had experienced only a few days of pain relief from the last thoracic ESI injection. She reported that her leg would give out on her, but that she had not fallen. She reported not being able to walk without pain and being limited to walking 10 minutes and sitting 30 minutes. She reported that the Vicodin and Oxycontin were helping to control her pain. She had a physical examination and was assessed with: lumbar radiculopathy; sacroiliitis, lumbar sprain; and, T11-12 mild disc bulging or herniation or spur formation with mild ligamentous hypertrophy at L4-5 and L5-S1. Pt. L was prescribed Elavil 25 mg. (30), Naprosyn 500 mg. (60), and Skelaxin 400 mg. (90). Physical therapy was ordered. The treatment plan was for her to have a series of lumbar ESIs. On November 20, 2002, Dr. Ogoke gave Pt. L a lumbar ESI #1 with fluoroscopy at the L3-L4 level. At this visit, she complained of pain levels of 4-8/10 in her mid and 8/10 in her lower back. Pt. L was prescribed Oxycontin 40 mg. (60) and Vicodin 10 mg. (90). On December 4, 2002, Dr. Ogoke gave Pt. L a bilateral SI injection with fluoroscopy. Pt. L complained of a pain level of 8/10 in her back. She was prescribed Elavil 25 mg. (30), Naprosyn 500 mg. (60), and Zanaflex 4 mg. (90). On December 18, 2002, Pt. L had a lumbar ESI #2 with fluoroscopy at the L5-S1 level. Pt. L reported a pain level in her back of 8/10 with "about 25% relief" from the lumbar ESI #1. She was prescribed Oxycontin 40 mg. (60) and Vicodin 10 mg. (90). Dr. Ogoke's office completed a disability evaluation form for Pt. L on or about December 20, 2002. Pt. L was claiming: "LBP [low back pain], PTSD, depression, anxiety." Dr. Ogoke's office offered information pertaining only to Pt. L's physical condition limitations. (Ex. 43: 80-91/3622-3633; 124-131/3666-3673; 134-135/3676-3677; 139-143/3681-3685; 146-149/3688-3691; 151-152/3693-3694 & 157-158/

3699-3700.)

11. Pt. L was seen at Dr. Ogoke's office on January 15, 2003. She reported a pain level of 8/10 level in her lower back, left side and hip, with pain radiating into her left leg. She reported limited pain relief of a few days from the lumbar ESI #2 done on December 20, 2002. A physical examination was performed. She was assessed with the same conditions of: lumbar sprain; lumbar radiculopathy; sacroiliitis; and, T11-12 mild disc bulging or herniation or spur formation with mild ligamentous hypertrophy at L4-5 and L5-S1 levels. The treatment plan for Pt. L was to have the lumbar ESI #3 done as soon as possible, and then to consider a facet diagnostic injection if necessary to help control the pain. After that, if needed, a radio frequency lesioning procedure would be considered. Pt. L's medications were renewed of Elavil 25 mg. (30), Oxycontin 40 mg. (60), Vicodin 10 mg. (90), Zanaflex 4 mg. (90), and Naprosyn 500 mg. (60). On February 6, 2003, Pt. L was prescribed Oxycontin 40 mg. (60), Vicodin 10 mg. (90), Naprosyn 500 mg. (60), Elavil 25 mg. (30), and Zanaflex 4 mg. (90). In early March 2003, Pt. L was seeking social security disability benefits. Dr. Ogoke filled out forms to help her with this claim. On or about March 14, 2003, Pt. L sought a transfer of all her medical records from Dr. Ogoke to her PCP. On June 26, 2003, Pt. L signed a form to have Dr. Ogoke receive all her medical records.¹⁴⁶ (Ex. 43: 78-79/3620-3621; 112/3654 & 114-123/3656-3665.)

Conclusion and Recommendation

The BORM's Statement of Allegations charges Dr. Ogoke with over-prescribing opioid medication for Pt. L when she returned to treat with him in September 2002, specifically prescribing Oxycontin 40 mg. to take twice a day, renewing the Vicodin 10 mg. she was already

¹⁴⁶ The sending out of Pt. L's medical records with Dr. Ogoke to her PCP in March 2003, and for her signing a release of all her medical records in June 2003 to Dr. Ogoke, was not explained in the medical records or through testimony. How her care ended with Dr. Ogoke does not appear in the medical records (Exhibit 43), and no testimony was provided to explain the end of her care with Dr. Ogoke.

taking, and also adding NSAID, tricyclic anti-depressants, and muscle relaxant medications. Pt. L reported her pain complaints to Dr. Ogoke at this visit to be at an 8-10/10 level. She reported suffering in her interpersonal relationships, and in her social and work lives due to the pain. She had returned for care with Dr. Ogoke upon referral by her PCP. This onset of pain had followed a recent heavy lifting episode in August 2002. The BORM did not prove these charges.

Dr. Satwicz supported the claim of the BORM that the prescribing Dr. Ogoke did at this visit in September 2002 was in violation of the standard of care; that Pt. L's clinical condition was one of moderate pain not warranting a high initial dose of the long-acting opioid, Oxycontin, along with Vicodin 10 mg. For Dr. Satwicz, Pt. L should have been tried on just short-acting opioids for awhile, and not initially started on the long-acting opioid of Oxycontin at the high dose of 40 mg. to take twice a day, especially in light of the Vicodin 10 mg. she was already taking and the large amount of NSAID, muscle relaxant, and tricyclic anti-depressant medications also being prescribed at this initial evaluation. In addition to his concerns about the high dose of opioids Pt. L was suddenly prescribed and the side-effects that could occur from any of the other medications she was also to be taking, Dr. Satwicz was concerned that Oxycontin was a drug of abuse and diversion that should be avoided when not necessary for pain management treatment.

In contrast, Dr. Trescot credibly explained that in September 2002, Oxycontin was not viewed as a drug too risky to prescribe due to its addictive effects and high street value to sell. She noted that in 2002, Oxycontin was viewed as an easy to take medication that worked without troublesome side-effects, and that as a long-acting opioid, it was not carrying the risk of being very addictive. Dr. Trescot explained that it was not until about 2005 that the addictive and risky features of Oxycontin emerged with patients figuring out how to remove the outer coating of the

tablet to make it a fast-acting opioid. Only then did the medical profession recognize the risk of addiction and diversion. Dr. Trescot thought it significant that the medical records showed that Dr. Ogoke was monitoring Pt. L's use of her prescribed medications, and that she had signed the narcotics agreement.

At the time Dr. Ogoke issued the prescription for Oxycontin 40 mg. to take twice a day, Dr. Trescot opined that this was reasonable following the comprehensive initial evaluation of Pt. L. Dr. Trescot found support in Pt. L's medical records that showed Dr. Ogoke's assessment of her pain complaints as high with no adequate pain control achieved on her existing medications. Dr. Trescot noted that her PCP referred her to Dr. Ogoke for pain management care.

The prescription of Oxycontin is the only allegation made against Dr. Ogoke that involved a charge that he violated a standard of care with Pt. L. Dr. Trescot focused on Pt. L. having severe pain complaints that gave her a diminished quality of life, and thus concluded that it was appropriate for Dr. Ogoke to have prescribed a long-acting opioid that would provide not spikes in pain control, but ongoing pain control for Pt. L's 8-10/10 unabated pain levels. Although Dr. Satwicz's assessment was of Pt. L. having moderate pain, Dr. Trescot opined that she might well have prescribed as Dr. Ogoke had at that September 2002 evaluation given Pt. L's severe, unrelenting pain. Dr. Trescot emphasized that it is the specialist pain management physician who is best able to determine the patient's need for pain control.

The incident that triggered Pt. L. returning to see Dr. Ogoke on September 19, 2002 for pain management care was about one month earlier when she moved and lifted furniture. She had troublesome lower back pain by the next day. At the September 19, 2002 initial evaluation, Pt. L. reported to Dr. Ogoke a pain level of 9/10 with sharp shooting and constant pain. She explained that at best the pain was at the 8/10 level, and at worse at the 10/10 level. She reported

feeling pins and needles in her low back area, and that the pain would go into her legs. She reported that the pain medicine she was taking made the pain better, but mild activities worsened the pain such as walking, lifting, or sitting. She was having trouble sleeping. She reported that her social interactions and family relationships had become strained.

After giving Pt. L a review of symptoms and a physical examination, nothing in the report of this initial evaluation included any findings by Dr. Ogoke that Pt. L was exaggerating her pain, or that her clinical examination did not correlate with the severity of her pain complaints. The report of this evaluation does not mention that Pt. L had previously treated with Dr. Ogoke for low back pain in 1998, but the report included findings from the August 1998 lumbar CT scan done while Pt. L was in Dr. Ogoke's care. Also included in the report of this September 2002 evaluation were the results of CT scans of the abdomen and pelvis done in August 2002. The earlier treatments Pt. L had with Dr. Ogoke in 1998 went well. Pt. L was compliant with her treatment plan. She ended up getting good pain control and having no further need for Dr. Ogoke's expert pain management care.

In the September 2002 evaluation report, Dr. Ogoke discussed his review of systems and examination results, and the patient interview and questionnaire answers. Dr. Ogoke prescribed Pt. L, not only the Oxycontin 40 mg. to take twice a day, but he continued her on the short-acting Vicodin 10 mg. she was already taking when she came to him. He also added NSAIDs, muscle relaxants and tricyclic anti-depressants. The treatment plan with this medication regimen was to review her condition on them and titrate them as needed. Dr. Ogoke also wanted Pt. L to have physical therapy, bioelectric treatments, and to have a lumbar MRI. He wanted to schedule her for an SI injection, and to consider giving her lumbar ESIs. The medical records show that Pt. L was seen again by Dr. Ogoke as soon as September 27, October 7, and October 22, 2002, and she

received interventional procedures. The Oxycontin and Vicodin prescriptions were continued at the same doses with no changes made to them after this initial September 20, 2002 evaluation.

A review of Pt. L's course of care with Dr. Ogoke from 1998 and then from September 2002 until February 2003 showed that she took not just opioid and other pain medications, but had interventional procedures and physical therapy treatments that were reported in her medical records as providing her with pain relief. The medical records did not show a change in her pain medications, including no increases in the Vicodin or Oxycontin doses.

Against this background, I was persuaded by Dr. Trescot that in 2002, Oxycontin was viewed as a useful drug to prescribe for strong pain symptoms, and that the great risks associated with the drug only became clearer by 2005. Dr. Satwicz never addressed what the medical profession knew in 2002 about Oxycontin prescribing. He also did not explain why, if there was no reason to doubt Pt. L had a high pain level upon coming to Dr. Ogoke in September 2002, Dr. Ogoke's prescription of a long-acting opioid that was known to be effective and easy to take, was prescribing in violation of the standard of care at that time. The dose was high at 40 mg., but the pain level Pt. L believably reported was also very high and negatively impacting her mobility and her quality of life.

Dr. Satwicz's expert testimony failed to address whether Dr. Ogoke's continuing treatment of Pt. L had any bearing on the question of the propriety of his initial prescription of Oxycontin. Dr. Ogoke saw Pt. L a number of times soon after September 20, 2002 to review whether interventional procedures were reducing her pain level, whether the prescription regimen was reducing her pain level, and whether the prescription regimen needed to be titrated. This course of events, showing Dr. Ogoke was aware that he needed to monitor Pt. L's medication treatment regimen, and in light of Dr. Trescot's persuasive information concerning

the use of Oxycontin in 2002 for pain management, has overcome Dr. Satwicz's opinion that the initial prescription of Oxycontin was inappropriate. The BORM has failed to meet its burden of proof that Dr. Ogoke violated the standard of care in his prescription in September 2002 of Oxycontin to be taken twice a day.

The course of care that Dr. Ogoke gave Pt. L starting in 1998 and then covering September 2002 through prescriptions written in February 2003, showed that Pt. L was compliant in meeting her treatment plan obligations, and that Dr. Ogoke made no clinical findings questioning her high pain complaints. There were no medical records I could locate about why Pt. L's care with Dr. Ogoke ended or exactly when it ended. There was no proof that Pt. L was found to have violated her narcotics agreement, for instance, or that she refused further interventional treatments as a reason why her care with Dr. Ogoke ended. Nothing in Pt. L's medical record or in the testimony presented showed that Pt. L became addicted to her opioid medication, diverted it, or developed a dangerous tolerance to the medication while she was in Dr. Ogoke's care. No evidence showed that Pt. L was engaged in drug-seeking behavior or ever became addicted to Oxycontin, and thus, no reason on these grounds to question Dr. Ogoke's prescription of Oxycontin at her return visit with him in 2002.

Patient M

Summary

Patient (Pt.) M did not testify. No complaint by Pt. M to the Board of Registration in Medicine was presented. (Ex. 83.)

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- At Pt. M's first visit, Dr. Ogoke inappropriately prescribed high doses of opioids for Pt. M's clinical condition.
- Dr. Ogoke failed to identify the doses and adjustments to opioid prescriptions he gave Pt. M in the reports of Pt. M's office visits.

The facts the BORM alleged to support its allegations included the following:

- Pt. M treated with Dr. Ogoke from May 2002 into October 2003 for back and hip pain complaints.
- Dr. Ogoke's diagnoses for Pt. M included: post-laminectomy syndrome lumbar spine; sacroiliitis; lumbar radiculopathy; cervical strain; and, myofascial pain syndrome.
- Dr. Ogoke treated Pt. M with a combination of pain medications. Included were the opioids; Percocet, Duregesic (Fentanyl) Patch, and Vicodin. He also treated Pt. M with interventional procedures, including epidural steroid injections, sacroiliac joint injections, and transforaminal injections.
- Pt. M came to Dr. Ogoke not taking any opioid medications. As a result of the initial evaluation, Dr. Ogoke prescribed Duregesic (Fentanyl) Patch at 50 mcg., Vicodin, non-steroidal anti-inflammatory drugs (NSAID), muscle relaxants, and tricyclic anti-depressant medications.
- Based on Pt. M's clinical condition at the time of Pt. M's initial evaluation, it was excessive to prescribe the Duregesic (Fentanyl) Patch at 50 mcg., in combination with Vicodin, non-steroidal anti-inflammatory drugs, muscle relaxants, and tricyclic anti-depressant medications.
- Dr. Ogoke did not identify the doses and adjustments of opioids he prescribed for Pt. M within his reports of visits.

Findings of Fact

1. Patient M was born in November 1969. He suffered a fall on January 21, 2001 as a truck driver while "trying to raise a trailer to get his truck under." After this fall, Pt. M continued

driving, and experienced pain and weakness in his lower extremities. He collided into an object at a toll booth. In May 2001, he had a surgical decompression L5-S1 discectomy with fusion. Conservative management for his subsequent continuing pain symptoms did not help. He had some injection treatments and took Vicodin. On December 26, 2001, Pt. M had a lumbar spine MRI due to about six weeks of bilateral leg pain and numbness. The result was compared to a March 18, 2001 lumbar spine MRI. The results showed:

[T]here is a transitional vertebra, which is thought to represent a partially lumbarized S1, which is consistent with the prior numbering pattern. Given this numbering system the patient is noted to be status-post left hemi-laminectomy and probable partial discectomy at L5-S1 without evidence of residual or recurrent disc herniation or central spinal stenosis. There is mild lumbar spynoylosis, degenerative disc changes as well as post-operative changes.

On January 24, 2002, Dr. Arnold J. Rossi, a neurosurgeon, reported his opinion that Pt. M might reasonably undergo a decompression, discectomy and fusion because conservative treatments had failed to provide relief from increasing pain following his right L5-S1 discectomy. Dr. Rossi mentioned in his report that Pt. M was taking “Vicodin three or four times a day.” Pt. M was referred to Dr. Ogoke for his ongoing pain symptoms by his primary care physician (PCP), and Dr. Ogoke evaluated Pt. M on May 1, 2002. He took a medical and social history, became aware of the accident, the subsequent fusion surgery, the pain management treatments, and the results of the diagnostic tests done. Dr. Ogoke had Pt. M complete a number of new patient forms,¹⁴⁷ including a questionnaire revealing his work, social, and medical history along with current pain complaints and medications he was taking. Pt. M described his pain at a 10/10 level and that the pain level could reach “20/10.” Pt. M reported that he was not taking any medications for his pain. He denied any drug or alcohol abuse. Pt. M reported back, leg and head pain. Due to his

¹⁴⁷ I could not locate within Pt. M’s medical records (Exhibit 43) a copy of a Narcotics Prescription Policy & Agreement (narcotics agreement) signed by Pt. M on May 1, 2002 when he signed other new patient forms.

pain Pt. M reported not being able to work, having a very diminished social life, and having problematic family relationships, including with his children. Dr. Ogoke produced a thorough report on his evaluation of Pt. M. He did a review of systems and gave a physical examination. He diagnosed: post-lumbar spine laminectomy syndrome; severe sacroiliitis; lumbar spondylosis; lumbar radiculopathy; lumbar disc bulge at L5-S1; cervical strain; and, cervical radiculitis with a need to rule out a herniation. Dr. Ogoke's treatment plan was to give Pt. M three lumbar epidural steroid injections (ESI) with reviews of how helpful they were for pain relief, and to give a sacroiliac joint (SI) injection after the lumbar ESI #1. Dr. Ogoke held open the possibility of giving Pt. M an epidurogram and a lysis of adhesion procedure. He started Pt. M on high dose NSAIDs, muscle relaxants, and tricyclic anti-depressant medications (Zanaflex 2 mg. (90), Elavil 50 mg. (30), and Bextra 10 mg. (30)). He also prescribed opioids; a Duregesic (Fentanyl) Patch 50 mcg. (10) to use every 19 hours for long-acting pain relief, and Vicodin ES (extra strength) (90) as needed for break-through pain relief in light of Pt. M's severe pain complaints. Dr. Ogoke ordered a physical therapy evaluation with treatment for the low back and neck, including Bioelectric treatment, followed by a review. This treatment plan was explained to Pt. M who agreed to it. The referring physician, Dr. Ramano, was sent a copy of the report of this initial visit. (Ex. 43: 41-51/3774-3784; 113/3846; 115-126/3848-3859 & 129/3862.)

2. Dr. Ogoke did not view the medication he prescribed for Pt. M at the May 2, 2002 initial visit as excessive. He concluded Pt. M was in need of medication that would alleviate the very high pain level he was experiencing. He was aware that Pt. M had tried Vicodin for pain relief. (Testimony of Dr. Ogoke, Vol. VII, 1451, 1454, 1456.)

3. Dr. Trescot opined that the medications Dr. Ogoke prescribed for Pt. M at the May 2, 2002 initial visit were not excessive given the severe pain complaints that Pt. M presented. At

the time Dr. Ogoke saw him, Pt. M had undergone back surgery about one year prior, with no back pain relief. He had been taking Vicodin three or four times a day at least as recently as January 2002 when he was seen by Dr. Rossi, the neurosurgeon. For Dr. Trescot, even if Pt. M had stopped using the Vicodin or other medications he may have been prescribed before his visit with Dr. Ogoke, he came to Dr. Ogoke with pain not sufficiently relieved by that Vicodin or by any other pain medication he may have taken. In addition, Pt. M reported on-going pain at a levels of 8-10/10 to as high as 20/10 at times. Dr. Trescot concluded that Dr. Ogoke's plan was to get Pt. M's pain level under control by providing him with the medications he did at this first visit. This included providing not just short-acting opioid pain relief, but long-acting slow release opioid pain relief using the Duragesic Patch. His treatment plan for Pt. M was to monitor his progress with pain relief, have Pt. M do physical therapy treatments, and also give Pt. M interventional procedures. Given Pt. M's diminished quality of life due to his severe pain, and in light of Dr. Ogoke's justified treatment plan, Dr. Trescot opined that Dr. Ogoke's prescribing all the doses and kinds of medications he did, including the Duragesic Patch at 50 mcg. and the Vicodin-ES, was not a violation of the standard of care. (Testimony of Dr. Trescot, Vol. XV, 2941-2942; Vol. XIII, 2600.)

4. Dr. Satwicz opined that the medications Dr. Ogoke prescribed to Pt. M at his first evaluation were excessive. Dr. Satwicz understood that Pt. M was not taking any medications when he saw Dr. Ogoke, so that he was opioid naïve at the time. Dr. Satwicz maintained this label as correct for Pt. M, even though Pt. M had been taking Vicodin in January 2002. To Dr. Satwicz there were too many high dose medications prescribed all at once, including the opioids of Vicodin at the ES dose, not at the lower level, and the Duragesic Patch at 50 mcg., a higher than usual initial patch dose. Dr. Satwicz opined that proper prescribing would not have

included so many medications at high doses for Pt. M to take suddenly; that doing so was improper practicing of medicine in violation of the standard of care. Dr. Satwicz opined that it is proper procedure for pain management specialists to start off a patient with pain medications, particularly opioids, at the low dose level. Dr. Satwicz opined:

Opioids are renowned as drugs of use and of diversion. It's a huge problem everywhere. The same with muscle relaxants ... drugs of significant potential abuse. The diversion rate and the abuse rates of those are very, very common, and these drugs given to a patient all at once in the first office visit without trying the lower-level ones, that is inappropriate to prescribe.

He took issue with prescribing for Pt. M so many other new non-opioid medications at high doses. Dr. Satwicz opined that nothing in any medical records he saw on Pt. M provided sufficient support for the kind of excessive prescribing that Dr. Ogoke did at this initial visit, even accepting that Pt. M reported he was in "very high" pain. Dr. Satwicz explained:

He [Pt. M] has not been tried on opioids. He has not had an opioid trial at all. He hasn't had a trial of anything and he has been prescribed the non-steroidals, the muscle relaxants. There are many issues surrounding the use of muscle relaxants. Tricyclic anti-depressants and the two opioids, all in one visit for neck and back pain. I think this is gross overdose of medication for this gentleman.

(Testimony of Dr. Satwicz, Vol. XII, 2194-2199, 2207-2210; Vol. XIII, 2598-2605 & Vol. XV, 2937-2942.)

5. Pt. M had lumbar spine x-rays on May 8, 2002 that showed: "Grade I retrolisthesis at L5 - transitional without instability", and "normal variant segmentation." (Ex. 43, 57/3790.)

6. Pt. M was again seen by Dr. Ogoke on September 3, 2002.¹⁴⁸ He was complaining of a pain level of 10/10 in his low back and right hip area with shooting pains. He complained of numbness in his legs. He reported that his right leg gave way while he was in a store. He went

¹⁴⁸ I could not locate any medical records or prescriptions written, between May and September 2002. On May 6, 2002, Pt. M's insurer informed Dr. Ogoke that Pt. M was authorized for ten visits between April 23 and October 23, 2002. (Ex. 43, 114/3847.)

to the emergency room, but was not given any particular treatment there. Dr. Ogoke gave a physical examination. His impressions were: post-laminectomy syndrome at L5; sacroiliitis; lumbar spine radiculopathy and an L5-S1 bulge; lumbar spine spondylosis; cervical strain; and, cervical radiculitis. The treatment plan was to do a lumbar ESI and then an SI injection. He prescribed Bextra and Elavil. Pt. M signed the narcotics agreement. Dr. Ogoke also ordered physical therapy treatments for the back. He went over the May 2002 lumbar spine x-rays with Pt. M. Pt. M had undergone a lumbar ESI in July 2002, but not with Dr. Ogoke. On September 11, 2002, Pt. M signed forms showing he understood what was involved in an ESI procedure, signed a consent form, and Dr. Ogoke gave him a lumbar ESI procedure with fluoroscopy at the L5-S1 levels. Pt. M reported before the procedure that his pain level was 8/10 in the low back with shooting pains in the hip and leg. On September 20, 2002, Dr. Ogoke gave Pt. M a bilateral SI injection with fluoroscopy. He came to the office reporting a pain level of 7/10 in his low back and legs. At this visit, he was prescribed Vicodin ES (90). By September 20, 2002, Pt. M was only receiving Elavil, Bextra, and Vicodin ES. (Ex. 43: 32-40/3765-3773; 100/3833 & 102-112/3835-3845.)

7. Pt. M did not return for visits to Dr. Ogoke's office before he underwent back surgery on December 9, 2002. On March 5, 2003, he had a lumbar spine MRI that revealed:

A metallic transpedicular posterior plate screw device obscures detail at L4-5 and L5-S1 ... The remainder of the lumbar spine is normal in appearance. No disc herniation is demonstrated ... There appears to be partially obscured fluid in the soft tissue posterior to L4-L5, which although not entirely specific, most likely represents a post-operative seroma.

Pt. M saw Dr. Ogoke on March 18, 2003. He reported a 10/10 pain level in his lower back. He complained that the pain worsened since the surgery. He reported becoming nauseous using morphine for pain relief. By now, Dr. Ogoke had the results of the March 2003 lumbar MRI that

to him showed evidence of an L4-5 seroma, possibly post-operative. Pt. M was to be seen by his surgeon on April 21, 2003. Dr. Ogoke did a review of systems and gave a physical examination. He ordered Sensory Nerve Conduction Threshold Testing for Pt. M to address his lumbar radiculopathy symptoms. He diagnosed: post-laminectomy syndrome; sacroiliitis; lumbar radiculopathy; and, cervical strain resolved. Dr. Ogoke's treatment plan was to give Pt. M an SI injection as soon as possible, and wait until the seroma issue resolved before scheduling any lumbar ESI injections. Dr. Ogoke prescribed lumbar physical therapy treatments. He prescribed Zonegran 100 mg. (45), Ultracet (90), Elavil 50 mg. (30), EC Naprosyn 500 mg. (60), Skelaxin 400 mg. (90), and Percocet 10/325 mg. (90). The treatment plan included monitoring Pt. M's progress in addressing his pain. On March 21, 2003, Dr. Ogoke gave Pt. M a bilateral SI injection with fluoroscopy. Pt. M signed the forms that explained the procedure as well as the consent form to have the procedure. At this visit, he reported a pain level of 10/10 in his back with pain radiating into his ankles and toes. On March 24, 2003, with a pain complaint of 10/10 in the back that sometimes radiated up the back as well as into his lower extremities, Dr. Ogoke gave Pt. M a lumbar ESI injection with fluoroscopy at the L4-5, L5-S1 levels. Pt. M was prescribed Zydane (90) at this visit. (Ex. 43: 22-31/3755-3764; 84-86/3817-3819, 89-92/3822-3825 & 94-98/3827-3831.)

8. Pt. M was seen by Dr. Ogoke on April 2, 2003. He complained of a pain level of 8/10 in his neck and a "20/10" pain level in his low back. Pt. M described numbness and burning in his right big toe as well as numbness in the right lateral leg "consistent with the L5 dermatome that goes into the right foot." He reported that the low back pain goes up into the area between his shoulder blades and into the right side of his neck. He reported that the Zydane medication and physical therapy treatments were not helping. He reported suffering no new

injuries or falls. Pt. M was very anxious. Dr. Ogoke did a review of systems and gave a physical examination. He diagnosed: post laminectomy syndrome; sacroiliitis; aggravated cervical strain; lumbar spine radiculopathy; and, myofascial pain syndrome in the thoracic and cervical muscles. Dr. Ogoke's treatment plan was to do a lumbar ESI on April 4, 2003, continue recently started physical therapy, take oral medications, and monitor progress. At this visit, Pt. M was prescribed Percocet 10/325 mg. (90). On April 14, 2003, Dr. Ogoke gave Pt. M the lumbar ESI injection with fluoroscopy at the L5-S1 level. He came to this visit reporting a pain level of 8/10 in his lower back. At this visit, he was prescribed Percocet 10/325 mg. (90) and Zydane (90). Pt. M was seen by Dr. Ogoke on April 30, 2003. After reporting he had about five days of pain relief down about 40% from what it had been, Pt. M explained that his pain level was again at a level of 10/10. He asked for stronger medications for pain relief. Dr. Ogoke explained that his kind of neuropathic pain does not respond well to high doses of narcotics that he tried in the past. Dr. Ogoke's treatment plan was to do an epidurogram and then a lysis of adhesions procedure at the lumbar level. Because Pt. M had not kept his physical therapy appointments on March 25 and April 1, 2003, Dr. Ogoke counseled Pt. M on the need to be compliant in doing the physical therapy treatments. Dr. Ogoke gave a physical examination. He assessed Pt. M with: post-laminectomy syndrome; sacroiliitis; lumbar spine radiculopathy; an aggravated cervical strain; and, a myofascial pain syndrome in the thoracic and cervical muscles. Pt. M was prescribed Zydane (90), Zonegran 100 mg. (90), and Elavil 100 mg. (30). (Ex. 43: 10-12/3743-3745; 15-21/3748-3754 & 79-83/3812-3816.)

9. Pt. M was seen by Dr. Ogoke on October 13, 2003.¹⁴⁹ He complained of a pain level

¹⁴⁹ It is not clear whether Pt. M continued his care with Dr. Ogoke between April 30, 2003 and this visit of October 13, 2003. I could not locate any medical records (Exhibit 43) covering this time span. In April 2003, Dr. Ogoke sought insurer authorization for Pt. M to have six visits, but I could not locate any record showing that this was allowed. (Ex. 43, 13-14/3746-3747.)

of 10/10 in his low back that radiated into the lower extremities. Pt. M wondered if something was wrong with his lumbar spine fusion operation. Dr. Ogoke gave him a physical examination. He prescribed Norflex 100 mg. (60), Elavil 50 mg. (60), and Roxicet (Percocet) 5/325 mg. (60). Dr. Ogoke continued to prescribe lumbar spine physical therapy treatments. On October 16, 2003, Pt. M had a lumbar spine MRI that showed: post-operative decompression and spinal fusion at L5-S1; post-operative epidural fibrosis at this level dorsally and particularly to the right; a post-operative fluid collection in the laminectomy gap nearly resolved representing the seroma condition; and, no other significant findings. On the same day, Pt. M has a thoracic spine MRI that showed a minimal generalized disc bulge at T5-6, T8-9 with an otherwise unremarkable exam. This MRI was compared to a prior March 5, 2003 radiograph. On October 20, 2003, Dr. Ogoke gave Pt. M a lumbar transforminal ESI on the right side with fluoroscopy at the L3, L4 and L5 levels. Pt. M complained that day of a 6/10 pain level. He was also very agitated and anxious. He was prescribed Ativan for use for the next procedure. Pt. M saw Dr. Ogoke on October 22, 2003. He reported low back and shoulder pain. He believed the Roxicet (Percocet) was not working. He was seeking a note to excuse him from work which Dr. Ogoke gave him. On October 23, 2003, Pt. M has a cervical spine MRI that showed: C3-4 and C4-5 right sided uncinate hypertrophy and right sided neural foramina narrowing; C5-6 disc osteophyte complex without significant spinal canal stenosis or neural foramina narrowing; spinal canal with a normal diameter; spinal cord with a normal signal and morphology; and, no parvertebral soft tissue swells. On October 27, 2003, Pt. M had Sensory Nerve Conduction and Threshold Testing.¹⁵⁰ (Ex. 43: 4-9/3737-3742; 55-56/3788-3789; 58-68/3791-3801 & 70-77/3803-3810.)

¹⁵⁰ I found no medical records (Exhibit 43) to address if Pt. M stopped care with Dr. Ogoke after October 27, 2003. There were no later dated medical records on Pt. M that I could locate.

10. Dr. Ogoke's written reports on Pt. M's visits did not consistently list the names of the opioid medications being prescribed at each visit with inclusion of the dose and amount. These reports did not always explain why particular opioid medications were being prescribed in the particular doses and amounts. Not to list with specificity the details of each prescription within a visit report when the prescription was written, was Dr. Ogoke's practice and not unique to Pt. M. Instead, he would make a copy of the prescription to keep in the patient's medical records. (Exs. 43 & 84.)

11. Dr. Satwicz viewed Pt. M as an opioid naïve patient when he first saw Dr. Ogoke and was prescribed opioid medications. He was particularly concerned that Dr. Ogoke prescribed the Duragesic (Fentanyl) Patch at 50 mcg. at this initial visit. He felt to start this patch should have been done at the lowest dose and not at this higher level. Dr. Satwicz would not have prescribed Fentanyl as a first-line opioid drug for Pt. M, especially given the opioid prescription for Vicodin ES that Pt. M was also given at this first visit. He opined that this was too much narcotic for Pt. M based on Pt. M's clinical findings. Dr. Satwicz explained:

[T]he package insert [for the Duragesic Patch] is very clear on this, [to use] after other oral modalities have failed. And starting at a dose of 50 micrograms in an opioid-naïve person ... is at least twice what would be appropriate. The 25 microgram patch is typically the starting dose ... in 2002 ... The same with Vicodin ES ... he has not had an opioid trial at all ... and he has been prescribed the non-steroidals ... all in one visit for neck and back pain. I think this is gross overdose of medication for this gentleman.

Dr. Satwicz concluded that Dr. Ogoke did not follow the standard of care in pain management because he should have started prescribing with lower doses of less strong pain medications to see if they provided adequate pain relief instead of simply using strong narcotics and a lot of medications, including the non-opioid medications, all at once. Dr. Satwicz opined that Dr. Ogoke failed to evaluate the effectiveness of potentially adequate less problematic medications.

For Dr. Satwicz: “Any opioid, and this is a key point, is started as a trial. It’s not an end treatment in [and] of itself, it’s a trial.” Dr. Satwicz opined:

[W]hen that trial is undertaken, we have to be very aware of the side effects or the issues associated with opioids. And there is a myriad of things that opioids and their chronic use can do, and we have to be very aware of those and watch for those, monitor that and include that monitoring in our follow-up notes when we see those patients back.

Dr. Satwicz acknowledged that he did not find another prescription written for the Duragesic Patch in Pt. M’s medical records. (Testimony of Dr. Satwicz, Vol. IX, 1712, 1719-1720; Vol. XII, 2195-2200-2210 & Vol. XIII, 2598-2605.)

12. Dr. Satwicz opined that Dr. Ogoke violated the standard of care in the practice of medicine by not providing in his visit reports, details about the dosage levels and amounts of the medications he was prescribing to Pt. M. Dr. Satwicz also concluded that Dr. Ogoke should have described the changes made to the medications prescribed at each visit with Pt. M, including an explanation within the visit reports of why any changes were made. Dr. Satwicz opined these failures were an issue of importance for any other physician involved in Pt. M’s care who was trying to learn what occurred at any particular visit with Dr. Ogoke. Dr. Satwicz opined that continuity of care requires this kind of information within medical records. For Dr. Satwicz, this meant Pt. M’s medical records had to be legible, even if in handwriting, including the prescription information. Dr. Satwicz concluded that because Dr. Ogoke was not Pt. M’s primary care physician (PCP), Pt. M’s actual PCP and Pt. M’s other treating physicians, should have been at all times able to read a visit report and gain the information they needed, including full prescription information, without having to try to locate a copy of a prescription to match up to the date of an office visit or report. Dr. Satwicz concluded Dr. Ogoke was not at all times able to provide legible medical records containing the opioid prescribing history readily discernable

so other physicians could learn why particular opioids and doses of them were prescribed at any given time. (Testimony of Dr. Satwicz, Vol. IX, 1670-1676, 1689-1692, 1702-1704, 1712, 1719-1723; Vol. XII, 2194-2210, 2292, 2406-2407 & Vol. XIII; 2598-2605.)

13. Dr. Trescot concluded from the medical records that Pt. M did not come to Dr. Ogoke as opioid naïve at the first visit in early May 2002. She understood that Pt. M had taken Vicodin three or four times a day at least in and around January 2002. For Dr. Trescot, Pt. M did not revert to being opioid naïve because he was not on pain medication at his first visit with Dr. Ogoke in early May 2002. As support for this assessment, Dr. Trescot noted that Pt. M reported to Dr. Ogoke that Vicodin had not helped to relieve his pain level, and the medical records revealed that he had been taking Vicodin in January 2002. For Dr. Trescot, the high degree of pain Pt. M described and reported to Dr. Ogoke in May 2002 at his initial visit was a significant factor in Dr. Ogoke's decision to prescribe opioids for Pt. M. Dr. Ogoke gave a comprehensive evaluation with detailed impressions reached, and only then decided to prescribe Pt. M a number of medications at this first visit that included two opioids. Pt. M was prescribed anti-inflammatory medications, muscle relaxants, tricyclic anti-depressants, and a transdermal or through-the-skin Duregesic (Fentanyl) patch for slow release of pain medication along with Vicodin for break-through pain. Dr. Trescot concluded that this prescribing was within the standard of care in the practice of pain management medicine in light of all these factors. To Dr. Trescot, this careful use of opioids was not overloading Pt. M with short-acting narcotics. In addition, the medical records revealed to Dr. Trescot that Pt. M's treatment with this medication regimen was well monitored by Dr. Ogoke. Dr. Trescot grounded her opinion as within the ASIPP Guidelines for prescribing for non-cancer chronic pain. She explained how the long-acting opioid patch would not have given Pt. M the "buzz" associated with "addiction" that

short-acting opioids could have. Dr. Trescot maintained that concerns about patients being able to remove the long-acting features of these opioids to experience that buzz did not begin to be recognized until about 2005, and this concern was not an issue with the Duregesic Patch because it was put on the skin. Dr. Trescot further opined that when Dr. Ogoke issued the opioid prescriptions in May 2002 to Pt. M, there were no fixed tables available for a physician to determine specific opioid doses to prescribe. She opined that the particular opioid dosages for patients were,

extraordinarily variable ... not based on weight but rather based on how the patient absorbs the medicine, how the body metabolizes the medicine, what type of pain problem they have. Different pain problems respond differently to different opioids. And it depends on the other medications that they are taking. So there is a genetic component and there is a pharmacologic component and then there is an absorption and excretion component.

(Ex. 85. Testimony of Dr. Trescot, Vol. XIV, 2661-2662, 2669-2672, 2676-2677, 2685-2688; Vol. XV, 2937-2946 & Testimony of Dr. Ogoke, Vol. VII, 1448-56.)

14. Dr. Trescot opined that the failure of Dr. Ogoke to list within each of his reports on Pt. M's visits the details of an ongoing prescription, was not practicing medicine below the standard of care. From her review of the medical records, Dr. Trescot concluded that when Dr. Ogoke made a prescription change or addition, if significant, the report of the visit explained the change or addition. Dr. Trescot opined that having a copy of the actual written prescription in Pt. M's medical records to line up with the report of a visit of the same date, was sufficient to provide any needed information to another physician providing care to Pt. M. For Dr. Trescot, no prescribing guidelines called for the full details of a prescription to always be included within the report of a visit when the prescription was written, just that the details of the prescription be available within the patient's medical records. For Dr. Trescot, there are a number of ways to organize a patient's medical records to allow another physician to gain needed background

information, including a prescription history on a mutual patient. (Ex. 84. Testimony of Dr. Trescot, Vol. XIV, 2685-2686, 2688 & Vol. XV, 3002, 3074.)

Conclusion and Recommendation

There are two claims brought by the BORM against Dr. Ogoke in the Statement of Allegations for violating the standard of care with Pt. M. One claim involved the initial visit and Dr. Ogoke prescribing extensive pain medications, including higher doses of opioids than the lowest doses of them, despite Pt. M at the time not taking opioids. The BORM did not prove this charge. The other charge involved the lack of essential information in the reports of Pt. M's visits, including the details of each prescription written, and the reasons for the prescribing decisions Dr. Ogoke made. The BORM has proven only the latter part of this charge involving the reasons for prescribing decisions. The BORM has not proven a violation of standard of care by Dr. Ogoke for not including the details of each prescription written within the report of the visit when the prescriptions were written.

Charge that Dr. Ogoke Overprescribed Pain Medications at Pt. M's Initial Visit

Dr. Ogoke concluded that Pt. M presented at the initial visit with unrelenting severe pain. Pt. M had either just recently stopped or a few months prior had stopped, taking Vicodin three or four times a day as he had been doing in January 2002 based on Dr. Rossi's report that Dr. Ogoke kept in Pt. M's medical records. Dr. Ogoke's initial visit report with the results of the detailed physical evaluation Pt. M received along with the background documents Pt. M provided about his condition and areas of pain, support Pt. M's need for effective pain control. There was no proof that Pt. M had provided a false prior medical history or had over-reported his high pain levels. No evidence showed that Dr. Ogoke made errors in the conditions he found Pt. M had and listed in his initial report. Nothing in the subsequent visits and physical examinations

and test results showed that Pt. M had been exaggerating his pain complaints.

Dr. Satwicz was concerned about a lack of discussion in the visit report of the initial evaluation of Pt. M about why Dr. Ogoke prescribed the medications he did, why at the doses he did, and why so many new medications were prescribed for Pt. M to take all at once having come to Dr. Ogoke being opioid naïve. Dr. Satwicz opined that being opioid naïve does not mean Pt. M never took opioids, but at least for a significant time period that he had not been taking opiates when Dr. Ogoke prescribed them at this initial visit. He opined that proper prescribing was not done by Dr. Ogoke who should have been more cautious and prescribed trial low doses of opioids, and not have prescribed so many medications for Pt. M to take for the first time due to concerns about side-effects. Dr. Satwicz opined that taking the more cautious route would not have been failing to address Pt. M's pain complaints.

Regardless of when Pt. M had stopped taking Vicodin, he came to Dr. Ogoke on no pain medications. The extent of his use of Vicodin prior to this initial visit did not emerge as crucial to Dr. Ogoke's assessment of his pain medication needs at this initial visit. Dr. Ogoke did not address in the report of this initial visit why he prescribed the higher doses and not the lowest dose levels of four non-opioid and two opioid medications. But, he did make it clear in his report and confirmed by his testimony, that he wanted to provide Pt. M with adequate pain control. Given Pt. M's high level pain complaints and his underlying conditions, Dr. Ogoke decided this could best be initially achieved by providing the particular medication regimen he devised. If that was all Dr. Ogoke was intending to do for Pt. M in his treatment plan, that would have needed more support in light of Dr. Satwicz's concerns about this kind of prescribing for Pt. M. But, the record shows this was an initial prescribing for Pt. M. Dr. Ogoke was embarking upon an ongoing treatment plan for Pt. M that would include more diagnostic tests, and other

pain reducing measures that included a physical therapy evaluation, Bioelectric treatments, and interventional procedures. Dr. Ogoke was expecting periodic visits with Pt. M going forward soon after this initial visit. He wrote in the report of this initial visit that Pt. M agreed to his treatment plan. Dr. Ogoke was not just establishing an ongoing medication regimen with high dose medications for Pt. M's pain.

Dr. Trescot supported the course of prescribing that Dr. Ogoke took at this initial visit by Pt. M that included a long-acting opioid medication, the Duregesic (Fentanyl) Patch and use of the Vicodin for break-through pain, noting the significance of not just increasing the amount of Vicodin Pt. M would take. Dr. Trescot also supported the overall treatment plan that Dr. Ogoke developed at this initial evaluation based on Dr. Ogoke's thorough evaluation of Pt. M. Dr. Trescot did not take issue with Dr. Ogoke's conclusion that Pt. M had severe pain that Dr. Ogoke was justified in trying to control. Dr. Trescot further explained that the Duregesic Patch releases the long-acting opioid, Fentanyl, through the skin so it is not taken orally. She explained that in 2002, there were fewer concerns about prescribing a long-acting opioid for severe and chronic pain, because using such medications avoided the spike in pain control followed by a lack of pain control the use of the short-acting opioid, Vicodin, would provide. Only in about 2005 did concerns arise that patients could remove the coating on long-acting opioid oral medications to make them short-acting which would be potentially quite risky if the patient abused the medication.

I found Dr. Trescot's opinion persuasive that Dr. Ogoke had not violated the standard of care in 2002 when he prescribed for Pt. M as he did at his initial visit, especially when this was a first step for Pt. M toward gaining pain relief to be followed by frequent re-examinations, interventional procedures, physical therapy treatments, diagnostic tests, and reviews of how well

the medication regimen was helping with pain relief. The charge against Dr. Ogoke of inappropriately prescribing high opioid doses of medication for Pt. M's clinical condition at the initial evaluation has not been proven by the BORM.

Charge of Prescription Details not in Visit Reports

Dr. Satwicz opined that Dr. Ogoke's visit reports on Pt. M should have contained the details of the prescriptions written at each visit to allow other evaluating and treating physicians to adequately follow Dr. Ogoke's medication treatment decisions for Pt. M. Dr. Satwicz did not agree that Dr. Ogoke addressed this need by placing copies of the prescriptions written into Pt. M's medical records. He contended that the copies of the prescriptions were not always adequately legible, likely due to difficulties in copying them off a prescription pad, and were not easy to locate within Pt. M's medical records to line-up with the particular visit when the prescription was written.

Dr. Satwicz's concerns are understandable. I did the best I could to provide in the findings of fact the course of care Pt. M received from Dr. Ogoke. I found some pages in the medical records were not legible. Some of the footnotes I made demonstrate cautions in my piecing together the course of events. In light of the lack of any chronological or other clear order for Pt. M's medical records, it was very time-consuming to produce findings of fact. Despite how Exhibit 43 was presented for me to use, I conclude insufficient proof was presented by the BORM that Dr. Ogoke's medical records on Pt. M were poorly maintained so that copies of the prescriptions were not reasonably accessible within Pt. M's medical records. The findings show I was able to line-up prescription details with particular visit reports when they were written. No specific regulations or guidelines required Dr. Ogoke at the time he cared for Pt. M to have included details on a prescription within the visit report when it was written.

Charge of Inadequate Details in Visit Reports on Why Prescriptions were Written and Treatments Plans were Reached

The BORM has proven the charge that Dr. Ogoke's visit reports that followed gaps in time when Pt. M did not return to care with Dr. Ogoke, failed contain adequate discussions about Pt. M's conduct between visits. This essential information concerned: whether Pt. M received pain management care with another treating physician; whether he received from another physician different prescriptions for pain relief or received renewals of Dr. Ogoke's prescriptions through another physician; and, whether he engaged in no further pain management care even after his prescriptions from Dr. Ogoke ran out. I found Dr. Satwicz's opinion to be persuasive to support this charge. Dr. Ogoke may have had adequate reasons for his treatment decisions after these time gaps, but his visit reports once Pt. M returned to his care required more detail to support them and to explain Pt. M's interim care or lack of care. This was misconduct by Dr. Ogoke in regard to his recordkeeping responsibilities.¹⁵¹

Dr. Satwicz opined that Dr. Ogoke had violated the standard of care regarding the adequacy of the information within the visit reports. This involved the charge that Dr. Ogoke did not discuss why he was continuing a certain medication or dose of it, or why he was changing or adjusting the dose of a prescribed medication, or whether Pt. M was a concern for diverting the opioid medication he was receiving. Dr. Satwicz wanted a visit report to explain everything about the care and progress Pt. M was making at the time, as well as discussions about whether he was being compliant with the medication regimen and with the treatment plan. I found merit to this concern when Dr. Ogoke failed to adequately address in the visit reports following long gaps of time when Pt. M did not see Dr. Ogoke.

¹⁵¹ There are three visit reports that address Pt. M's prescriptions and other treatment plans **determined** after these time gaps: September 3, 2002-Ex. 43, 38/337; March 18, 2003-Ex. 43, 29-30/3762-3763; and, September 13, 2003-Ex. 43, 9/3742.

The aftermath of the initial visit for Pt. M involved a time gap of about four months before Pt. M returned to see Dr. Ogoke. There was a need for information in a subsequent visit report to address Pt. M's progress with the initially determined treatment plan, including the medication regimen, especially given the many high dose medications, including opioids, that Pt. M had been prescribed to get his pain level under better control as a priority of care. Pt. M did not return for care with Dr. Ogoke until September 3, 2002. There is a medical record that listed Pt. M as having had a lumbar ESI procedure in July 2002 by another physician, and there is the record of Pt. M in May 2002 having lumbar spine x-rays that Dr. Ogoke ordered. But, that is it. Did another physician take over Pt. M's care during this time period and maintain Dr. Ogoke's medication regimen, and if so why? Nothing in the visit report of September 3, 2002 explained the care Pt. M received during this time gap and whether after the initial prescribing Dr. Ogoke had done on May 1, 2002, Pt. M took no further medication or even if Pt. M filled his prescriptions. If Pt. M did not communicate with Dr. Ogoke's office during this time gap, and said nothing about what medications he took during this time gap, that information was not found in the September 3, 2002 visit report.

The failure to address this gap in time supports Dr. Satwicz's opinion that Dr. Ogoke did not maintain Pt. M's medical records with adequate information on Dr. Ogoke's care of Pt. M. Neither the testimony of Dr. Ogoke nor the opinion evidence of Dr. Trescot provided sufficient proof to explain what happened with Pt. M's treatment plan with Dr. Ogoke during those four months. During September 2002 when Pt. M again saw Dr. Ogoke, he received prescriptions for Bextra and Elavil, two of the prescriptions he had received at the initial visit on May 1, 2002, but there was no medical record containing the actual prescriptions to determine whether the doses had been reduced, were the same, or were increased. Also, at the September 20, 2002 visit, Pt.

M was prescribed Vicodin ES, which was what he had been prescribed at the May 1, 2002 visit. I could not locate any medical record to show Pt. M was also prescribed the Duregesic (Fentanyl) Patch, which he had been prescribed on May 1, 2002. The September 2002 visit reports did not address if this prescription was discontinued or never renewed after May 1, 2002, or never filled by Pt. M. This does show a failure of standard of care by Dr. Ogoke; a combination of prescribing high medication doses of many medications including two opioids at an initial visit to a new patient who at the time was on no opioid pain medications, with no medical record demonstrating that over those four months there was any monitoring that was done in terms of the medication treatment regimen as was expected to have occurred from a review of the initial evaluation report. In this regard, I found that Dr. Trescot's opinion seemed to assume there had been monitoring of the medication regimen that occurred over these four months. Since there was no such monitoring proven, I do not find Dr. Trescot's opinion can be fully relied upon as to this important point.

The same lack of sufficient information in a visit report occurred when there were further time gaps in Dr. Ogoke's care of Pt. M. After the month of September 2002, Pt. M did not return to treat with Dr. Ogoke until March 18, 2003. He had further back surgery in December 2002, but he had left Dr. Ogoke's care on September 20, 2002 with a detailed treatment plan and medication regimen. There was no discussion in the March 18, 2003 visit report explaining what kind of treatments Pt. M received prior to the surgery or after the surgery. Another gap in time occurred between April 30, 2003 and October 13, 2003. Pt. M had left the April 30, 2003 visit with prescription and other treatment regimens. The October 13, 2003 report did not address what kinds of prescription and other treatment regimens Pt. M pursued, if any, during this time gap. The BORM has proven that this lack of adequate discussion within Pt. M's visit reports

following these gaps in time was a violation of standard of care regarding Dr. Ogoke's recordkeeping practice.

Patient N

Summary

Patient (Pt.) N did not testify. No complaint by Pt. N to the Board of Registration in Medicine was presented. (Ex. 83.)

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Dr. Ogoke inappropriately prescribed high doses of opioids based on Pt. N's clinical condition.
- Dr. Ogoke continued to prescribe opioids despite multiple failed urine drug screen tests.

The facts the BORM alleged to support its allegations included the following:

- Pt. N treated with Dr. Ogoke December 2003 into July 2006 for shoulder, neck, and back pain.
- Dr. Ogoke's diagnoses for Pt. N included: impingement syndrome in the shoulder; rotator cuff tendinitis; acromioclavicular joint strain; shoulder contusion; myalgia of the right arm; and, cervical strain.
- Dr. Ogoke treated Pt. N with a combination of pain medications, including Percocet, MS Contin, and Oxydocone. He also treated Pt. N with multiple interventional procedures including epidural steroid, sacroiliac joint, and facet joint injections.
- Pt. N underwent several urine drug screens that tested positive for cocaine while in care with Dr. Ogoke, who continued to prescribe opioids to Pt. N, and who failed to address these positive results.
- Pt. N also had several urine drug screens that tested negative for opioids although Dr. Ogoke was prescribing opioids to Pt. N. Dr. Ogoke failed to address these results in his visit reports and continued to prescribe opioid medication to Pt. N.

Findings of Fact

1. Pt. N was a thirty year old male working full time in communications when he started care with Dr. Ogoke on December 19, 2003. He came with a history of an injury from April 2003 when he swung a golf club and hit a rock causing a sudden onset of pain in his right shoulder that radiated down his right arm into his right hand. Pt. N came to Dr. Ogoke having taken Naproxen, Allegra, and Vioxx for pain. At his initial evaluation, Pt. N reported primarily

right shoulder area radiating pain that was sharp, shooting, and constant, with a pain level rating of 10/10 or more with activity, and only rest alleviating the pain down to an 8/10 level. He had undergone a bone scan in November 2003 to address right hip pain and rule out any fracture. The bone scan was normal for the whole body, and the right hip findings were unremarkable. Pt. N had no prior surgeries. Dr. Ogoke had Pt. N complete a questionnaire providing a medical and personal history, and he signed various new patient forms, including the Narcotics Prescription Policy & Agreement (narcotics agreement). Pt. N reported that he did not use any illicit or narcotic drugs. He complained that his pain level was disturbing his sleep and interfering with his work and personal life. In addition to his right shoulder radiating pain, Pt. N reported left wrist and hand pain. Dr. Ogoke did a review of systems, and gave a comprehensive physical examination.¹⁵² He saw a need for a right shoulder MRI, partly to rule out a rotator cuff tear. He ordered left wrist x-rays to rule out a fracture. He assessed Pt. N with: an acromioclavicular joint strain; myofascial pain syndrome; left wrist pain; and, left CMC (carpometacarpal) joint tenderness. At this initial evaluation, Dr. Ogoke prescribed a high dose NSAID medication, Skelaxin 800 mg. (120), and Ambien 5 mg. (14) for the sleep issue. He prescribed Percocet 10/325 mg. (90) for pain. (Ex. 43: 362-365/4225-4228; 367-369/4230-4232; 372-375/4235-4238; 427-431/4290-4294; 433-438/4296-4301 & 441/4304.)

2. Dr. Satwicz opined that prescribing the opioid Percocet for Pt. N at the high dose level of 10/325 mg. instead of the lowest dose level of 5/325 mg. at this initial visit, was excessive. Pt. N was not at the time taking any opioids. (Testimony of Dr. Satwicz at Vol. XII, 2218-2221.)

¹⁵² Although Dr. Ogoke's physician assistant is the first signer of the comprehensive initial visit report and Dr. Ogoke the second signer, I concluded Dr. Ogoke and not his physician assistant did the review of systems, gave the comprehensive physical examination, and reached the diagnoses and treatment plan for Pt. N. The record shows it was Dr. Ogoke's practice to provide this initial visit comprehensive evaluation and not have his physician assistant do that. (Ex. 43, 362/4225.)

3. Pt. N was seen at Dr. Ogoke's office on January 12, 2004, reporting a pain level of 9/10 in the right shoulder. He reported not being able to do the shoulder MRI due to claustrophobia. The treatment plan remained for Pt. N to have a right shoulder MRI and left hand and wrist x-rays. He received prescriptions at this visit for Elavil 25 mg. (30), Skelaxin 400 mg. (120), and Percocet 10/325 mg. (90). (Ex. 43: 361/4224; 439-440/4302-4303 & 442-443/4305-4306.)

4. On February 6, 2004, Pt. N was seen at Dr. Ogoke's office. He reported right shoulder deep achy pain at a level of 8-9/10 that radiated into his right arm and hand with numbness in the hand. He also reported left wrist and hand pain. He acknowledged having been in several motor vehicle accidents. He had not had spinal imaging done. He was given a physical examination and was assessed with: a cervical strain with radiculopathy; myofascial pain syndrome; and, a right AC (acromioclavicular) joint strain. The treatment plan was to order a cervical MRI to rule out any herniation, and left wrist and hand x-rays. Physical therapy was ordered for the right shoulder, neck and trap. He was to have trigger point injections for the rotator cuff and for the AC joint strain. He signed various consent forms for having the procedures. At this visit he was prescribed Flexeril 10 mg. (90), Elavil 25 mg. (60), and Percocet 10/325 mg. (60). (Ex. 43; 358-360/4221-4223 & 446-449/4309-4312.)

5. Pt. N had a right shoulder MRI on February 11, 2004. No rotator cuff abnormality was detected. A small inferolateral acromion osteophyte was detected. The rest of the MRI was unremarkable, although the MRI did not exclude an adhesive capsulitis. On February 25, 2004, Pt. N was seen at Dr. Ogoke's office seeking medication refills. The treatment plan was for Pt. N to have a cervical MRI, and left wrist and hand x-rays. He was prescribed Flexeril 10 mg. (90), Percocet 10/325 mg. (60), and Elavil 25 mg. (60). Also on February 25, 2004, Pt. N had a

cervical MRI showing a C6-7 level small left paracentral herniated disk with mild left neural foramina narrowing. (Ex. 43: 355/4218 & 451-456/4314-4319.)

6. Pt. N was seen at Dr. Ogoke's office on March 12, 2004. He reported achy and severe pain in his right shoulder at an 8/10 level. At this point, Pt. N had not had any trigger point injections. He acknowledged having a fear of needles. His recent cervical MRI was read as showing arthritis at the C5-6 level and a herniation at the C6-7 level. Pt. N reported a recent exacerbation of low back pain that was intermittent with a pain range of 0-8/10 levels, and that at times reached his right leg to the knee. He described the pain as a "pulling sensation." He was given a physical examination, and assessed with: lumbar spine radiculopathy and a need to rule out any herniation; right shoulder AC joint osteoarthritis based on the recent MRI; cervical facet arthropathy at the C5-6 level with a herniation at the C6-7 level; left hand and wrist pain with a need to rule out osteoarthritis or an occult fracture; myofascial pain syndrome; and, a right AC joint sprain. The treatment plan was to do a lumbar spine MRI and schedule a trigger point injection for the right AC joint sprain and for the rotator cuff symptoms. Pt. N received prescriptions for Percocet 10/325 mg. (60), Ativan 2 mg. (2) for anxiety relating to the procedures, and Flexeril 10 mg. (90). Pt. N was seen by Dr. Ogoke on March 19, 2004. He reported a pain level of 8/10 in his right shoulder. Dr. Ogoke gave Pt. N a right shoulder acromioclavicular joint injection and a subacromial injection into the rotator cuff on the infraspinatus and supraspinatus tendons. Pt. N was seen at Dr. Ogoke's office on March 25, 2004. He reported his right shoulder pain was at a 10/10 level and no better, and that his low back pain was at a 5/10 level. He was given a physical examination. The treatment plan was to start physical therapy as soon as possible. He received a prescription for Percocet 10/325 mg. (90). (Ex. 43: 6/3869; 8-9/3871-3872 & 350-357/4213-4220.)

7. Pt. N was seen at Dr. Ogoke's office on April 22, 2004. He reported that the right shoulder pain was now significantly improved at about 80% from the baseline pain level following the March 19, 2004 injection. He reported being able to use his right arm more freely. He reported low back pain that reached at times into his right leg to his knee. He described this pain as achy, especially in the morning. He had experienced this pain over several years but he denied it was due to any specific injury. He had a physical examination. He was assessed with: cervical strain; cervical radiculopathy; facet arthropathy at C5-6 and disk herniation at C6-7; lumbar strain and radiculopathy with a need to rule out disk herniation; right shoulder AC joint osteoarthritis; left hand and wrist pain with a need to rule out osteoarthritis or an occult fracture; myofascial pain syndrome biceps attachment site of the Coracoid process of the right shoulder; and, right AC joint sprain. The treatment plan was to have: a lumbar spine MRI and consider doing a lumbar epidural steroid injection (ESI) series upon review; a cervical ESI series as soon as possible; and, continue physical therapy home exercises. A urine drug screen (UDS) was done. He was prescribed Percocet 10/325 mg. (90), Ativan 2 mg. (2) for procedures, and Flexeril 10 mg. (90). The April 24, 2004 results of the UDS were negative for opiates, and the April 30, 2004 result of the Oxycodone (Percocet) screen was positive. Pt. N was given a note to excuse him from work. (Ex. 43: 10/3873; 12-15/3875-3878; 19-21/3882-3884; 34-35/3897-3898; & 47-49/ 4210-4212.)

8. Pt. N had a lumbar spine MRI on April 23, 2004 that showed:

Mild to moderate degenerative changes at L4-5 and L5-S1 ... greatest at L5-S1 where the disc bulge abuts but does not appear to displace the right S5 nerve root and there is mild bilateral neural foraminal narrowing.

(Ex. 43, 16-17/3879-3980.)

9. Pt. N had a right shoulder MRI on May 4, 2004 that showed:

No obvious rotator cuff tear although some fluid is present between the infraspinatus and supraspinatus proximal to the tendon insertions. Clinical correlation recommended. Mild DJD [degenerative joint disease] AC joint.

This test was “significantly limited” due to Pt. N’s movements during it, and repeating this MRI was recommended. (Ex. 43; 24/3887 & 32-33/3895-3896.)

10. Pt. N was seen at Dr. Ogoke’s office on May 21, 2004. He reported right shoulder pain at a level of 8/10. Although he received some pain relief from the trigger point injections done in March 2004, the pain returned and was “intermittent and burning,” as well as radiating into the right arm. Pt. N’s right shoulder MRI was read as showing “AC joint arthritis with mild type II acromion as well as inflammation of infraspinatus and supraspinatus tendon.” The source of the pain was considered as possibly emanating from the neck in light of Pt. N’s “arthritis ... as well as cervical disk bulge at C6-C7.” He reported “0/10” low back pain and “1/10” neck pain. He was given a physical examination. The assessment remained unchanged. The right shoulder MRI results and the treatment plan were discussed with Pt. N. The treatment plan was to do a cervical ESI series as soon as possible. Pt. N was referred to an orthopedic surgeon concerning his shoulder condition. A UDS was to be done at the next visit. Pt. N received prescriptions for Percocet 10/325 mg. (90) and Flexeril 10 mg. (90). These two prescriptions were renewed on June 17, 2004. On July 15, 2004 Pt. N received prescriptions for Percocet 7.5/325 mg. (30), Ativan 2 mg. (2) for procedures, and Bextra 20 mg. (60). Also on July 15, 2004, a note was entered into Pt. N’s medical record by Dr. Ogoke’s office stating that Pt. N was non-compliant with planned treatments and was seeing a chiropractor. The note mentioned that Pt. N requested Percocet refills. On July 23, 2004, Dr. Ogoke gave Pt. N a right-sided subacromial injection into the rotator cuff of the infraspinatus and supraspinatus tendons. He came to this visit with a pain complaint of 8-9/10 in the right shoulder. He requested Percocet refills, and received a

prescription for Percocet 7.5/325 mg. (90). (Ex. 43: 25-26/3888-3889; 36-39/3899-3902 & 341-346/4204-4209.)

11. On August 16, 2004, Pt. N had a new medical record set up for him in Dr. Ogoke's practice, and had a new comprehensive initial examination done by Dr. Ogoke to address injuries from a car accident on August 13, 2004. He reported he was struck by a car that was going at a slow speed. He did not fall but stretched out his arms and hands to break a fall. He reported experiencing "immediate pain of the right wrist and hand ... sharp ... constant ... [m]ovement worsens the pain ... disturbing his sleep." The pain level was reported as 10/10 and could worsen with activity. He also reported right shoulder and neck pain. Pt. N acknowledged feeling under stress from the pain with his work and social-family life negatively impacted. Pt. N completed a set of new patient forms, and again signed the narcotics agreement. He was taking Percocet and Naprosyn. Dr. Ogoke did a review of systems and a comprehensive physical examination. The impressions reached were: a shoulder contusion; cervical strain aggravated; upper extremity sympathetically maintained pain; and, myalgia of the forearm and arm. Pt. N was prescribed muscle relaxants, NSAIDs (non-steroidal anti-inflammatory drugs), Doxepin 2 mg. (30), and Percocet 7.5/325 mg. (90). He was given an elastic bandage for his wrist and hand. The treatment plan was to have right shoulder and wrist x-rays, and to defer physical therapy. Also on August 16, 2004, Dr. Ogoke gave Pt. N a cervical ESI with fluoroscopy at the C3-4 level. On August 18, 2004, Pt. N had right shoulder and right wrist x-rays. Both showed no fractures. Pt. N was seen at Dr. Ogoke's office on August 30, 2004 complaining of a pain level of 8/10 in the right shoulder and right wrist, but he rated his neck pain level as 0/10. A physical therapy evaluation was ordered. (Ex. 43: 29-31/3892-3894; 39/3902; 41-42/3904-3905; 191-199/4054-4062; 222-243/4085-4106; 246-248/4109-4111; 250-251/4113-4114; 253/4116 & 337-

339/4200-4202.)

12. On September 7, 2004, Pt. N was seen at Dr. Ogoke's office. He reported a pain level of 10/10 in his right shoulder that caused him trouble with sleep, became worse with activity, and could be alleviated with rest. He reported a 0/10 pain level in his neck with relief from his last cervical ESI procedure. He reported low back pain that ranged from levels of 2-9/10 that was "deep, achy, diffuse," and at times radiated into his legs. He was given a physical examination and assessed with: cervical strain resolved; cervical radiculopathy resolved; cervical facet arthropathy at C5-6; cervical disk herniation at C6-7; right shoulder acromioclavicular joint osteoarthritis; right shoulder rotator cuff tendonitis; right shoulder subacromial bursitis; right shoulder type II acromian; lumbar sprain; lumbar radiculopathy; lumbar disk bulging at L3 through S1; lumbar facet arthropathy; and, lumbar degenerative disk disease at L4-5. The treatment plan was to have a right shoulder trigger point injection as soon as possible, continue physical therapy for the right shoulder, and to be seen as needed. Pt. N was prescribed Percocet 7.5/325 mg. (90) and Ativan 2 mg. (2) for procedures. A September 17, 2004 report on his seven physical therapy treatments for the right shoulder and right wrist showed minimal improvement with the treatments having provided only temporary relief. Nevertheless, the recommendation was to continue the physical therapy. Dr. Ogoke gave Pt. N a right shoulder acromioclavicular joint injection on September 23, 2004. Pt. N was seen at Dr. Ogoke's office on September 24, 2004 seeking medication refills and complaining of pain in his right wrist. He received prescriptions for Percocet 7.5/325 mg. (90) and Ativan 2 mg. (2) for procedures. He received a note to keep him out from work. On September 29, 2004, Dr. Ogoke gave Pt. N a cervical ESI with fluoroscopy at the C3-4 level. Pt. N complained at that visit of a pain level of 7/10 in his neck. On October 6, 2004, Pt. N received a prescription for Ativan 2 mg. (2) for procedures. On

October 14, 2004, he received a prescription for Percocet 7.5/325 mg. (90), Ativan 2 mg. (2) for procedures, as well as another Ativan 2 mg. (2) prescription not to be filled until October 15, 2004. Also on October 14, 2004, Dr. Ogoke gave Pt. N a second right shoulder acromio-clavicular joint injection. (Ex. 43: 44-45/3907-3908; 200-202/4063-4065; 219-220/4082-4083; 254-260/4117-4123; 262-266/4125-4129 & 331-336/4194-4199.)

13. On November 3, 2004, Pt. N was seen at Dr. Ogoke's office. He was seeking medication refills and was prescribed Percocet 7.5/325 mg. (90), Skelaxin 800 mg. (60), Elavil 25 mg. (30), and Ativan 2 mg. (10) for procedures.¹⁵³ After completing consent and information forms on November 4, 2004, Dr. Ogoke gave Pt. N a transforaminal lumbar ESI with fluoroscopy at the L5-S1 level for his lumbar radiculopathy. Pt N was prescribed a Lidoderm Patch 5% (90) that day. After completing consent and information forms, on November 23, 2004, Dr. Ogoke gave Pt. N a bilateral sacroiliac joint (SI) injection. Also on November 23, 2004, Pt. N sought refills of his prescriptions. He reported having lost the prescription slip for the Lidoderm Patch. He was prescribed Skelaxin 800 mg. (120), Percocet 7.5/325 mg. (90), Ativan 2 mg. (2), Elavil 25 mg. (60), and another prescription for a Lidoderm Patch 5% (90). Pt. N had a UDS done at this visit. The results showed that he was positive for Cocaine, negative for opiates, and negative for Oxycodone following an Oxycodone screen. Dr. Ogoke's office circled these results on the UDS results sheet. (Ex. 43: 49-54/3912-3917; 56-64/3919-3927; 271-276/4134-4139 & 324-330/4187-4193.)

14. Pt. N was seen by Dr. Ogoke on December 24, 2004. He was complaining of right shoulder pain at a 9-10/10 level. Dr. Ogoke found Pt. N "definitely very uncomfortable with

¹⁵³ Although the prescription for Ativan (Ex. 43, 50/3913) explained this was to be taken in connection with procedures, there was no explanation provided that I could read in the handwritten report of this visit to explain this large number of pills which was different from prior prescriptions written for Ativan. Pt. N received another prescription for Ativan 2 mg. (2) on November 23, 2004 (Ex. 43, 58/3921).

difficulty with impingement of the shoulder with diminished range of motion of abduction ... claims compliance with his medications with little relief.” Dr. Ogoke confronted Pt. N with the results of the November 23, 2004 UDS that were positive for Cocaine and negative for opiates and Oxycodone. Dr. Ogoke’s report of this visit did not mention Cocaine, or even more generally, that an illicit drug was detected in the November 23, 2004 UDS results. He did not list in the visit report any reaction by Pt. N to receiving this information about use of an illicit drug. Dr. Ogoke noted in the visit report that Pt. N claimed he had run out of his prescribed medication by the time the urine specimen was taken. Pt. N was told he would now be subject to random UDS testing to ensure compliance in taking medications as prescribed. He was warned that if he was not compliant, he would need to seek evaluation and treatment with an addiction specialist to continue care with Dr. Ogoke. The name of Dr. Kishore was mentioned in this visit report as someone he could be given a reference to see. The visit report explained:

[Dr. Ogoke] will be subjecting him to additional random screening to determine if the patient is staying compliant to his current medications or whether it was the result of his having run out of his medications at the time he had his urine drug screen done, according to the patient. I will monitor his overall response and make that determination as to when the patient can be able to see Dr. Kishore to be able to evaluate him with respect to the results of the urine drug screen tests.

Dr. Ogoke gave a physical examination at this visit. He listed Pt. N’s assessed conditions as: right shoulder impingement with a need to rule out a rotator cuff tear; rotator cuff tendonitis; an acromioclavicular joint strain; a right shoulder contusion; myalgia of the right forearm and hand; a cervical strain, aggravated; and, right upper extremity sympathetic maintained pain, improved. Dr. Ogoke ordered a right shoulder MRI and physical therapy for the shoulder. Dr. Ogoke’s visit report mentioned that Pt. N would receive “pain medication” and be maintained “on high-dose non-steroidal anti-inflammatory drugs.” The visit report listed “other [treatment] options [under consideration] including repeat acromioclavicular joint and subacromial injections directed to the

right shoulder region.” At this visit, Pt. N received prescriptions for Percocet 7.5/325 mg. (90) and Mobic 7.5 mg. (1). These two prescriptions were not listed by name within the report of this visit. (Ex. 43; 209-211/4072-4074 & 277-280/4140-4143.)

15. It was a violation of the narcotics agreement Pt. N signed to use Cocaine. The Percocet prescribed was a non-scheduled opiate to take as needed, to provide short-acting pain relief. As a result, the Oxycodone from the Percocet might not show in a UDS specimen if for some days prior to the specimen, no Percocet was taken. Dr. Ogoke did not want to mention the use of Cocaine in the December 24, 2004 report to label Pt. N as an illicit drug user based on this one UDS result, but did make a reference in the report to Dr. Kishore, an addiction specialist who Dr. Ogoke might decide to make Pt. N see if Pt. N did not stay compliant in taking his prescribed medications. For Dr. Ogoke, the UDS results were at least a red flag to require more monitoring of Pt. N with more frequent UDS tests. He also accepted Pt. N’s excuse for why no opiates/Oxycodone were detected in his November 23, 2004 UDS specimen; that he had accelerated use of the Percocet to help him control his pain. Dr. Ogoke’s protocol was for his staff to highlight a UDS result showing illicit drug use and to show the result to him once the result was received. (Testimony of Dr. Ogoke, Vol. VIII, 1475-1486.)

16. Dr. Trescot agreed with Dr. Ogoke’s approach of addressing the Cocaine positive UDS result with Pt. N by engaging in increased monitoring of Pt. N’s compliance with his narcotic agreement, and by providing Pt. N with the name of an addiction medicine specialist he could see. Dr. Trescot agreed with how Dr. Ogoke addressed this issue in the December 24, 2004 visit report by not specifically mentioning the UDS test was positive for Cocaine or even for an illicit drug to not label with this one UDS result, Pt. N as an illicit drug user. Dr. Trescot opined that Dr. Ogoke’s counseling Pt. N about a need to stay compliant with his narcotic

agreement and to see an addictionologist if he needed to, along with increased monitoring through more UDS testing, was practicing within the standard of care in addressing Pt. N's red flag conduct. (Dr. Trescot, Vol. XV, 2948-2952, 2960.)

17. Dr. Satwicz disagreed. He opined that Dr. Ogoke was not justified in continuing to prescribe the opioid, Percocet, to Pt. N after a UDS result positive for Cocaine. Cocaine has a short life-span in the urine so that it is likely Pt. N was using cocaine shortly before his UDS specimen was collected on November 23, 2004. Dr. Satwicz would have expected Dr. Ogoke to have taken clear action with Pt. N to stop his care with Pt. N until he was detoxed off Cocaine. Dr. Satwicz also concluded that the lack of the prescribed Oxycodone in the UDS specimen would mean Pt. N had none in his system at least for a day or two before the specimen was taken. For Dr. Satwicz, any self-adjustment Pt. N might have engaged in of taking the Percocet other than as prescribed was another narcotics agreement violation triggering a clear need to stop prescribing opioids to Pt. N. He opined that Dr. Ogoke needed to have provided a thorough explanation in the visit report about the accelerated use of opiates Pt. N claimed he made, especially since Pt. N claimed at the December 24, 2004 visit that he was compliant in taking the medications. Dr. Satwicz summarized his position:

I would not give more opioids to somebody who just had Cocaine in his urine and had just run out of his Percocet ahead of the time.

(Testimony of Dr. Satwicz, Vol. XII, 2224-2234.)

18. Pt. N was seen at Dr. Ogoke's office on January 12, 2005. He reported his neck pain was at a 0/10 level, but his right shoulder pain was at a 7/10 level with intermittent low back pain from a 3-6/10 level depending on his activity level. Because he had felt "very uncomfortable," Pt. N reported taking additional doses of his Skelaxin and Percocet medications. Because of this

accelerated use of prescribed medications, the treatment plan was to put him on a “longer acting narcotic” while giving him “an appropriate nerve block to be able to reduce his narcotic requirements with respect to the short-acting medications especially.” He was prescribed Avinza 60 mg. (30) as a long-acting narcotic medication to be taken once a day. This detail on the Avinza was in the visit report. Pt. N was counseled about the need to be compliant in taking his medications and that he would be “monitored closely.” He continued to be prescribed Percocet 7.5/325 mg. (90) to take as needed for break-through pain. The hope was that the long-acting opioid would lead to Pt. N taking less Percocet. He was also prescribed his non-narcotic medications, including Skelaxin. He was prescribed Ativan 2mg. (2) for procedures. Pt. N was given a physical examination. He was diagnosed with: sacroiliitis; right shoulder impingement syndrome; acromioclavicular joint strain/arthritis; and, subacromial bursitis. Pt. N’s treatment plan was to do an AC joint injection, a subacromial injection, an SI injection, and the lumbar transforaminal ESI injection, all as soon as possible. This visit lasted 35-40 minutes. Nothing in this visit report discussed whether or not Pt. N had seen or was going to see Dr. Kishore. Nothing in the visit report indicated that a repeat UDS was done as follow-up regarding the Cocaine found in the November 23, 2004 UDS specimen. (Ex. 43; 75-76/3938-3939 & 320-323/4183-4186. Testimony of Dr. Ogoke, Vol. VIII, 1487-1450)

19. Dr. Satwicz addressed the January 12, 2005 prescription given Pt. N for Avinza 60 mg. (30), a long-acting morphine typically taken once a day. He opined the prescription was a fairly dramatic acceleration in the opioid dose of somebody who lacked control over his impulses who had recently used Cocaine, and who had run out of his Percocet prescription early once again. (Dr. Satwicz, Vol. XII, 2234-2236.)

20. Pt. N had a right shoulder MRI on January 19, 2005. It showed “no evidence of

rotator cuff tear” and “mild to moderate AC joint edema” that might connect “to clinical findings of an AC joint strain,” and “minimal lateral down-sloping which may contribute to an impingement-like syndrome.” (Ex. 43, 283-284/4146-4147.)

21. On February 2, 2005, Pt. N was seen by Dr. Ogoke. He complained of right shoulder pain at a 10/10 level. He reported that the right shoulder injections had helped relieve the pain for awhile. Dr. Ogoke found him to be very uncomfortable. The MRI right shoulder findings from January 19, 2005 were discussed. Dr. Ogoke found Pt. N’s clinical findings were consistent with what the MRI revealed of,

an acromioclavicular joint strain with mild to moderate acromioclavicular joint edema ... Minimal lateral down-sloping of the acromion was also noted that may contribute to impingement-like syndrome, according to the radiologist. The nature of these findings ... suggested ... a cramped area of the shoulder ... that had a high predisposition to impingement syndrome of the shoulder, which is his clinical presentation ... and when he had his accident, resulting in swelling ... in that ... impingement.

Dr. Ogoke concluded that Pt. N should have,

an initial therapeutic trial with subacromial injection, acromioclavicular joint injection (repeat) and then consider him, if he still does not improve, for surgical options, which may include a resection of the acromion to allow for improvement in the range of motion in that particular area.

Dr. Ogoke assessed Pt. N with: shoulder impingement syndrome with downsloping acromion confirmed by MRI; rotator cuff tendinopathy; acromioclavicular joint strain; cervical strain; and, myalgia of the right forearm and arm area. The treatment plan was for Pt. N to return for another right shoulder injection, and to consider injection into the subacromial area with special attention to the supraspinatus tendon and possibly the infraspinatus tendon. In addition, compliance in taking medications was discussed with Pt. N along with “other issues,”¹⁵⁴ and the need to monitor his overall progress with a re-evaluation. No UDS was done. Pt. N’s medications were

¹⁵⁴ There is no discussion in the February 2, 2005 visit report about what the “other issues” were, but I assumed this had to do with the prior UDS that was positive for Cocaine.

renewed. He was prescribed Percocet 7.5/325 mg. (90) and Avinza 60 mg. (30). On February 3, 2005, Dr. Ogoke gave Pt. N a lumbar right-sided transforaminal ESI with fluoroscopy for lumbar radiculopathy at the L4, L5 and SI levels. He reported his low back pain was at an 8/10 level. No UDS was done. On February 9, 2005, Pt. N complained of right shoulder pain at a 10/10 level, and Dr. Ogoke gave him an AC joint injection to the right shoulder with fluoroscopy. At this visit, he was prescribed Ativan 2 mg. (2) for procedures and Avinza 90 mg. (15). No UDS was done. Pt. N was seen at Dr. Ogoke's office on February 23, 2005. He reported an 8/10 pain level in his right shoulder and was seeking medication refills. The recent right shoulder injection had decreased his pain but the pain was returning. Dr. Ogoke continued to find Pt. N had genuine pain issues that called for both the long-acting and short-acting opioid medications. He was prescribed Percocet 7.5/325 mg. (90), Avinza 60 mg. (30), Ativan 2 mg. (2) for procedures, and Mobic 7.5 mg. (30). No UDS was done. The treatment plan was to have the right shoulder evaluated by Dr. Chertoff, a surgeon who specializes in shoulder surgeries, and he received an appointment for May 9, 2005. (Ex. 43: 77-79/3940-3942; 82-83/3945-3946; 203-207/4066-4070; 285-290/4148-4153; 293/4156; 317-319/4180-4182 & 399/4262. Dr. Ogoke, Vol. VIII, 1501-1504.)

22. On March 3, 2005, Pt. N was seen at Dr. Ogoke's office. He reported neck pain at a 7-8/10 level. Dr. Ogoke gave Pt. N a cervical ESI with fluoroscopy at the C3-4 level. At this visit, Pt. N received prescriptions for Kadian 100 mg. (14)¹⁵⁵ and Ativan 2 mg. (2) for procedures. Pt. N was seen on March 10, 2005 at Dr. Ogoke's office. He reported pain relief from the cervical ESI. He reported low back pain at an 8/10 level that was achy but intermittent and that radiated at times into his right leg and into his left hip. He was given a physical examination. He was diagnosed with: lumbar sprain; lumbar radiculopathy; lumbar disk bulge,

¹⁵⁵ Googling Kadian showed it to be an opioid, a morphine slow-release pain medication.

L3-S1; lumbar facet arthropathy; lumbar degenerative disk disease, L4-5; cervical strain; cervical radiculopathy improved; cervical facet arthropathy; cervical disk herniation; right shoulder acromioclavicular joint osteoarthritis; right rotator cuff tendonitis; right shoulder subacromial bursitis; and, type 2 acromion, right shoulder. Pt. N's treatment plan was to have another lumbar transforaminal injection as soon as possible, and to renew his prescriptions. Pt. N agreed to this plan. No UDS was done. He received prescriptions for MS Contin 100 mg. (60), Actiq 600 mg. (6) for procedures, and Percocet 7.5/325 mg. (90). The MS Contin was in place of the Avinza that Pt. N's insurer was not covering. The MS Contin was, like the Avinza, a scheduled long-acting opioid medication. Pt. N was seen at Dr. Ogoke's office on March 30, 2005. He reported right shoulder pain at an 8.5 /10 level. He was seeking medication refills. He received a prescription for Percocet 7.5/325 mg.¹⁵⁶ No UDS was ordered. On April 7, 2005, Dr. Ogoke gave Pt. N a right-sided lumbar transforaminal ESI with fluoroscopy at the L4, L5 and S1 levels for his lumbar radiculopathy. Pt. N complained of a 5/10 low back pain level that day. He was prescribed MS Contin 100 mg. (60), Actiq 600 mg. (6) for procedures, and Percocet 7.5/325 mg. (90). No UDS was done. He was given a note to stay out from work. On April 28, 2005, he was seen at Dr. Ogoke's office and reported an 8/10 right shoulder pain level. He was prescribed Percocet 7.5/325 mg. (120) and MS Contin 100 mg. (60). The treatment plan remained for Pt. N to have a consult with the orthopedic surgeon, Dr. Chertoff. No UDS was done. On May 5, 2005, Pt. N's health care insurer denied coverage for the cost of Actiq 600 mg. (8) for use during interventional injection treatments that would occur over weeks or months, because Pt. N did not have cancer. There was a right to appeal this denial. (Ex. 43: 84-85/3947-3948; 87-89/3950-

¹⁵⁶ The amount of the Percocet prescription was not legible as copied onto the disc, and this prescription with the amount of Percocet was not included in the visit report. (Ex. 43, 294/4157.) I could not locate other prescriptions written for Pt. N at this visit.

3952; 92-93/3955-3956; 95-96/3958-3959; 208/4071; 213/4076; 294-295/4157-4158; 299/4162; 310-312/4173-4175; 316/4179; 399/4262 & 418-426/4281-4289.)

23. Dr. Satwicz did not find justifiable, the use by Dr. Ogoke of Actiq for Pt. N to use to control pain during interventional procedures. He opined that taking this potent cancer pain medication was excessive given Pt. N's underlying condition. He opined that prescribing six Actiq units in one prescription "defies any logic." Dr. Ogoke and Dr. Trescot disagreed, both opining that Actiq is a fast-acting oral pain medication that is very useful during an injection procedure when the patient might be prone to move during the procedure due to discomfort or some pain, or when the procedure is long. Although two units is the amount typically used, it is possible a patient would take more units during a procedure. Dr. Trescot opined that even if Actiq was a pain control drug used primarily with cancer patients, this did not prevent its use by patients during interventional procedures. The drug did not cause drowsiness. Dr. Ogoke would at times prescribe Actiq to be used in connection with interventional procedures in more than a usual prescription of two units when there would be a number of upcoming interventional procedures to spread out use of the units. (Testimony of Dr. Ogoke, Vol. VIII, 1510, 1512, 1514- 1519. Testimony of Dr. Satwicz, Vol. XII, 2240-41. Testimony of Dr. Trescot, Vol. XVI, 3231-3234.)

24. Pt. N was seen at Dr. Ogoke's office on May 27, 2005. He reported pain in his right shoulder at a 9/10 level. He reported that rest and use of the pain medications brought the level down to 5/10. He described the pain as constant, achy, and aggravated by activity. He had been evaluated by Dr. Chertoff. Pt. N reported that Dr. Chertoff recommended continuing physical therapy treatments to the shoulder for another three months before considering any surgery. Pt. N was given a physical examination. He was assessed with: a right shoulder impingement

syndrome; right shoulder rotator cuff tendonitis; and, a right side AC joint strain. He received prescriptions for MS Contin 100 mg. (60) and Percocet 7.5/325 mg. (120). He was to follow-up with Dr. Chertoff and to return in about three to four weeks to Dr. Ogoke's office. No UDS was done. Pt. N had prescriptions written on June 20, 2005 for MS Contin 100 mg. (60) and Percocet 7.5/325 mg. (90). Pt. N was seen at Dr. Ogoke's office on June 21, 2005. He reported right shoulder pain at an 8-9/10 pain level. A UDS was done.¹⁵⁷ The results showed Pt. N was positive for Cocaine, positive for opiates, and positive for the oxycodone screen. Pt. N was seen at Dr. Ogoke's office on July 15, 2005. He reported a pain level of 8/10 in his low back brought on by turning while getting out of a car. He was given a physical examination and the plan was to have a lumbar facet joint ESI series as soon as possible. He was prescribed MS Contin 100 mg. (60), Percocet 7.5/325 mg. (120), Actiq 600 mg. (2) for use in connection with procedures, and Valium 10 mg. (2) for use prior to procedures. No UDS was done. Within the note of the July 15, 2005 visit there was no mention of the UDS results from the June 21, 2005 specimen. (Ex. 43: 97/3960; 214-216/4077-4079; 300/4163; 302-307/4165-4170; 313/4176 & 417/4280.)

25. Pt. N was seen at Dr. Ogoke's office on August 5, 2005 and reported a pain level in his back of 8-9/10. Dr. Ogoke gave Pt. N a bilateral lumbar facet joint injection with fluoroscopy at the L2-3, L3-4, L4-5, and L5-S1 levels for lumbar arthropathy. Pt. N was given prescriptions for MS Contin 100 mg. (60) and Percocet 7.5/325 mg. (120). No report from this visit addressed the positive Cocaine UDS finding from the June 21, 2005 specimen. On September 14, 2005, Dr. Ogoke gave Pt. N a bilateral lumbar facet joint injection with fluoroscopy at the L2-3, L3-4, L4-5, and L5-S1 levels. He reported pain relief from the August 5, 2005 procedure. He came to this visit with a pain complaint of 8/10 in his lower back. Pt. N

¹⁵⁷ Pt. N's medical records (Exhibit 43) show that the last UDS had been done on November 23, 2004 when the results showed Pt. N was positive for Cocaine.

was seen at Dr. Ogoke's office on September 22, 2005. He reported an "achy" pain in his back at an 8/10 level. He was given prescriptions for MS Contin 100 mg. (60), Percocet 7.5/325 mg. (120), and Ativan 2 mg. (2) for procedures. He had a UDS done. The results showed Pt. N was negative for Cocaine and negative for opiates (MS Contin).¹⁵⁸ By this time, there had been no visit report addressing Pt. N's UDS specimen from June 21, 2005 that was positive for Cocaine. (Ex. 43: 99-102/3962-3965; 104/3967; 106-107/3969-3970; 109-110/3972-3973 & 410-416/4273-4279.)

26. Pt. N was seen at Dr. Ogoke's office on October 19, 2005. He reported low back pain at an 8/10 level. The report of this visit noted how Pt. N had tested negative from the September 22, 2005 UDS for opiates despite being prescribed MS Contin for months as a scheduled medication. Another UDS was done with the specimen sent to a different laboratory. At this visit, Pt. N was prescribed Percocet 7.5/325 mg. (120) and MS Contin 100 mg. (60). The UDS results from October 20, 2005 showed Pt. N's specimen was negative for Cocaine, opiates, and Oxycodone, and positive for Benzodiazepine, which would show up if Ativan was present in the system. Pt. N was seen at Dr. Ogoke's office on November 17, 2005. The last UDS results were discussed with Pt. N, because the opiate and Oxycodone screens would have been expected to be positive. He had another UDS specimen taken at this visit. He felt his current medications were helping him, but he reported an 8/10 pain level. There was no discussion in this visit report concerning Pt. N's prior use of Cocaine. He was prescribed, Percocet 7.5/325 mg. (120), MS

¹⁵⁸ Pt. N's prescriptions were typically written to cover a month or at least three weeks. The UDS done on September 22, 2005 was over a month after Pt. N had last received prescriptions on August 5, 2005 including for Percocet (Oxycodone) and MS Contin (opiate). He may run out of these medications by then to explain why the opiate test was negative. I could not locate whether an Oxycodone screen was done. I could not locate any prescriptions written on September 14, 2005 when Pt. N had an interventional procedure.

Contin 100 mg. (60), EC Naprosyn 375 mg. (60), and Actiq (2)¹⁵⁹ for procedures. Pt. N was seen at Dr. Ogoke's office on December 19, 2005. He reported a pain level of 8/10. The results from the November 17, 2005 UDS testing were still pending. He was prescribed Percocet 7.5/325 mg.

(90), MS Contin 100 mg. (60), and EC Naprosyn 375 mg. (60). (Ex. 43: 67/3930; 111-13/3974-3976; 115-116/3978-3979; 308-309/4171-4172 & 407-409/4270-4272. Testimony of Dr. Ogoke, Vol. VIII, 1546-1547.)

27. On January 11, 2006, Pt. N received a final report from Dr. Ogoke regarding his treatment of injuries suffered in his August 2004 motor vehicle accident. The report summarized the course of care Pt. N received and the impressions reached concerning the conditions that Dr. Ogoke related to the accident. These conditions involved his right shoulder area and right wrist. Additional pain complaints were noted in his neck and low back. This report was intended for an attorney and not to be a treatment record. Nothing in this report addressed any of the UDS results that were positive for Cocaine and negative MS Contin and Percocet. Dr. Ogoke's report noted how Pt. N was already taking Percocet and Naprosyn when he first examined him in August 2004 concerning this accident. The initial impression reached was reported as: a right shoulder contusion; myalgia forearm; sympathetic maintained pain in the upper right extremity; and, an aggravated cervical strain. The visit report explained: Pt. N had right shoulder and right wrist x-rays that showed no fractures; a right shoulder MRI that was consistent with an acromioclavicular joint strain; and, was prescribed high doses of NSAIDs, muscle relaxants, and Percocet. Pt. N was described as having a constant and ongoing high pain level. Dr. Ogoke's report noted how Pt. N experienced pain relief and an increase in movement in the right shoulder

¹⁵⁹ No dose for the Actiq was listed on the copy of the prescription or was legible on the copy. When Actiq had been written for Pt. N previously, it had been at a 600 mg. level. (Ex. 43, 115/3978).

area following a trigger point injection treatment. The report listed Dr. Ogoke's treatment plan from an August 30, 2004 evaluation "to continue the patient on oral medications." The report noted that on September 23, 2004, Pt. N had a right acromioclavicular joint injection that "reduced" Pt. N's right shoulder area pain, and that this injection was repeated on October 14, 2004. Due to Pt. N's anxiety during such procedures, Dr. Ogoke's report addressed how he prescribed Ativan for Pt. N to take prior to an injection procedure. Dr. Ogoke explained that in October 2004, he increased the dose of Pt. N's Avinza medication due to the ongoing pain complaints. By the end of December 2004, the report noted that Dr. Ogoke had assessed Pt. N with: right shoulder impingement syndrome; right rotator cuff tendonitis; acromioclavicular joint strain; right shoulder contusion; myalgia of the right forearm; an aggravated cervical strain; and, a right upper extremity sympathetic maintained pain that had improved. Dr. Ogoke discussed in the report that by March 2005, he referred Pt. N for physical therapy and to an orthopedic surgeon for consideration of surgery to the right shoulder area. Dr. Ogoke noted in the report that Pt. N did not have shoulder surgery but did have physical therapy treatments. Dr. Ogoke's report explained that Pt. N's condition had improved by June 21, 2005. Dr. Ogoke opined in the report that the right shoulder condition was caused by the motor vehicle accident in August 2004. He wrote:

The patient's last visit was June 21, 2005, and the patient reports, that as of this time his pain has essentially resolved in the shoulder area completely. He is no longer on any medication for that specifically.

This report closed out Dr. Ogoke's treatment of Pt. N for injuries from the motor vehicle accident. The medical records relating to this care were maintained apart from the medical records kept on Pt. N for treatment of his other conditions, including his back condition and residuals from having swung the golf club and hitting the rock in April 2003. (Ex. 43, 397-

400/4260-4263. Testimony of Dr. Ogoke, Vol. VIII, 1533-1539.)

28. Dr. Ogoke thought that when Pt. N's motor vehicle accident medical records were closed out, the results of the UDS done on June 21, 2005 may have been placed into the closed file on this motor vehicle accident to explain why this UDS result that was positive for Cocaine was not addressed at any subsequent visits. Dr. Ogoke also explained that he often had to wait for months to receive UDS results from the outside laboratories he used. Although the final report was produced on the motor vehicle-accident-related treatments in January 2006, the record for this accident could have been closed nearer the time of the June 21, 2005 UDS specimen being taken. (Testimony of Dr. Ogoke, Vol. VIII, 1523-1539; Vol VII, 1458-1466.)

29. On January 11, 2006, Pt. N had a UDS done. The January 30, 2006 UDS results were negative for opiates and Oxycodone.¹⁶⁰ On February 9, 2006, Dr. Ogoke gave Pt. N a bilateral SI injection with fluoroscopy for sacroiliitis. Pt. N came to this visit reporting a pain level of 8/10 in his lower back. He was prescribed MS Contin 100 mg. (60), EC Naprosyn 375 mg. (60) and Percocet 10/325 mg. (90). This was a higher dose of Percocet. A UDS was done. The results of that UDS screen were negative for opiates (MS Contin), Oxycodone, and Cocaine. No discussion was included concerning the negative opiate and Oxycodone results from the January 11, 2006 UDS tests. On March 9, 2006, Dr. Ogoke gave Pt. N a bilateral lumbar facet joint injection with fluoroscopy for lumbar arthropathy at the L2-3, L3-4, L4-5 and L5-S1 levels. He came to this visit reporting a pain level of 7.5-8/10. He was prescribed MS Contin 100 mg. (60), EC Naprosyn 375 mg. (60), and Percocet 10/325 mg. (60).¹⁶¹ He was prescribed Valium

¹⁶⁰ I could not locate or decipher whether the UDS was negative for Cocaine. The laboratory was asked to test for Cocaine. (Ex. 43, 69/3932.)

¹⁶¹ Although hard to decipher, I concluded that Ex. 43, 137/4000 showed this prescription for Percocet on March 9, 2006.

10 mg. (2) for preparation for his next procedure. A UDS was done. The results were negative for opiates and Cocaine, and positive for Oxycodone. (Ex. 43: 69-72/3932-3935; 119-122/3982-3985; 125-131/3988-3994; 134/3997; 136-143/3999-4006; 394-396/4257-4259 & 402-404/4265-4267.)

30. Pt. N was seen at Dr. Ogoke's office on April 6, 2006. He reported that the prior week he fell using a four wheel all-terrain vehicle, re-injuring his right shoulder area that had recovered well. He also complained of back pain. He had a physical examination. The assessment reached was: impingement syndrome in the right shoulder with downsloping acromium; rotator cuff tendonitis; acromioclavicular joint strain; shoulder contusion; myalgia in the right forearm; cervical strain (aggravated); and, right upper extremity sympathetic maintained pain (improved). A UDS was done. The treatment plan was to: do a lumbar spine MRI; stop the Percocet due to GERD (gastroesophageal reflux disease); renew his other medications; and, have a left lumbar facet joint injection. Pt. N agreed to this plan. A prescription was written for Oxycodone 10 mg. (90) for break-through pain to be in place of Percocet. This prescription could not be filled by Pt. N's pharmacy and Pt. N requested to stay on Percocet. He returned the Oxycodone prescription and received a prescription for Percocet 7.5/325 mg. (90). Pt. N was also prescribed MS Contin 100 mg. (60), EC Naprosyn (60), and Ativan 2mg. (2) for procedures. The UDS results were reached on April 14, 2006.¹⁶² (Ex. 43: 144/4007; 146-147/4009-4010 & 390-393/4253-4256.)

31. Pt. N was seen on May 1, 2006 at Dr. Ogoke's office. He reported pain symptoms in

¹⁶² Only one not fully legible page of the UDS results from April 14, 2006 was found in Pt. N's medical records (Ex. 43, 144/4007).

the lower back. He was prescribed MS Contin 100 mg. (60), Oxycodone (180),¹⁶³ and Ativan 2 mg. (2) for procedures. X-rays of the left hand were ordered. A UDS was done. The UDS results from May 10, 2006 were negative for Cocaine and negative for both opiates and the Oxycodone screen. Pt. N was seen at Dr. Ogoke's office on June 2, 2006. He had not undergone the planned lumbar facet joint injection for his low back pain. He reported shoulder and left hand pain. He had not had the x-rays of his left hand. Pt. N had a physical examination. He was assessed with: lumbar pain and radiculopathy; sacroiliitis; carpometacarpal joint strain; left hand pain, rule out any fracture; and, cervical pain. He was prescribed Oxycodone 5 mg. (180), EC Naprosyn 500 mg. (60), MS Contin 100 mg. (60), and Ativan 2 mg. (2) for procedures. Pt. N reported that his pharmacy could not fill the 180 count of Oxycodone and only filled a 141 count. He did not also receive a prescription for Percocet. The results of the May 1, 2006 UDS specimen testing were not discussed within the report of the June 2, 2006 visit, but a UDS was done at this visit. The UDS results from June 3, 2006 were positive for the Oxycodone screen, and negative for opiates and Cocaine. On June 20, 2006, Dr. Ogoke gave Pt. N a bilateral SI injection with fluoroscopy. He had not had the left hand x-rays or the lumbar facet joint injection as had been planned. He was prescribed Oxycodone 5 mg. (39). Blood work was ordered. A UDS was done. Nothing in the report of this visit addressed UDS results from his prior tests that showed non-compliance issues to resolve about how he was taking his MS Contin and Oxycodone or Percocet. Pt. N was seen on July 3, 2006 at Dr. Ogoke's office. He reported a "50%" improvement in his low back pain following the SI injection. He was given a physical examination and assessed with: sacroiliitis; lumbar strain; lumbar radiculopathy; cervical strain; and, carpal/metacarpal joint strain. He was prescribed Elavil 25 mg. (60), Oxycodone 5 mg.

¹⁶³ The dose level of the Oxycodone was not legible on the copy of the prescription, and the prescription was not detailed in the report of the May 1, 2006 visit. (Ex. 43, 156/4019.)

(180), MS Contin 100 mg. (60), EC Naprosyn 375 mg. (60), and Ativan 2 mg. (2) for procedures. The treatment plan was for Pt. N to have the lumbar facet joint injection and a CMC joint injection as soon as possible. A UDS was done. The July 5, 2006 UDS results were negative for opiates and the Oxycodone screen, and positive for Cocaine. (Ex. 43: 151-158/4014-4021; 160-164/4023-4027; 167/4030; 170-171/4033-4034; 173/4036; 175-176/4038-4039; 178/4041; 180/4043; 182-186/4045-4049; 376-380/4239-4243; 382/4245 & 385-389/4248-4252.)

32. Pt. N had signed the narcotics agreement when he was receiving care with Dr. Ogoke. He tested positive for Cocaine from his UDSs on November 23, 2004, June 21, 2005, and July 3, 2006. Dr. Ogoke did not end his care of Pt. N for taking illicit drugs as a result of any of the first two UDS results showing Cocaine, but he likely terminated Pt. N's care after learning of the July 5, 2006 result. Dr. Ogoke concluded that he would have seen the positive for Cocaine result from July 5, 2006 even if there was a long delay in his receipt of the results from the outside laboratory. Dr. Ogoke opined that he would not have continued Pt. N in his care once aware of this further illicit drug use without stopping opioid prescribing for Pt. N until he was cleared by an addiction medicine specialist. No further medical records were found on Pt. N after the July 5, 2006 UDS results.¹⁶⁴ (Testimony of Dr. Ogoke, Vol. VIII, 1570-1577.)

33. Pt. N had UDS results that were negative for opiates despite ongoing prescriptions for them, including at times for MS Contin, which was a scheduled medication and expected to be found in a UDS specimen. But, if the UDS specimen was taken at a time when the MS Contin prescription had ended a few days prior, Dr. Ogoke opined that this could explain some of the negative UDS results for opiates. When Dr. Ogoke received the UDS results even after months of delay, the visit reports never showed that he or his physician assistants questioned Pt.

¹⁶⁴ No termination of care letter was found for Pt. N in his medical records (Exhibit 43).

N about his use of the MS Contin. The UDS results also showed Pt. N was negative for the Percocet and Oxycodone he took for break through pain as shown by the negative Oxycodone screen results. These UDS results occurred on: April 22, 2004; April 30, 2004; November 23, 2004; September 23, 2005; October 19, 2005; March 9, 2006; April 5, 2006, May 1, 2006; June 2, 2006; and, July 3, 2006. Dr. Ogoke was less concerned with those negative UDS results because those opioids were for break-through pain and not scheduled medications. He opined that such medications might not have been taken by Pt. N at and around the time of the UDS tests that often occurred at the times of scheduled visits when medications would have needed to be renewed. Dr. Ogoke was not able to get his patients to come to his office for frequent UDS tests within their monthly prescription cycles when UDS results might have been able to show clear non-compliance by Pt. N in taking his medications as prescribed. (Ex. 43: 15/3878; 20-21/3883-3884; 34-35/3897-3898; 110/3973; 126-127/3989-3990; 140-144/4003-4007; 152-155/4015-4018; 161-164/4024-4027; 183-186/4046-4049; 271-276/4134-4139 & 308-309/4171-4172. Testimony of Dr. Ogoke, Vol. VIII, 1559-1571.)

34. At and around the time that the UDS results for Pt. N were negative his opioid medications, the following opioid prescriptions for them were written by Dr. Ogoke's office. He was prescribed Percocet for break through pain on: March 12, 2004; March 25, 2004; April 22, 2004; May 21, 2004; June 17, 2004; July 15, 2004; August 16, 2004; September 7, 2004; September 24, 2004; October 14, 2004; November 3, 2004; November 23, 2004; and, December 24, 2004. On March 3, 2005, the opioid Kadian was prescribed. Dr. Ogoke added to the on-going prescription for Percocet, the long-acting scheduled opioid of Avinza on January 12, 2005 and February 23, 2005. The on-going prescription for Percocet continued, but added was the long-acting opioid of MS Contin in place of the Avinza on: March 10, 2005; March 30, 2005;

April 7, 2005; April 28, 2005; May 27, 2005; June 20, 2005; July 15, 2005; August 5, 2005; September 22, 2005; October 19, 2005; November 17, 2005; December 19, 2005; January 11, 2006; February 9, 2006; March 9, 2006; April 6, 2006; and, April 16, 2006. Dr. Ogoke substituted Oxycodone for the Percocet prescription to address break-through pain on: May 1, 2006; June 2, 2006; June 20, 2006; and, July 3, 2006. (Ex. 43: 6/3869; 9/3872; 13/3876; 25/3888; 36/3899; 37/3900; 39/3902; 49/3912; 58/3921; 64/3927; 67/3930; 71/3934; 75/3938; 89/3952; 95/3958; 97/3960; 104/3967; 109/3972; 111-112/3974-3975; 121/3984; 137/4000; 147/4010; 156/4019; 175-176/4038-4039; 180/4043; 254/4117; 268/4131; 280/4143; 286/4149; 289/4152; 293-294/4156-4157; 299-300/4162-4163 & 313/4176.)

35. Pt. N had injection treatments that covered at least a two year time period. He had an acromioclavicular joint injection on March 19, 2004. He had another one on July 23, 2004. He had a cervical ESI to the C3-4 level on August 16, 2004. He had another acromioclavicular joint injection on September 23, 2004, and a cervical ESI at C3-4 on September 29, 2004. Pt. N had another acromioclavicular joint injection on October 14, 2004. He had a lumbar ESI at L5-S1 on November 4, 2004, and a bilateral SI injection on November 23, 2004. He had a lumbar transforaminal joint injection at the L4 through the S1 levels on February 3, 2005, and an acromioclavicular joint injection on February 9, 2005. On April 7 and 16, 2005, he had lumbar ESIs at the L4 through the S1 levels. On August 5, 2005, Pt. N had a bilateral facet joint injection at the L2-3 through the L5-S1 levels. On February 9, 2006, he had a bilateral SI injection, and on March 9, 2006, he had another bilateral lumbar facet joint injection at the L2-3 through the L5-S1 levels. He had a bilateral SI injection on June 20, 2006. (Ex. 43:44-45/ 3907-3908; 51-54/3914-3917; 60-62/3923-3925; 93/3956; 99-102/3962-3965; 170-171/4033-4034; 201/4064; 203/4066; 265-266/4128-4129; 317-319/4180-4182; 337/4200; 341-342/4204-4205;

351/4214; 394-396/4257-4259; 402-404/4265-4267; 414-416/4277-4279; 418-420/4281-4283 & 425-426/4288-4289.)

Conclusion and Recommendation

The findings show that Dr. Ogoke violated the standard of care in the practice of medicine with Pt. N as alleged by the BORM, for failing to terminate care of Pt. N for his use of Cocaine on more than one occasion over a significant time span. Pt. N was first found to have a positive UDS test for Cocaine in November 2004. Dr. Ogoke addressed this issue with Pt. N, although he did not require Pt. N to first be cleared by an addiction medicine specialist before he would receive further opioid prescriptions. Dr. Ogoke only provided a resource to Pt. N of the name of an addiction medicine specialist. The second time Pt. N had a UDS finding positive for Cocaine was in June 2005. The findings show that Dr. Ogoke may not have seen this result because the document may have been placed into a closed Pt. N file. The medical records and Dr. Ogoke's persuasive testimony supports him not seeing this UDS result for this reason. There is no medical record information in any document or visit report acknowledging this UDS result with Dr. Ogoke determining despite it, that Pt. N would have no need to see an addiction medicine specialist to be cleared to receive further opioid medicine, or that Dr. Ogoke did not find that result significant. The third time Pt. N had a UDS finding positive for Cocaine was in July 2006 after which there are no further medical records on Pt. N. Dr. Ogoke's testimony is persuasive that this third UDS result that was positive for Cocaine likely led to an end of care for Pt. N; at least an end to his receiving opioid prescriptions. This means that from the end of November 2004 through the start of July 2006, Pt. N continued to receive significant opioid medications on an on-going basis. Even if Dr. Ogoke did not intentionally ignore the second UDS result positive for Cocaine, he is responsible for this error. The BORM has proven a

violation of the standard of care in Dr. Ogoke's practice of pain management medicine due to this error that resulted in no adequate attention paid to Pt. N's use of Cocaine after the June 2005 UDS result. The main monitoring being done to check on Pt. N's compliance in taking no illicit drugs were the UDS tests he received.

The findings also show that Dr. Ogoke continued to prescribe opioids to Pt. N, even in accelerated doses, after having a number of UDS results that showed Pt. N may not have been compliant in taking his opiate medication such as the long-acting MS Contin and the Percocet for break through pain. Pt. N reported at a few times that he had accelerated his use of the Percocet to gain better pain control to explain the negative Oxycodone UDS results. This reasoning, in light of the visit evaluations determining Pt. N had genuine high level pain complaints, led Dr. Ogoke to prescribe a long-acting opioid on an on-going basis so that hopefully Pt. N would not need to use as much of the break through opioid for pain control. The long-acting opioid medication was a scheduled medication for Pt. N to routinely take so that it was more likely than not to show up in UDS results as a positive finding from the opiate test. This was often not what was shown in the UDS test results. At times, the visit reports contained information that Pt. N was counseled about the importance of being compliant in taking his medications as prescribed. Dr. Ogoke explained that depending on when the UDS specimen was taken, Pt. N might have been days beyond the time his prescription for the long-acting opioid was finished to explain a negative opiate UDS result. It is unlikely though, that Pt. N was never out of compliance in taking both the long acting and the break through opioids given the many UDS tests done that were negative for one or the other or for both. This kind of red flag was never addressed within the visit reports with any specificity to be able to determine whether Dr. Ogoke always addressed this narcotics agreement violation; that the only times Dr. Ogoke determined that Pt. N engaged

in non-compliant use of opioid medication was when a visit report discussed giving him counseling. That is just not credible. The findings show some likely narcotic agreement violations continued to occur even after Pt. N was talked to by Dr. Ogoke (and his physician assistants) about the need to take opiate medication only as prescribed.

It may have been that UDS results were never timely addressed. There were too many instances in Pt. N's medical records, as shown in the findings, when Pt. N's UDS results from the outside laboratories seemed never to have been received. No visit reports included information that this issue was pursued with the outside laboratory even though doing UDS tests was an important monitoring tool used to determine whether Pt. N was being compliant in taking his medications as prescribed, and after that November 2004 use of Cocaine, if he was further using illicit drugs. It also seemed that when UDS results were received showing potential out of compliance use of the prescribed opioids, that the subsequent visit reports only rarely addressed Pt. N receiving counseling about the need to be compliant. It is not credible that unless a visit report addressed that Pt. N received counseling, that all the other red flag UDS results were resolved with Pt. N having had the UDS test done after he had run out of his prescription opioid medication for a few days to explain a negative result. I conclude that the BORM has proven this failure to adequately address Pt. N's compliance issues as a violation of the narcotics agreement and as a violation of the standard of care in the practice of pain management medicine.

The other allegation made by the BORM is that Dr. Ogoke violated the standard of care by inappropriately prescribing high doses of opioids to treat Pt. N's pain complaints that were due to underlying conditions that did not merit treatment with such high doses of narcotics. In making this allegation, the BORM relied on Dr. Satwicz's expert opinion.

Dr. Satwicz opined that prescribing Avinza was accelerating Pt. N's use of opioids for no sufficient reason. He explained why Avinza was too powerful an opioid for Pt. N and not needed for treatment of Pt. N's pain. Avinza was prescribed as a long-acting opioid with the opioid Percocet continuing to be prescribed for break through pain. The Avinza was prescribed for a short time span that followed the November 24, 2004 UDS result showing Pt. N positive for Cocaine. Avinza was only prescribed in January and February 2005, but was the first time a long-acting opioid medication had been prescribed. After Avinza was no longer prescribed, Pt. N continued thereafter to be taking Percocet for break through pain along with MS Contin as Pt. N's long-acting opioid medication. I did not find sufficient proof from Dr. Satwicz's opinion to find that prescribing Avinza for Pt. N was accelerating Pt. N's use of opioids for no sufficient reason. In terms of Pt. N being prescribed an on-going long-acting opioid throughout most of his care with Dr. Ogoke into July 2006, the visit reports contained Pt. N's complaints of most often chronic high pain levels. His complaints were evaluated at these visits with physical examinations that resulted in no findings that Pt. N was exaggerating his pain complaints to make them not credible. To prescribe a long-acting opioid against that ongoing background does not show Dr. Ogoke was overprescribing opioids for Pt. N by prescribing long-acting and short-acting opioid medications. Further support for not finding Dr. Ogoke was overprescribing with Avinza or with MS Contin, is that Pt. N's treatment plan continued to include interventional procedures to also help alleviate the pain. And, in general, the dose levels of these long-acting opioids did not change over the course of care.

Dr. Satwicz also opined that prescribing Actiq, a pain drug for cancer, even if for use by Pt. N during interventional procedures, was done in violation of the standard of care by Dr. Ogoke and his physician assistants. In particular, Dr. Satwicz found no logic and no justification

for ever including in one prescription for Pt. N, six Actiq units at 600 mg. each. Dr. Ogoke and Dr. Trescot, opined the Actiq was appropriate for use to help Pt. N get through interventional injection procedures without moving or to get through longer procedures. Both Dr. Ogoke and Dr. Trescot opined that typically two units per procedure would be sufficient, and just prescribing two units for an upcoming procedure is what Dr. Ogoke typically prescribed. But, they also opined that sometimes using more than just two units during a procedure would be appropriate. To use Actiq during injection procedures this way was not proven to have been a violation of standard of care.

There were two visits, one following the other, when each time six units of the Actiq 600 mg. were prescribed. Dr. Ogoke testified that he would provide the estimated number of Actiq units he would be prescribing over a particular time period, over weeks or months, to the patient's insurer to get approval for coverage of the cost of the Actiq. That was credible. But, here, Pt. N was receiving within a few months, twelve units of Actiq 600 mg. Even though they were known by Pt. N to be used only during his interventional procedures, Pt. N by the time the six units were prescribed at two consecutive visits, had red flags concerning his staying compliant in taking his opioid medications, and had already been known to have used Cocaine. Against this background it is not understandable why Pt. N would have been prescribed quite so many powerful pain killer Actiq units over so short a time. No visit reports addressed how Pt. N used up those twelve Actiq 600 mg. units during the procedures he had.

The findings show Pt. N was prescribed Actiq 600 mg. (6) on March 30, 2005 with his treatment plan from March 10, 2005 to have a lumbar transforaminal injection as soon as possible. He had this procedure on April 7, 2005. He also received another prescription for Actiq 600 mg. (6) on April 7, 2005. There is a document in Pt. N's medical record that on May

5, 2005, his insurer would not cover the Actiq, at least as prescribed. There is a medical record showing the treatment plan for Pt. N on July 15, 2005 was to do a lumbar facet joint ESI as soon as possible. On that date Pt. N was prescribed Actiq 600 mg. (2). This bilateral procedure at levels L2-3 through L5-S1 was done on August 5, 2005. Without another Actiq prescription, Pt. N had another such procedure on September 14, 2005. The next prescription for Actiq 600 mg. was on November 17, 2005 for two units. The next interventional procedure, an SI injection, was done on January 11, 2006.

Dr. Satwicz's concerns are persuasive that Pt. N received an excessively large dose of six units of Actiq 600 mg. in one prescription. All three physicians acknowledge Actiq is a fast-acting powerful pain killer. The medical records show Actiq 600 mg. was prescribed in six units at two consecutive visits to a patient who had shown himself to have red flags due to his use of Cocaine and due to his inconsistent compliance in taking his opioid medications as prescribed. No visit report contained information that explained why these high number of units of Actiq 600 mg. were prescribed so close in time. The BORM has proven its claim regarding the Actiq 600 mg. (6) prescriptions as being over prescribing of powerful opioids to a patient with non-compliance issues and a patient who had used Cocaine with no clearance to receive further opioid prescriptions from an addiction medicine specialist to provide at least some reassurance that he would likely only use the Actiq during procedures. I conclude the BORM has proven that at least at to the time period when six units of Actiq were prescribed at two consecutive visits, that this was overprescribing opioids to Pt. N. I conclude this appreciating that this prescribing occurred when Pt. N had a number of planned interventional procedures when taking two units of Actiq during them would not have been a violation of standard of care. I conclude this even though Pt. N was counseled that the Actiq was to be taken only during procedures.

Patient O

Summary

Patient (Pt.) O did not testify. No complaint by Pt. O to the Board of Registration in Medicine was presented. (Ex. 83.)

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Dr. Ogoke inappropriately prescribed high doses of opioids in light of Pt. O's history of opioid abuse.
- Dr. Ogoke inappropriately prescribed high doses of opioids despite Pt. O's ongoing drug seeking behavior.

The facts the BORM alleged to support its allegations included the following:

- Pt. O treated with Dr. Ogoke 2001 through 2004 for low back and leg pain, and atypical facial pain.
- Dr. Ogoke's diagnoses for Pt. O included: lumbar strain; lumbar radiculopathy; grade I spondylolisthesis of the L3-4 spine level; lumbar degenerative disk disease; lumbar degenerative joint disease; lumbar spinal canal stenosis at the L3-4 level; post-lumbar laminectomy syndrome; right knee and right hip osteoarthritis; sacroiliitis; and, atypical facial pain.
- Pt. O had a documented history of opioid abuse.
- Pt. O showed signs of drug seeking behavior while under Dr. Ogoke's care.
- Dr. Ogoke treated Pt. O with a combination of pain medications, including Oxycontin, Methadone, and Duragesic Patch.
- Dr. Ogoke treated Pt. O with multiple interventional procedures including epidural steroid injections, sacroiliac joint injections, and facet joint injections.

Findings of Fact

1. Pt. O, born in 1950, was initially evaluated by Dr. Ogoke on November 16, 2000. She was referred to Dr. Ogoke by Dr. Kirinkumar Chauhan to address her left jaw area pain. Pt. O was forty-nine years old, unemployed and on disability. She had temporomandibular joint disorder (TMJ). She had an initial TMJ surgery in 1975 in which her left mandible was broken

and reunited to provide her with a new alignment. Pt. O lacked a sufficient union post-surgery, and had further surgeries with the same surgeon. In the course of having these further surgeries, Pt. O experienced “a left facial nerve palsy and ... had metal implants in the jaw.” After one of the further surgeries, she was unable “to control her eyelid on one side, requiring ... eye drops in the eye which was covered with a patch.” Pt. O’s pain was described by Dr. Ogoke in his report of her initial visit with him:

Burning, sharp pain, aching pain, cramping, sensitive and shooting pain that is always present since her problem started. The left jaw area pain is associated with chronic swelling. The patient believes she has lost mandibular bone during multiple surgeries and now has facial asymmetry. Pain tends to radiate into the left side of the mandible as well. Her pain is ... at ... 10/10. Chewing apparently does not make the pain better. Pain tends to disturb the patient’s sleep every night. She has done multiple radiologic studies, including one scheduled CT scan to be done next week, according to the patient, at the request of one of her providers.

The patient no longer engages in social activities due to her pain. Family relationships have become strained and she is unable to work. Her interpersonal relationships have become almost nonexistent.

Dr. Ogoke understood Pt. O was scheduled to have another facial surgery with Dr. Cottrell. She told Dr. Ogoke she had hypertension, quit smoking about six months ago, and had no history of “drug, alcohol or caffeine abuse.” Dr. Ogoke did a review of systems and gave a physical examination. He noted Pt. O’s “depressed affect ... appears to be in some moderately acute distress ... appears quite anxious.” He made diagnoses of: atypical facial pain; facial neuritis with neuropathic pain possibly secondary to scar tissue and compression; and, left facial nerve palsy, rule out iatrogenic etiology. Dr. Ogoke’s treatment plan for Pt. O was to treat her with tricyclic anti-depressant and anti-inflammatory medications;

Elavil 50 mg. p.o.q.h.s. and tritrate upwards ... [S]tart ... Mobic 7.5 mg. p.o.q.d. and Percocet 5 mg. to be taken every 6 hours p.r.n. ... Neurontin 600 mg. p.o. to be taken three times daily as well as Norflex 100 mg. p.o. t.i.d., and Oxycontin 20 mg. p.o.q.12h. and be monitored. She started Oxycontin only in the past few days

(less than two weeks).

Dr. Ogoke encouraged her “to keep her appointment with the maxillofacial surgeon,” and to do a follow-up visit with him in two weeks “for review and other considerations.” PT. O was seen by Dr. Ogoke on November 29, 2000. She was prescribed Neurontin 600 mg. (90), Percocet 5 mg. (120), Relafen 500 mg. (60), Elavil 75 mg. (30), and Skelaxin 400 mg. (240). (Ex. 43, 191-192/4510-4511. Ex. 108. Testimony of Dr. Ogoke, Vol. VIII, 1578-1580.)

2. Dr. Trescot noted that Pt. O had a long history of intractable facial pain that was constant and included swelling. The pain occurred when talking, chewing or yawning. She had also sustained facial nerve damage from complications during her surgeries. She viewed Pt. O’s neuropathic pain as related to scar tissue wrapping around the nerves and/or from compression of the nerves that caused her facial nerve palsy, or drooping of her facial muscles. In light of her on-going high pain levels, Dr. Trescot opined that Dr. Ogoke acted appropriately in prescribing as he did for Pt. O at her initial visit. (Testimony of Dr. Trescot, Vol. XV, 2966-2971.)

3. On December 7, 2000, Pt. O reported to the police that her pocketbook was missing or lost. She came to Dr. Ogoke’s office on or about December 8, 2000 seeking a prescription for a medication that had been in her pocketbook that she claimed was now lost. A police report was completed based on her claim. She signed Dr. Ogoke’s Narcotics Prescription Policy & Agreement (narcotics agreement) on December 8, 2000. Dr. Ogoke’s policy of requiring a police report to help explain a need for an early refill of a medication, was to address a red flag/caution that Pt. O might be showing drug-seeking behavior. To provide a police report when prescriptions are lost or stolen is a term in the narcotics agreement. Providing a police report does not entitle the patient to another prescription for the missing medication. It is one factor to consider when determining whether or not another prescription will be written for the

patient. At the December 8, 2000 visit, Pt. O was prescribed Oxycontin 20 mg. (42) to cover use of this medication until the time when her medication needs would be addressed. She was also prescribed Neurontin 600 mg. (180). On December 9, 2000, Pt. O had two chest x-rays taken at Baystate Medical Center (not ordered by Dr. Ogoke). On December 27, 2000, Dr. Ogoke prescribed non-opioid medications for Pt. O; Elavil 100 mg. (30), Relafen 500 mg. (60), and Neurontin 600 mg. (120). (Ex. 43, 184-190/4503-4509. Testimony of Dr. Ogoke, Vol. VIII, 1582-1584 & Dr. Satwicz, Vol. XII, 2263-2268.)

4. Pt. O was seen at Dr. Ogoke's office on January 30, 2001 with a left jaw area pain complaint of 2-3/10, improved from prior pain levels since she began use of a Duragesic Patch (25 mcg.).¹⁶⁵ At this visit, Dr. Ogoke's office learned that Pt. O had been hospitalized twice in the last month for overdosing on tricyclic anti-depressant medication. She did not have suicidal ideation. She was treating with Dr. Sewell, a psychiatrist for depression, and was being prescribed Effexor XR. Dr. Ogoke gave Pt. O a physical examination and assessed her with: atypical facial pain; facial neuritis with neuropathic pain; and, facial nerve palsy, rule out iatrogenic injury left side. Dr. Ogoke secured a list of medications Pt. O was being dispensed daily at Pt. O's home by a visiting nurse with Loving Care Staff Builders. The list was dated January 30, 2001 and included; Effexor XR (150 mg.), Paxil (10 mg.), Neurontin (400 mg.), Duragesic Patch (25 mcg.), Trazodone (100 mg.), Klonadine (0.1 mg.), Prozac (20 mg.), and Norvasc (10 mg.). These medications included the medications Dr. Sewell was prescribing.¹⁶⁶ Pt. O was prescribed Neurontin 600 mg. (90), Effexor XR 225 mg. (90), a dose increase from

¹⁶⁵ I could not locate or decipher in Pt. O's medical records (Exhibit 43) when or who prescribed a Duregesic Patch.

¹⁶⁶ The list of medications being dispensed daily to Pt. O, produced by Kimberly Diaz, RN of Loving Care Staff Builders, referred to a hospital discharge summary that I could not locate in Pt. O's medical records (Exhibit 43).

150 mg., a Duragesic Patch 25 mcg. (5), and nutrition drink supplements such as Ensure or Boost due to Pt. O's difficulty with chewing solids because of jaw pain. Pt. O was to return for a follow-up visit in two weeks and to continue to treat with her psychiatrist. Pt. O was discontinued on Elavil. The psychiatrist had stopped that prescription and replaced it with Effexor. Effexor is an anti-depressant medication and a serotonin norepinephrine re-uptake inhibitor preventing the body from breaking down serotonin and norepinephrine in the brain and spinal cord. This blocks pain. Depression decreases serotonin and norepinephrine levels. Dr. Ogoke's office had not previously prescribed Effexor for Pt. O. (Ex. 43; 74-76/4393-4395 & 181-182/4500-4501. Testimony of Dr. Ogoke, Vol. VIII, 1581-1584 & Dr. Trescot, Vol. XV, 2975-2988 & Vol. XVII, 3292-3294.)

5. Dr. Satwicz opined, that Pt. O having been hospitalized for overdosing on medicines, showed she was not in control of taking her medications properly. This was also why she needed the extraordinary help of daily dispensing of her prescribed medications by a home healthcare nurse. With this history, Dr. Satwicz would not have further prescribed Pt. O opioid medications. Even the Duragesic Patch, which releases the opioid Fentanyl through the skin for seventy-two hours at a time, requires assurance that the patch was used properly with good skin contact and without bubbling or peeling under the patch. Dr. Satwicz expected Pt. O's medical records to have addressed this issue through a finding from a physical examination whether the patch was properly on the skin. There is no information in Pt. O's medical records to show this monitoring was done. (Testimony of Dr. Satwicz, Vol. XII, 2269-2271 & 2606-2610.)

6. Pt. O was seen at Dr. Ogoke's office on February 21, 2001. She reported the pain in her left jaw was down to a 3/10 level due to improvements from her current medication regimen of Effexor, Neurontin, and the Duragesic Patch. She was still having the home healthcare

provider nurse distribute daily her medications to her. Pt. O received a physical examination. The impression reached was: atypical facial pain; facial neuritis with neuropathic pain; and, facial nerve palsy, rule out iatrogenic injury left side. The treatment plan was to wean Pt. O off the Duragesic Patch and switch her to Oxycontin 20 mg. (28) with the goal of weaning her off narcotics. She was to come for a follow-up evaluation in two weeks. (Ex. 43; 70/4389 & 72/4391.)

7. On March 7, 2001, the visiting nurse who had been dispensing daily to Pt. O her prescribed medications, called Dr. Ogoke's office. She explained that, in cleaning out Pt. O's medicine cabinet, she accidentally threw out Pt. O's script for Oxycontin 20 mg. (28) from February 21, 2001. According to Dr. Ogoke's protocol, the content of this call was entered into Pt. O's medical record. Dr. Ogoke's staff told the visiting nurse to secure a police report concerning this lost prescription script before Dr. Ogoke's office could consider re-issuing a substitute prescription to Pt. O. Pt. O was seen at Dr. Ogoke's office on March 9, 2001, complaining of jaw pain that was at a 9/10 level. She reported that further jaw surgery was scheduled for April 30, 2001. She was given a physical examination. She had not been using the Duragesic Patch for about two weeks. The time that had elapsed from the date the Oxycontin prescription had been written, meant this original prescription was too old to be filled. The new treatment plan was to prescribe an increase in the dose of Oxycontin from 20 mg. to 40 mg. given Pt. O's high level pain complaint. She was instructed to continue taking her other medications, and to follow-up with her oral surgeon. (Ex. 43; 66-69/4385-4388 & 211/4530. Testimony of Dr. Ogoke, Vol. VIII, 1585-1587.)

8. Pt. O was seen at Dr. Ogoke's office on April 6, 2001. She reported a pain level in her jaw area of 2-3/10. She reported her surgery was scheduled for May 15, 2001 to involve

“harvesting bone from her hips to make a new condyle of the left jaw, in the temporomandibular joint.” Pt. O had been unable to chew solids. Her pain symptoms were being fairly well controlled with the Oxycontin 40 mg. Pt. O was seeking prescription renewals. She was given a physical examination. The treatment plan was to continue her medication regimen, and the Oxycontin was renewed at 40 mg. (60). She was to be seen again in about one month. (Ex. 43; 63/4382 & 65/4384.)

9. Pt. O was seen at Dr. Ogoke’s office on May 4, 2001. Her surgery was re-scheduled for June 29, 2001. Her reported jaw pain was 2-3/10, and she sought renewals of her pain medications. She was given a physical examination and was assessed with: atypical facial pain; facial neuritis with neuropathic pain; and, left facial palsy, rule out iatrogenic injury. She was prescribed Oxycontin 40 mg. (60), Neurontin 600 mg. (90), and Effexor XR 75 mg. (90). She was to return for follow-up in one month. Pt. O was seen by Dr. Ogoke on June 1, 2001, complaining of jaw pain at a 2-3/10 level. Her surgery had been postponed to July 27, 2001. Pt. O was given a physical examination. Her assessment was unchanged. Pt. O’s medications were changed and a verbal order was given about the changes to Pt. O’s visiting nurse who daily dispensed Pt. O’s medications to her. The Oxycontin dose was reduced to 20 mg., the Neurontin was discontinued with Zonegran 100 mg. prescribed instead, with the plan to titrate up as needed. The Effexor XR dose was reduced to 150 mg. from 225 mg. Dr. Ogoke spent about fifteen minutes with Pt. O discussing the need to be compliant in properly taking her medications. Dr. Ogoke explained his medication changes as follows:

I am concerned ... that the patient’s pain control can be better achieved with a lower dose of Oxycontin and also a need to change the Neurontin to Zonegran and titrate up as needed. The Effexor dose is currently at a dose of 225 mg. and I have been reducing it to 150 mg. and titrating the dose of the anti-convulsant, Zonegran, accordingly.

On June 18, 2001, the visiting nurse reported to Dr. Ogoke's office that Pt. O had been nauseous with diarrhea for about ten days, and that she had an increase in her pain level from 4/10 to 9/10. The caregiver was told to discontinue the Zonegran and increase the Oxycontin to a 40 mg. dose level. Pt. O was seen by Dr. Ogoke on June 26, 2001. Pt. O reported a pain level in the jaw of 9/10. He gave her a physical examination. The following note appeared within the report of this visit under the treatment plan:

Discontinue Zonegran as the patient is not able to tolerate the medication from a GI standpoint and restart Neurontin ... to 800 mg. #90, 1 p.o.t.i.d. [three times a day.] Increase Oxycontin from 20 mg. to 30 mg. and prescriptions ... written for Oxycontin 20 mg. #60 and Oxycontin 10 mg. #60 for a total of Oxycontin 30 mg. p.o. every 12 hours. Will also increase Effexor back to 225 mg. per day and a prescription was renewed for Effexor XR 75 mg. #90.

On June 28, 2001, the visiting nurse was given another verbal order to give Oxycontin at 30 mg., Neurontin at 800 mg., and Effexor XR at 225 mg. On July 11, 2001, Dr. Ogoke's office wrote Pt. O prescriptions for Neurontin 800 mg. (21) and Effexor XR 225 mg. (21). (Ex. 43: 56-59/4375-4378; 61-62/4380-4381; 174-176/4493-4495; 178-180/4497-4499 & 213-214/4532-4533.)

10. Pt. O was seen in follow-up by Dr. Ogoke on July 24, 2001. She reported her left jaw area pain at a level of 7/10 with an inability to chew solids. She had been using nutrition drinks. Her surgery had been postponed until the end of August 2001, which she did not like. Pt. O had found that the Neurontin at 800 mg. was "tremendous with pain control," but the pain was determined not to be "totally" controlled at 800 mg. A physical examination was done. No changes were made to her assessed conditions. The treatment plan was to increase the Neurontin dosage to 1600 mg. p.o.t.i.d. [three times a day.] The Effexor XR was to be at 150 mg., and the Oxycontin dose was to stay at 30 mg. p.o.q. [every] 12 hours. Pt. O was to be seen again in one month and to follow-up with her oral surgeon. Pt. O received prescriptions on July 24, 2001 for

Oxycontin 10 mg. (60) and 20 mg. (60), Neurontin 800 mg. (180), and Effexor XR 150 mg. (30). Pt. O was seen at Dr. Ogoke's office on August 22, 2001. She complained of left jaw area pain at a 7-8/10 level. She reported that the increase in the Neurontin dose dulled the neuropathic pain, but she continued to experience "throbbing" pain at times. She wanted an increase in the Oxycontin strength to 40 mg. for that. Pt. O appeared "tearful" and "depressed" at this visit. She had a new oral surgeon with an appointment in September 2001. She was given a physical examination. The impressions were unchanged. She was prescribed Neurontin 800 mg. (180), OxyContin 20 mg. (60), and 10 mg. (60), and Effexor XR 150 mg. (30). Her request for the increase in the Oxycontin dose to 40 mg. was to be reassessed in one month. Pt. O was seen at Dr. Ogoke's office on September 25, 2001. She reported a left jaw area pain of 6/10. She had seen the new oral surgeon who recommended a tomogram and panoramic dental films. She had a follow-up appointment with the oral surgeon on October 19, 2001. She also felt she had an eye infection, and she was instructed to see an ophthalmologist for evaluation and care. Pt. O reported that she had been compliant in taking her medications. She wanted refills. She was given a physical examination. The assessments remained unchanged. Her medication regimen was continued, and she was prescribed OxyContin 20 mg. (60) and 10 mg. (60), Neurontin 800 mg. (180), and Effexor XR 150 mg. (30). (Ex. 43: 44-52/4363-4371; 209-210/4528-4529 & 212/4531.)

11. Pt. O fell in a pothole while walking her dog and had a twisting injury. She had right knee and ankle x-rays on October 18, 2001 that showed no acute fractures or dislocations. She was fitted with an air cast. She had a mild soft tissue swelling injury. Pt. O saw Dr. Ogoke on October 25, 2001. She complained of left jaw area pain at a 6/10 level, had not had the oral surgery, but had an appointment scheduled with the surgeon. She reported right ankle and knee

10 mg. (2) for preparation for his next procedure. A UDS was done. The results were negative for opiates and Cocaine, and positive for Oxycodone. (Ex. 43: 69-72/3932-3935; 119-122/3982-3985; 125-131/3988-3994; 134/3997; 136-143/3999-4006; 394-396/4257-4259 & 402-404/4265-4267.)

30. Pt. N was seen at Dr. Ogoke's office on April 6, 2006. He reported that the prior week he fell using a four wheel all-terrain vehicle, re-injuring his right shoulder area that had recovered well. He also complained of back pain. He had a physical examination. The assessment reached was: impingement syndrome in the right shoulder with downsloping acromium; rotator cuff tendonitis; acromioclavicular joint strain; shoulder contusion; myalgia in the right forearm; cervical strain (aggravated); and, right upper extremity sympathetic maintained pain (improved). A UDS was done. The treatment plan was to: do a lumbar spine MRI; stop the Percocet due to GERD (gastroesophageal reflux disease); renew his other medications; and, have a left lumbar facet joint injection. Pt. N agreed to this plan. A prescription was written for Oxycodone 10 mg. (90) for break-through pain to be in place of Percocet. This prescription could not be filled by Pt. N's pharmacy and Pt. N requested to stay on Percocet. He returned the Oxycodone prescription and received a prescription for Percocet 7.5/325 mg. (90). Pt. N was also prescribed MS Contin 100 mg. (60), EC Naprosyn (60), and Ativan 2mg. (2) for procedures. The UDS results were reached on April 14, 2006.¹⁶² (Ex. 43: 144/4007; 146-147/4009-4010 & 390-393/4253-4256.)

31. Pt. N was seen on May 1, 2006 at Dr. Ogoke's office. He reported pain symptoms in

¹⁶² Only one not fully legible page of the UDS results from April 14, 2006 was found in Pt. N's medical records (Ex. 43, 144/4007).

the lower back. He was prescribed MS Contin 100 mg. (60), Oxycodone (180),¹⁶³ and Ativan 2 mg. (2) for procedures. X-rays of the left hand were ordered. A UDS was done. The UDS results from May 10, 2006 were negative for Cocaine and negative for both opiates and the Oxycodone screen. Pt. N was seen at Dr. Ogoke's office on June 2, 2006. He had not undergone the planned lumbar facet joint injection for his low back pain. He reported shoulder and left hand pain. He had not had the x-rays of his left hand. Pt. N had a physical examination. He was assessed with: lumbar pain and radiculopathy; sacroiliitis; carpometacarpal joint strain; left hand pain, rule out any fracture; and, cervical pain. He was prescribed Oxycodone 5 mg. (180), EC Naprosyn 500 mg. (60), MS Contin 100 mg. (60), and Ativan 2 mg. (2) for procedures. Pt. N reported that his pharmacy could not fill the 180 count of Oxycodone and only filled a 141 count. He did not also receive a prescription for Percocet. The results of the May 1, 2006 UDS specimen testing were not discussed within the report of the June 2, 2006 visit, but a UDS was done at this visit. The UDS results from June 3, 2006 were positive for the Oxycodone screen, and negative for opiates and Cocaine. On June 20, 2006, Dr. Ogoke gave Pt. N a bilateral SI injection with fluoroscopy. He had not had the left hand x-rays or the lumbar facet joint injection as had been planned. He was prescribed Oxycodone 5 mg. (39). Blood work was ordered. A UDS was done. Nothing in the report of this visit addressed UDS results from his prior tests that showed non-compliance issues to resolve about how he was taking his MS Contin and Oxycodone or Percocet. Pt. N was seen on July 3, 2006 at Dr. Ogoke's office. He reported a "50%" improvement in his low back pain following the SI injection. He was given a physical examination and assessed with: sacroiliitis; lumbar strain; lumbar radiculopathy; cervical strain; and, carpal/metacarpal joint strain. He was prescribed Elavil 25 mg. (60), Oxycodone 5 mg.

¹⁶³ The dose level of the Oxycodone was not legible on the copy of the prescription, and the prescription was not detailed in the report of the May 1, 2006 visit. (Ex. 43, 156/4019.)

(180), MS Contin 100 mg. (60), EC Naprosyn 375 mg. (60), and Ativan 2 mg. (2) for procedures. The treatment plan was for Pt. N to have the lumbar facet joint injection and a CMC joint injection as soon as possible. A UDS was done. The July 5, 2006 UDS results were negative for opiates and the Oxycodone screen, and positive for Cocaine. (Ex. 43: 151-158/. 4014-4021; 160-164/4023-4027; 167/4030; 170-171/4033-4034; 173/4036; 175-176/4038-4039; 178/4041; 180/4043; 182-186/ 4045-4049; 376-380/4239-4243; 382/4245 & 385-389/4248-4252.)

32. Pt. N had signed the narcotics agreement when he was receiving care with Dr. Ogoke. He tested positive for Cocaine from his UDSs on November 23, 2004, June 21, 2005, and July 3, 2006. Dr. Ogoke did not end his care of Pt. N for taking illicit drugs as a result of any of the first two UDS results showing Cocaine, but he likely terminated Pt. N's care after learning of the July 5, 2006 result. Dr. Ogoke concluded that he would have seen the positive for Cocaine result from July 5, 2006 even if there was a long delay in his receipt of the results from the outside laboratory. Dr. Ogoke opined that he would not have continued Pt. N in his care once aware of this further illicit drug use without stopping opioid prescribing for Pt. N until he was cleared by an addiction medicine specialist. No further medical records were found on Pt. N after the July 5, 2006 UDS results.¹⁶⁴ (Testimony of Dr. Ogoke, Vol. VIII, 1570-1577.)

33. Pt. N had UDS results that were negative for opiates despite ongoing prescriptions for them, including at times for MS Contin, which was a scheduled medication and expected to be found in a UDS specimen. But, if the UDS specimen was taken at a time when the MS Contin prescription had ended a few days prior, Dr. Ogoke opined that this could explain some of the negative UDS results for opiates. When Dr. Ogoke received the UDS results even after months of delay, the visit reports never showed that he or his physician assistants questioned Pt.

¹⁶⁴ No termination of care letter was found for Pt. N in his medical records (Exhibit 43).

N about his use of the MS Contin. The UDS results also showed Pt. N was negative for the Percocet and Oxycodone he took for break through pain as shown by the negative Oxycodone screen results. These UDS results occurred on: April 22, 2004; April 30, 2004; November 23, 2004; September 23, 2005; October 19, 2005; March 9, 2006; April 5, 2006, May 1, 2006; June 2, 2006; and, July 3, 2006. Dr. Ogoke was less concerned with those negative UDS results because those opioids were for break-through pain and not scheduled medications. He opined that such medications might not have been taken by Pt. N at and around the time of the UDS tests that often occurred at the times of scheduled visits when medications would have needed to be renewed. Dr. Ogoke was not able to get his patients to come to his office for frequent UDS tests within their monthly prescription cycles when UDS results might have been able to show clear non-compliance by Pt. N in taking his medications as prescribed. (Ex. 43: 15/3878; 20-21/3883-3884; 34-35/3897-3898; 110/3973; 126-127/3989-3990; 140-144/4003-4007; 152-155/4015-4018; 161-164/4024-4027; 183-186/4046-4049; 271-276/4134-4139 & 308-309/4171-4172. Testimony of Dr. Ogoke, Vol. VIII, 1559-1571.)

34. At and around the time that the UDS results for Pt. N were negative his opioid medications, the following opioid prescriptions for them were written by Dr. Ogoke's office. He was prescribed Percocet for break through pain on: March 12, 2004; March 25, 2004; April 22, 2004; May 21, 2004; June 17, 2004; July 15, 2004; August 16, 2004; September 7, 2004; September 24, 2004; October 14, 2004; November 3, 2004; November 23, 2004; and, December 24, 2004. On March 3, 2005, the opioid Kadian was prescribed. Dr. Ogoke added to the on-going prescription for Percocet, the long-acting scheduled opioid of Avinza on January 12, 2005 and February 23, 2005. The on-going prescription for Percocet continued, but added was the long-acting opioid of MS Contin in place of the Avinza on: March 10, 2005; March 30, 2005;

April 7, 2005; April 28, 2005; May 27, 2005; June 20, 2005; July 15, 2005; August 5, 2005; September 22, 2005; October 19, 2005; November 17, 2005; December 19, 2005; January 11, 2006; February 9, 2006; March 9, 2006; April 6, 2006; and, April 16, 2006. Dr. Ogoke substituted Oxycodone for the Percocet prescription to address break-through pain on: May 1, 2006; June 2, 2006; June 20, 2006; and, July 3, 2006. (Ex. 43: 6/3869; 9/3872; 13/3876; 25/3888; 36/3899; 37/3900; 39/3902; 49/3912; 58/3921; 64/3927; 67/3930; 71/3934; 75/3938; 89/3952; 95/3958; 97/3960; 104/3967; 109/3972; 111-112/3974-3975; 121/3984; 137/4000; 147/4010; 156/4019; 175-176/4038-4039; 180/4043; 254/4117; 268/4131; 280/4143; 286/4149; 289/4152; 293-294/4156-4157; 299-300/4162-4163 & 313/4176.)

35. Pt. N had injection treatments that covered at least a two year time period. He had an acromioclavicular joint injection on March 19, 2004. He had another one on July 23, 2004. He had a cervical ESI to the C3-4 level on August 16, 2004. He had another acromioclavicular joint injection on September 23, 2004, and a cervical ESI at C3-4 on September 29, 2004. Pt. N had another acromioclavicular joint injection on October 14, 2004. He had a lumbar ESI at L5-S1 on November 4, 2004, and a bilateral SI injection on November 23, 2004. He had a lumbar transforaminal joint injection at the L4 through the S1 levels on February 3, 2005, and an acromioclavicular joint injection on February 9, 2005. On April 7 and 16, 2005, he had lumbar ESIs at the L4 through the S1 levels. On August 5, 2005, Pt. N had a bilateral facet joint injection at the L2-3 through the L5-S1 levels. On February 9, 2006, he had a bilateral SI injection, and on March 9, 2006, he had another bilateral lumbar facet joint injection at the L2-3 through the L5-S1 levels. He had a bilateral SI injection on June 20, 2006. (Ex. 43:44-45/ 3907-3908; 51-54/3914-3917; 60-62/3923-3925; 93/3956; 99-102/3962-3965; 170-171/4033-4034; 201/4064; 203/4066; 265-266/4128-4129; 317-319/4180-4182; 337/4200; 341-342/4204-4205;

351/4214; 394-396/4257-4259; 402-404/4265-4267; 414-416/4277-4279; 418-420/4281-4283 & 425-426/4288-4289.)

Conclusion and Recommendation

The findings show that Dr. Ogoke violated the standard of care in the practice of medicine with Pt. N as alleged by the BORM, for failing to terminate care of Pt. N for his use of Cocaine on more than one occasion over a significant time span. Pt. N was first found to have a positive UDS test for Cocaine in November 2004. Dr. Ogoke addressed this issue with Pt. N, although he did not require Pt. N to first be cleared by an addiction medicine specialist before he would receive further opioid prescriptions. Dr. Ogoke only provided a resource to Pt. N of the name of an addiction medicine specialist. The second time Pt. N had a UDS finding positive for Cocaine was in June 2005. The findings show that Dr. Ogoke may not have seen this result because the document may have been placed into a closed Pt. N file. The medical records and Dr. Ogoke's persuasive testimony supports him not seeing this UDS result for this reason. There is no medical record information in any document or visit report acknowledging this UDS result with Dr. Ogoke determining despite it, that Pt. N would have no need to see an addiction medicine specialist to be cleared to receive further opioid medicine, or that Dr. Ogoke did not find that result significant. The third time Pt. N had a UDS finding positive for Cocaine was in July 2006 after which there are no further medical records on Pt. N. Dr. Ogoke's testimony is persuasive that this third UDS result that was positive for Cocaine likely led to an end of care for Pt. N; at least an end to his receiving opioid prescriptions. This means that from the end of November 2004 through the start of July 2006, Pt. N continued to receive significant opioid medications on an on-going basis. Even if Dr. Ogoke did not intentionally ignore the second UDS result positive for Cocaine, he is responsible for this error. The BORM has proven a

violation of the standard of care in Dr. Ogoke's practice of pain management medicine due to this error that resulted in no adequate attention paid to Pt. N's use of Cocaine after the June 2005 UDS result. The main monitoring being done to check on Pt. N's compliance in taking no illicit drugs were the UDS tests he received.

The findings also show that Dr. Ogoke continued to prescribe opioids to Pt. N, even in accelerated doses, after having a number of UDS results that showed Pt. N may not have been compliant in taking his opiate medication such as the long-acting MS Contin and the Percocet for break through pain. Pt. N reported at a few times that he had accelerated his use of the Percocet to gain better pain control to explain the negative Oxycodone UDS results. This reasoning, in light of the visit evaluations determining Pt. N had genuine high level pain complaints, led Dr. Ogoke to prescribe a long-acting opioid on an on-going basis so that hopefully Pt. N would not need to use as much of the break through opioid for pain control. The long-acting opioid medication was a scheduled medication for Pt. N to routinely take so that it was more likely than not to show up in UDS results as a positive finding from the opiate test. This was often not what was shown in the UDS test results. At times, the visit reports contained information that Pt. N was counseled about the importance of being compliant in taking his medications as prescribed. Dr. Ogoke explained that depending on when the UDS specimen was taken, Pt. N might have been days beyond the time his prescription for the long-acting opioid was finished to explain a negative opiate UDS result. It is unlikely though, that Pt. N was never out of compliance in taking both the long acting and the break through opioids given the many UDS tests done that were negative for one or the other or for both. This kind of red flag was never addressed within the visit reports with any specificity to be able to determine whether Dr. Ogoke always addressed this narcotics agreement violation; that the only times Dr. Ogoke determined that Pt. N engaged

in non-compliant use of opioid medication was when a visit report discussed giving him counseling. That is just not credible. The findings show some likely narcotic agreement violations continued to occur even after Pt. N was talked to by Dr. Ogoke (and his physician assistants) about the need to take opiate medication only as prescribed.

It may have been that UDS results were never timely addressed. There were too many instances in Pt. N's medical records, as shown in the findings, when Pt. N's UDS results from the outside laboratories seemed never to have been received. No visit reports included information that this issue was pursued with the outside laboratory even though doing UDS tests was an important monitoring tool used to determine whether Pt. N was being compliant in taking his medications as prescribed, and after that November 2004 use of Cocaine, if he was further using illicit drugs. It also seemed that when UDS results were received showing potential out of compliance use of the prescribed opioids, that the subsequent visit reports only rarely addressed Pt. N receiving counseling about the need to be compliant. It is not credible that unless a visit report addressed that Pt. N received counseling, that all the other red flag UDS results were resolved with Pt. N having had the UDS test done after he had run out of his prescription opioid medication for a few days to explain a negative result. I conclude that the BORM has proven this failure to adequately address Pt. N's compliance issues as a violation of the narcotics agreement and as a violation of the standard of care in the practice of pain management medicine.

The other allegation made by the BORM is that Dr. Ogoke violated the standard of care by inappropriately prescribing high doses of opioids to treat Pt. N's pain complaints that were due to underlying conditions that did not merit treatment with such high doses of narcotics. In making this allegation, the BORM relied on Dr. Satwicz's expert opinion.

Dr. Satwicz opined that prescribing Avinza was accelerating Pt. N's use of opioids for no sufficient reason. He explained why Avinza was too powerful an opioid for Pt. N and not needed for treatment of Pt. N's pain. Avinza was prescribed as a long-acting opioid with the opioid Percocet continuing to be prescribed for break through pain. The Avinza was prescribed for a short time span that followed the November 24, 2004 UDS result showing Pt. N positive for Cocaine. Avinza was only prescribed in January and February 2005, but was the first time a long-acting opioid medication had been prescribed. After Avinza was no longer prescribed, Pt. N continued thereafter to be taking Percocet for break through pain along with MS Contin as Pt. N's long-acting opioid medication. I did not find sufficient proof from Dr. Satwicz's opinion to find that prescribing Avinza for Pt. N was accelerating Pt. N's use of opioids for no sufficient reason. In terms of Pt. N being prescribed an on-going long-acting opioid throughout most of his care with Dr. Ogoke into July 2006, the visit reports contained Pt. N's complaints of most often chronic high pain levels. His complaints were evaluated at these visits with physical examinations that resulted in no findings that Pt. N was exaggerating his pain complaints to make them not credible. To prescribe a long-acting opioid against that ongoing background does not show Dr. Ogoke was overprescribing opioids for Pt. N by prescribing long-acting and short-acting opioid medications. Further support for not finding Dr. Ogoke was overprescribing with Avinza or with MS Contin, is that Pt. N's treatment plan continued to include interventional procedures to also help alleviate the pain. And, in general, the dose levels of these long-acting opioids did not change over the course of care.

Dr. Satwicz also opined that prescribing Actiq, a pain drug for cancer, even if for use by Pt. N during interventional procedures, was done in violation of the standard of care by Dr. Ogoke and his physician assistants. In particular, Dr. Satwicz found no logic and no justification

for ever including in one prescription for Pt. N, six Actiq units at 600 mg. each. Dr. Ogoke and Dr. Trescot, opined the Actiq was appropriate for use to help Pt. N get through interventional injection procedures without moving or to get through longer procedures. Both Dr. Ogoke and Dr. Trescot opined that typically two units per procedure would be sufficient, and just prescribing two units for an upcoming procedure is what Dr. Ogoke typically prescribed. But, they also opined that sometimes using more than just two units during a procedure would be appropriate. To use Actiq during injection procedures this way was not proven to have been a violation of standard of care.

There were two visits, one following the other, when each time six units of the Actiq 600 mg. were prescribed. Dr. Ogoke testified that he would provide the estimated number of Actiq units he would be prescribing over a particular time period, over weeks or months, to the patient's insurer to get approval for coverage of the cost of the Actiq. That was credible. But, here, Pt. N was receiving within a few months, twelve units of Actiq 600 mg. Even though they were known by Pt. N to be used only during his interventional procedures, Pt. N by the time the six units were prescribed at two consecutive visits, had red flags concerning his staying compliant in taking his opioid medications, and had already been known to have used Cocaine. Against this background it is not understandable why Pt. N would have been prescribed quite so many powerful pain killer Actiq units over so short a time. No visit reports addressed how Pt. N used up those twelve Actiq 600 mg. units during the procedures he had.

The findings show Pt. N was prescribed Actiq 600 mg. (6) on March 30, 2005 with his treatment plan from March 10, 2005 to have a lumbar transforaminal injection as soon as possible. He had this procedure on April 7, 2005. He also received another prescription for Actiq 600 mg. (6) on April 7, 2005. There is a document in Pt. N's medical record that on May

5, 2005, his insurer would not cover the Actiq, at least as prescribed. There is a medical record showing the treatment plan for Pt. N on July 15, 2005 was to do a lumbar facet joint ESI as soon as possible. On that date Pt. N was prescribed Actiq 600 mg. (2). This bilateral procedure at levels L2-3 through L5-S1 was done on August 5, 2005. Without another Actiq prescription, Pt. N had another such procedure on September 14, 2005. The next prescription for Actiq 600 mg. was on November 17, 2005 for two units. The next interventional procedure, an SI injection, was done on January 11, 2006.

Dr. Satwicz's concerns are persuasive that Pt. N received an excessively large dose of six units of Actiq 600 mg. in one prescription. All three physicians acknowledge Actiq is a fast-acting powerful pain killer. The medical records show Actiq 600 mg. was prescribed in six units at two consecutive visits to a patient who had shown himself to have red flags due to his use of Cocaine and due to his inconsistent compliance in taking his opioid medications as prescribed. No visit report contained information that explained why these high number of units of Actiq 600 mg. were prescribed so close in time. The BORM has proven its claim regarding the Actiq 600 mg. (6) prescriptions as being over prescribing of powerful opioids to a patient with non-compliance issues and a patient who had used Cocaine with no clearance to receive further opioid prescriptions from an addiction medicine specialist to provide at least some reassurance that he would likely only use the Actiq during procedures. I conclude the BORM has proven that at least at to the time period when six units of Actiq were prescribed at two consecutive visits, that this was overprescribing opioids to Pt. N. I conclude this appreciating that this prescribing occurred when Pt. N had a number of planned interventional procedures when taking two units of Actiq during them would not have been a violation of standard of care. I conclude this even though Pt. N was counseled that the Actiq was to be taken only during procedures.

Patient O

Summary

Patient (Pt.) O did not testify. No complaint by Pt. O to the Board of Registration in Medicine was presented. (Ex. 83.)

In the Statement of Allegations, Dr. Ogoke was charged with practicing medicine in violation of the standard of care as follows:

- Dr. Ogoke inappropriately prescribed high doses of opioids in light of Pt. O's history of opioid abuse.
- Dr. Ogoke inappropriately prescribed high doses of opioids despite Pt. O's ongoing drug seeking behavior.

The facts the BORM alleged to support its allegations included the following:

- Pt. O treated with Dr. Ogoke 2001 through 2004 for low back and leg pain, and atypical facial pain.
- Dr. Ogoke's diagnoses for Pt. O included: lumbar strain; lumbar radiculopathy; grade I spondylolisthesis of the L3-4 spine level; lumbar degenerative disk disease; lumbar degenerative joint disease; lumbar spinal canal stenosis at the L3-4 level; post-lumbar laminectomy syndrome; right knee and right hip osteoarthritis; sacroiliitis; and, atypical facial pain.
- Pt. O had a documented history of opioid abuse.
- Pt. O showed signs of drug seeking behavior while under Dr. Ogoke's care.
- Dr. Ogoke treated Pt. O with a combination of pain medications, including Oxycontin, Methadone, and Duragesic Patch.
- Dr. Ogoke treated Pt. O with multiple interventional procedures including epidural steroid injections, sacroiliac joint injections, and facet joint injections.

Findings of Fact

1. Pt. O, born in 1950, was initially evaluated by Dr. Ogoke on November 16, 2000. She was referred to Dr. Ogoke by Dr. Kirinkumar Chauhan to address her left jaw area pain. Pt. O was forty-nine years old, unemployed and on disability. She had temporomandibular joint disorder (TMJ). She had an initial TMJ surgery in 1975 in which her left mandible was broken

and reunited to provide her with a new alignment. Pt. O lacked a sufficient union post-surgery, and had further surgeries with the same surgeon. In the course of having these further surgeries, Pt. O experienced “a left facial nerve palsy and ... had metal implants in the jaw.” After one of the further surgeries, she was unable “to control her eyelid on one side, requiring ... eye drops in the eye which was covered with a patch.” Pt. O’s pain was described by Dr. Ogoke in his report of her initial visit with him:

Burning, sharp pain, aching pain, cramping, sensitive and shooting pain that is always present since her problem started. The left jaw area pain is associated with chronic swelling. The patient believes she has lost mandibular bone during multiple surgeries and now has facial asymmetry. Pain tends to radiate into the left side of the mandible as well. Her pain is ... at ... 10/10. Chewing apparently does not make the pain better. Pain tends to disturb the patient’s sleep every night. She has done multiple radiologic studies, including one scheduled CT scan to be done next week, according to the patient, at the request of one of her providers.

The patient no longer engages in social activities due to her pain. Family relationships have become strained and she is unable to work. Her interpersonal relationships have become almost nonexistent.

Dr. Ogoke understood Pt. O was scheduled to have another facial surgery with Dr. Cottrell. She told Dr. Ogoke she had hypertension, quit smoking about six months ago, and had no history of “drug, alcohol or caffeine abuse.” Dr. Ogoke did a review of systems and gave a physical examination. He noted Pt. O’s “depressed affect ... appears to be in some moderately acute distress ... appears quite anxious.” He made diagnoses of: atypical facial pain; facial neuritis with neuropathic pain possibly secondary to scar tissue and compression; and, left facial nerve palsy, rule out iatrogenic etiology. Dr. Ogoke’s treatment plan for Pt. O was to treat her with tricyclic anti-depressant and anti-inflammatory medications;

Elavil 50 mg. p.o.q.h.s. and tritrate upwards ... [S]tart ... Mobic 7.5 mg. p.o.q.d. and Percocet 5 mg. to be taken every 6 hours p.r.n. ... Neurontin 600 mg. p.o. to be taken three times daily as well as Norflex 100 mg. p.o. t.i.d., and Oxycontin 20 mg. p.o.q12h. and be monitored. She started Oxycontin only in the past few days

(less than two weeks).

Dr. Ogoke encouraged her “to keep her appointment with the maxillofacial surgeon,” and to do a follow-up visit with him in two weeks “for review and other considerations.” PT. O was seen by Dr. Ogoke on November 29, 2000. She was prescribed Neurontin 600 mg. (90), Percocet 5 mg. (120), Relafen 500 mg. (60), Elavil 75 mg. (30), and Skelaxin 400 mg. (240). (Ex. 43, 191-192/4510-4511. Ex. 108. Testimony of Dr. Ogoke, Vol. VIII, 1578-1580.)

2. Dr. Trescot noted that Pt. O had a long history of intractable facial pain that was constant and included swelling. The pain occurred when talking, chewing or yawning. She had also sustained facial nerve damage from complications during her surgeries. She viewed Pt. O’s neuropathic pain as related to scar tissue wrapping around the nerves and/or from compression of the nerves that caused her facial nerve palsy, or drooping of her facial muscles. In light of her on-going high pain levels, Dr. Trescot opined that Dr. Ogoke acted appropriately in prescribing as he did for Pt. O at her initial visit. (Testimony of Dr. Trescot, Vol. XV, 2966-2971.)

3. On December 7, 2000, Pt. O reported to the police that her pocketbook was missing or lost. She came to Dr. Ogoke’s office on or about December 8, 2000 seeking a prescription for a medication that had been in her pocketbook that she claimed was now lost. A police report was completed based on her claim. She signed Dr. Ogoke’s Narcotics Prescription Policy & Agreement (narcotics agreement) on December 8, 2000. Dr. Ogoke’s policy of requiring a police report to help explain a need for an early refill of a medication, was to address a red flag/caution that Pt. O might be showing drug-seeking behavior. To provide a police report when prescriptions are lost or stolen is a term in the narcotics agreement. Providing a police report does not entitle the patient to another prescription for the missing medication. It is one factor to consider when determining whether or not another prescription will be written for the

patient. At the December 8, 2000 visit, Pt. O was prescribed Oxycontin 20 mg. (42) to cover use of this medication until the time when her medication needs would be addressed. She was also prescribed Neurontin 600 mg. (180). On December 9, 2000, Pt. O had two chest x-rays taken at Baystate Medical Center (not ordered by Dr. Ogoke). On December 27, 2000, Dr. Ogoke prescribed non-opioid medications for Pt. O; Elavil 100 mg. (30), Relafen 500 mg. (60), and Neurontin 600 mg. (120). (Ex. 43, 184-190/4503-4509. Testimony of Dr. Ogoke, Vol. VIII, 1582-1584 & Dr. Satwicz, Vol. XII, 2263-2268.)

4. Pt. O was seen at Dr. Ogoke's office on January 30, 2001 with a left jaw area pain complaint of 2-3/10, improved from prior pain levels since she began use of a Duragesic Patch (25 mcg.).¹⁶⁵ At this visit, Dr. Ogoke's office learned that Pt. O had been hospitalized twice in the last month for overdosing on tricyclic anti-depressant medication. She did not have suicidal ideation. She was treating with Dr. Sewell, a psychiatrist for depression, and was being prescribed Effexor XR. Dr. Ogoke gave Pt. O a physical examination and assessed her with: atypical facial pain; facial neuritis with neuropathic pain; and, facial nerve palsy, rule out iatrogenic injury left side. Dr. Ogoke secured a list of medications Pt. O was being dispensed daily at Pt. O's home by a visiting nurse with Loving Care Staff Builders. The list was dated January 30, 2001 and included; Effexor XR (150 mg.), Paxil (10 mg.), Neurontin (400 mg.), Duragesic Patch (25 mcg.), Trazodone (100 mg.), Klonadine (0.1 mg.), Prozac (20 mg.), and Norvasc (10 mg.). These medications included the medications Dr. Sewell was prescribing.¹⁶⁶ Pt. O was prescribed Neurontin 600 mg. (90), Effexor XR 225 mg. (90), a dose increase from

¹⁶⁵ I could not locate or decipher in Pt. O's medical records (Exhibit 43) when or who prescribed a Duregesic Patch.

¹⁶⁶ The list of medications being dispensed daily to Pt. O, produced by Kimberly Diaz, RN of Loving Care Staff Builders, referred to a hospital discharge summary that I could not locate in Pt. O's medical records (Exhibit 43).

150 mg., a Duragesic Patch 25 mcg. (5), and nutrition drink supplements such as Ensure or Boost due to Pt. O's difficulty with chewing solids because of jaw pain. Pt. O was to return for a follow-up visit in two weeks and to continue to treat with her psychiatrist. Pt. O was discontinued on Elavil. The psychiatrist had stopped that prescription and replaced it with Effexor. Effexor is an anti-depressant medication and a serotonin norepinephrine re-uptake inhibitor preventing the body from breaking down serotonin and norepinephrine in the brain and spinal cord. This blocks pain. Depression decreases serotonin and norepinephrine levels. Dr. Ogoke's office had not previously prescribed Effexor for Pt. O. (Ex. 43; 74-76/4393-4395 & 181-182/4500-4501. Testimony of Dr. Ogoke, Vol. VIII, 1581-1584 & Dr. Trescott, Vol. XV, 2975-2988 & Vol. XVII, 3292-3294.)

5. Dr. Satwicz opined, that Pt. O having been hospitalized for overdosing on medicines, showed she was not in control of taking her medications properly. This was also why she needed the extraordinary help of daily dispensing of her prescribed medications by a home healthcare nurse. With this history, Dr. Satwicz would not have further prescribed Pt. O opioid medications. Even the Duragesic Patch, which releases the opioid Fentanyl through the skin for seventy-two hours at a time, requires assurance that the patch was used properly with good skin contact and without bubbling or peeling under the patch. Dr. Satwicz expected Pt. O's medical records to have addressed this issue through a finding from a physical examination whether the patch was properly on the skin. There is no information in Pt. O's medical records to show this monitoring was done. (Testimony of Dr. Satwicz, Vol. XII, 2269-2271 & 2606-2610.)

6. Pt. O was seen at Dr. Ogoke's office on February 21, 2001. She reported the pain in her left jaw was down to a 3/10 level due to improvements from her current medication regimen of Effexor, Neurontin, and the Duragesic Patch. She was still having the home healthcare

provider nurse distribute daily her medications to her. Pt. O received a physical examination. The impression reached was: atypical facial pain; facial neuritis with neuropathic pain; and, facial nerve palsy, rule out iatrogenic injury left side. The treatment plan was to wean Pt. O off the Duragesic Patch and switch her to Oxycontin 20 mg. (28) with the goal of weaning her off narcotics. She was to come for a follow-up evaluation in two weeks. (Ex. 43; 70/4389 & 72/4391.)

7. On March 7, 2001, the visiting nurse who had been dispensing daily to Pt. O her prescribed medications, called Dr. Ogoke's office. She explained that, in cleaning out Pt. O's medicine cabinet, she accidentally threw out Pt. O's script for Oxycontin 20 mg. (28) from February 21, 2001. According to Dr. Ogoke's protocol, the content of this call was entered into Pt. O's medical record. Dr. Ogoke's staff told the visiting nurse to secure a police report concerning this lost prescription script before Dr. Ogoke's office could consider re-issuing a substitute prescription to Pt. O. Pt. O was seen at Dr. Ogoke's office on March 9, 2001, complaining of jaw pain that was at a 9/10 level. She reported that further jaw surgery was scheduled for April 30, 2001. She was given a physical examination. She had not been using the Duragesic Patch for about two weeks. The time that had elapsed from the date the Oxycontin prescription had been written, meant this original prescription was too old to be filled. The new treatment plan was to prescribe an increase in the dose of Oxycontin from 20 mg. to 40 mg. given Pt. O's high level pain complaint. She was instructed to continue taking her other medications, and to follow-up with her oral surgeon. (Ex. 43; 66-69/4385-4388 & 211/4530. Testimony of Dr. Ogoke, Vol. VIII, 1585-1587.)

8. Pt. O was seen at Dr. Ogoke's office on April 6, 2001. She reported a pain level in her jaw area of 2-3/10. She reported her surgery was scheduled for May 15, 2001 to involve

“harvesting bone from her hips to make a new condyle of the left jaw, in the temporomandibular joint.” Pt. O had been unable to chew solids. Her pain symptoms were being fairly well controlled with the Oxycontin 40 mg. Pt. O was seeking prescription renewals. She was given a physical examination. The treatment plan was to continue her medication regimen, and the Oxycontin was renewed at 40 mg. (60). She was to be seen again in about one month. (Ex. 43; 63/4382 & 65/4384.)

9. Pt. O was seen at Dr. Ogoke’s office on May 4, 2001. Her surgery was re-scheduled for June 29, 2001. Her reported jaw pain was 2-3/10, and she sought renewals of her pain medications. She was given a physical examination and was assessed with: atypical facial pain; facial neuritis with neuropathic pain; and, left facial palsy, rule out iatrogenic injury. She was prescribed Oxycontin 40 mg. (60), Neurontin 600 mg. (90), and Effexor XR 75 mg. (90). She was to return for follow-up in one month. Pt. O was seen by Dr. Ogoke on June 1, 2001, complaining of jaw pain at a 2-3/10 level. Her surgery had been postponed to July 27, 2001. Pt. O was given a physical examination. Her assessment was unchanged. Pt. O’s medications were changed and a verbal order was given about the changes to Pt. O’s visiting nurse who daily dispensed Pt. O’s medications to her. The Oxycontin dose was reduced to 20 mg., the Neurontin was discontinued with Zonegran 100 mg. prescribed instead, with the plan to titrate up as needed. The Effexor XR dose was reduced to 150 mg. from 225 mg. Dr. Ogoke spent about fifteen minutes with Pt. O discussing the need to be compliant in properly taking her medications. Dr. Ogoke explained his medication changes as follows:

I am concerned ... that the patient’s pain control can be better achieved with a lower dose of Oxycontin and also a need to change the Neurontin to Zonegran and titrate up as needed. The Effexor dose is currently at a dose of 225 mg. and I have been reducing it to 150 mg. and titrating the dose of the anti-convulsant, Zonegran, accordingly.

On June 18, 2001, the visiting nurse reported to Dr. Ogoke's office that Pt. O had been nauseous with diarrhea for about ten days, and that she had an increase in her pain level from 4/10 to 9/10. The caregiver was told to discontinue the Zonegran and increase the Oxycontin to a 40 mg. dose level. Pt. O was seen by Dr. Ogoke on June 26, 2001. Pt. O reported a pain level in the jaw of 9/10. He gave her a physical examination. The following note appeared within the report of this visit under the treatment plan:

Discontinue Zonegran as the patient is not able to tolerate the medication from a GI standpoint and restart Neurontin ... to 800 mg. #90, 1 p.o.t.i.d. [three times a day.] Increase Oxycontin from 20 mg. to 30 mg. and prescriptions ... written for Oxycontin 20 mg. #60 and Oxycontin 10 mg. #60 for a total of Oxycontin 30 mg. p.o. every 12 hours. Will also increase Effexor back to 225 mg. per day and a prescription was renewed for Effexor XR 75 mg. #90.

On June 28, 2001, the visiting nurse was given another verbal order to give Oxycontin at 30 mg., Neurontin at 800 mg., and Effexor XR at 225 mg. On July 11, 2001, Dr. Ogoke's office wrote Pt. O prescriptions for Neurontin 800 mg. (21) and Effexor XR 225 mg. (21). (Ex. 43: 56-59/4375-4378; 61-62/4380-4381; 174-176/4493-4495; 178-180/4497-4499 & 213-214/4532-4533.)

10. Pt. O was seen in follow-up by Dr. Ogoke on July 24, 2001. She reported her left jaw area pain at a level of 7/10 with an inability to chew solids. She had been using nutrition drinks. Her surgery had been postponed until the end of August 2001, which she did not like. Pt. O had found that the Neurontin at 800 mg. was "tremendous with pain control," but the pain was determined not to be "totally" controlled at 800 mg. A physical examination was done. No changes were made to her assessed conditions. The treatment plan was to increase the Neurontin dosage to 1600 mg. p.o.t.i.d. [three times a day.] The Effexor XR was to be at 150 mg., and the Oxycontin dose was to stay at 30 mg. p.o.q. [every] 12 hours. Pt. O was to be seen again in one month and to follow-up with her oral surgeon. Pt. O received prescriptions on July 24, 2001 for

Oxycontin 10 mg. (60) and 20 mg. (60), Neurontin 800 mg. (180), and Effexor XR 150 mg. (30). Pt. O was seen at Dr. Ogoke's office on August 22, 2001. She complained of left jaw area pain at a 7-8/10 level. She reported that the increase in the Neurontin dose dulled the neuropathic pain, but she continued to experience "throbbing" pain at times. She wanted an increase in the Oxycontin strength to 40 mg. for that. Pt. O appeared "tearful" and "depressed" at this visit. She had a new oral surgeon with an appointment in September 2001. She was given a physical examination. The impressions were unchanged. She was prescribed Neurontin 800 mg. (180), OxyContin 20 mg. (60), and 10 mg. (60), and Effexor XR 150 mg. (30). Her request for the increase in the Oxycontin dose to 40 mg. was to be reassessed in one month. Pt. O was seen at Dr. Ogoke's office on September 25, 2001. She reported a left jaw area pain of 6/10. She had seen the new oral surgeon who recommended a tomogram and panoramic dental films. She had a follow-up appointment with the oral surgeon on October 19, 2001. She also felt she had an eye infection, and she was instructed to see an ophthalmologist for evaluation and care. Pt. O reported that she had been compliant in taking her medications. She wanted refills. She was given a physical examination. The assessments remained unchanged. Her medication regimen was continued, and she was prescribed OxyContin 20 mg. (60) and 10 mg. (60), Neurontin 800 mg. (180), and Effexor XR 150 mg. (30). (Ex. 43: 44-52/4363-4371; 209-210/4528-4529 & 212/4531.)

11. Pt. O fell in a pothole while walking her dog and had a twisting injury. She had right knee and ankle x-rays on October 18, 2001 that showed no acute fractures or dislocations. She was fitted with an air cast. She had a mild soft tissue swelling injury. Pt. O saw Dr. Ogoke on October 25, 2001. She complained of left jaw area pain at a 6/10 level, had not had the oral surgery, but had an appointment scheduled with the surgeon. She reported right ankle and knee

pain at a 9/10 level from her twisting injury. Pt. O wanted pain medicine to help with this new pain. She was given a physical examination. She was again found to have atypical facial pain and facial neuritis with neuropathic pain. She was also assessed with an acute ankle sprain and a knee contusion with a need to rule out a meniscal injury. Dr. Ogoke continued Pt. O on her medications for her left jaw area pain of Oxycontin, Neurontin and Effexor XR up to 150 mg.¹⁶⁷ He was aware that she would be having physical therapy for her ankle and knee injuries, and that no MRIs would be done until that process had run its course. He opined that high dose non-steroidal anti-inflammatory medications were useful for those injuries. Pt. O was seen at Dr. Ogoke's office on November 20, 2001. She reported a pain level in her left jaw area of 5/10. She had surgery scheduled in February 2002. Pt. O was seeking a refill of her prescriptions. She was prescribed Oxycontin 20 mg. (16), Neurontin 800¹⁶⁸ mg. (180), and Effexor XR 150 mg. (30). Pt. O reported ankle and knee pain. She was now having physical therapy and care with an orthopedic specialist. According to Pt. O, a recent MRI of her knee showed cartilage damage. She was still wearing an air cast. She was told to continue care with the orthopedist. (Ex. 43; 38-43/4357-4362 & 208/4527.)

12. Pt. O was seen by Dr. Ogoke on December 26, 2001. She reported left area jaw pain at a 7/10 level, and pain so bad that at one point she went to the Mercy Hospital emergency room where she was prescribed Percocet. Dr. Ogoke was concerned that he had not been contacted before she received the Percocet prescription. Pt. O was weaning off narcotics and expressed concerns about withdrawal symptoms although not relating them to her jaw pain. Dr. Ogoke

¹⁶⁷ I could not locate copies of prescriptions written on October 25, 2001 in Pt. O's medical records (Exhibit 43).

¹⁶⁸ The visit report listed Neurontin 80 mg., but based on Pt. O's receipt of this medication, I believe this was a typo and she received a dose of 800 mg. I could not locate copies of the prescriptions written on November 20, 2001 in Pt. O's medical records (Exhibit 43).

provided her with prescription refills for her jaw pain. She was prescribed Oxycontin to reach 30 mg., Neurontin, and Effexor XR.¹⁶⁹ (Ex. 43; 32/4351 & 36-37/4355-4356.)

13. Pt. O was seen at Dr. Ogoke's office on January 23, 2002. She reported left area jaw pain at a level of 9/10 as she awaited jaw surgery likely to occur in early March 2002. She was tearful at the start of her visit while describing her pain, but her mood improved by the close of the visit. She wanted refills of her prescriptions of Effexor, OxyContin, and Neurontin. She reported that she tolerated the medications well. She was given a physical examination. The impressions reached were the ongoing conditions of: atypical facial pain; facial neuritis with neuropathic pain; and facial neuritis, rule out iatrogenic injury. Her current medications were renewed at the same doses despite her request that the Oxycontin dose be increased. She was prescribed Effexor XR 150 mg. (30), Oxycontin 10 mg. (60) and 20 mg. (60) for a total of 30 mg. to take every 12 hours and to be filled January 25, 2002, and Neurontin 800 mg. (42). The decision was made to "defer increasing the Oxycontin dose as requested by the patient due to the chronic nature of her pain and potential improvement with surgical intervention." Pt. O was seen on February 21, 2002 at Dr. Ogoke's office. Two weeks prior, she had been hospitalized for an infection in her left jaw area. Due to this infection, her surgery was postponed. She reported a pain level of 7/10 and was seeking refills of her medications. She had a physical examination. The impressions remained unchanged. She was instructed to follow-up with her oral surgeon. Her medications were renewed. She was prescribed Neurontin 800 mg. (42), Effexor XR 150 mg. (30), and Oxycontin 10 mg. (60) and 20 mg. (60) to be filled on February 24, 2002. She was scheduled to return in a month. (Ex. 43: 29-31/4348-4350; 33-35/4352-4354 & 206-207/4525-4526.)

¹⁶⁹ I could not locate copies of prescriptions written on December 26, 2001 in Pt. O's medical records (Exhibit 43).

14. On March 7, 2002, Dr. Ogoke's office issued an instruction to Pt. O's visiting nurse about the ability to keep the Oxycontin available to Pt. O, independent from only being given her daily dose of it by the visiting nurse. The visiting nurse had asked that this occur. Dr. Ogoke opined that at this point Pt. O was able to be more independent in taking her medications. On March 26, 2002, Pt. O received prescriptions from Dr. Ogoke's office for OxyContin 10 mg. (60) and 20 mg. (60), Effexor XR 150 mg. (30), and Neurontin 800 mg. (84). Dr. Richard Listerud, Pt. O's treating psychiatrist, wrote to Dr. Ogoke on March 26, 2002. Dr. Listerud remarked that he saw Pt. O on March 19, 2002 after not having seen her for four months. He noted his understanding that Pt. O in the interim had been prescribed Paxil 10 mg., which he had previously discontinued in July 2001, Trazadone 100 mg., and Effexor 150 mg., despite her taking 225 mg. in the past. Dr. Listerud noted that he would now be taking over management of these medications. He wanted all questions about her psychiatric medications to be referred to him. He understood that her visiting nurse was ending daily dispensing of Pt. O's medications as of March 22, 2002. Dr. Listerud agreed to this plan. On April 11, 2002, Dr. Listerud spoke to Dr. Ogoke. He discussed a new development. Pt. O had taken too many medications without supervision, was hospitalized over this, and was now back having a visiting nurse dispensing daily all of her medications. Dr. Listerud and Dr. Ogoke agreed to the arrangement of Dr. Listerud prescribing the psychiatric medications and Dr. Ogoke prescribing the pain medication. (Ex. 43; 26-28/ 4345-4347 & 203-205/4522-4524. Testimony of Dr. Ogoke, Vol. VIII, 1590-1593.)

15. Pt. O was seen by Dr. Ogoke on April 23, 2002. She reported left jaw pain at a 9/10 level. Her most recent hospitalization was referred to as a drug overdose incident. She denied having suicide ideation at that time. She explained that she had taken someone else's medication

with alcohol to get pain relief. She presented at this visit with a depressed affect and was tearful discussing her circumstances. She was seeking medication renewals. Dr. Ogoke noted in the report of this visit that Dr. Listerud would be monitoring Pt. O's compliance in taking her psychiatric medications. Dr. Ogoke gave Pt. O a physical examination. His impressions were unchanged: atypical facial pain; facial neuritis with neuropathic pain; and, facial neuritis, rule out iatrogenic injury. Dr. Ogoke prescribed Effexor XR 150 mg. (30), Neurontin 800 mg. (60), Duragesic Patch 50 mcg. (10), and Oxy IR 5 mg. (100) for use until the Duragesic Patch dosage was titrated. She had been taking Oxycontin at the 30 mg. strength. He explained his treatment plan:

[R]enew the patient's medication including Effexor XR, Neurontin at 800 mg. to be taken 3 or 4x daily using 2 tablets at a time, meaning 1600 mg. 3x a day. Duragesic Patch will also be made available ... at 50 mcg. level and titrated as tolerated. Oxy IR 5 mg. will also be made available to the patient for pain control in the interim. Lastly, the patient has been asked to continue care with psychiatrist who will be monitoring her overall compliance with oral medication and situation.

Pt. O was seen by Dr. Ogoke on April 26, 2002. Pt. O complained of a pain level of 8-9/10 with the Duragesic Patch not helping her enough, but that her oral pain medications had helped her to control her pain. Dr. Ogoke decided to increase the dosage of the Duragesic Patch to 100 mcg. and to wean Pt. O off Oxycontin. (Ex. 43: 25/4344; 108-112/4427-4431 & 200-201/4519-4520.)

16. Dr. Satwicz opined that the Duregesic Patch, going from 50 mcg. to 100 mcg. was now at a very high dose of Fentanyl, and the Duregisic Patch still held a risk for abuse of the Fentanyl by Pt. O. Dr. Satwicz opined this was not a sound decision to prescribe for Pt. O who was not opioid naïve and had shown poor self-control in using her prescribed medications having had another hospitalization for a medication overdose since starting care with Dr. Ogoke. (Testimony of Dr. Satwicz, Vol. XII, 2275-2278.)

17. Pt. O was seen by Dr. Ogoke on May 8, 2002. Pt. O reported a pain level of 8/10 with the Duragesic Patch helping her pain control except for her break-through pain. She had changed oral surgeons because of all the delays in getting the surgery done. Pt. O seemed “slightly depressed.” Dr. Ogoke gave her a physical examination. The impressions reached were: atypical facial pain; facial neuritis with neuropathic pain; right knee pain, rule out meniscal tear; and, right ankle sprain acute, resolved. Dr. Ogoke decided to add Methadone at 10 mg. (60) to her medications and discontinue the other medications other than the Duragesic Patch at 100 mcg. Dr. Ogoke’s plan was to monitor Pt. O’s use of this new medication regimen with a follow-up visit in two weeks. He wrote in the report of this visit:

Proper dose adjustments will be made thereafter regarding the actual dose of methadone that she requires for her pain control. It is important to note that the patient does not have a history of intravenous drug use and that methadone is used purely for chronic pain control.

Dr. Ogoke testified that the use of Methadone was a precautionary measure for Pt. O. He opined that the Methadone and the Duragesic Patch would not likely lead Pt. O to overdose on them. Methadone would not provide Pt. O any “high,” but it would address well her nerve pain issues. Methadone “kicks in” slowly and stays in the body longer. Nevertheless, it was not to be used as a scheduled medication, but as a medication for break-through pain. Pt. O was seen on May 22, 2002 by Dr. Ogoke with a pain complaint in the jaw area of 8-9/10 despite what she reported was good pain control using the Duragesic Patch. She was wearing her last Patch at this visit. Dr. Ogoke concluded that Pt. O had made progress with her new pain medication regimen that had her discontinuing Oxy IR due to being on Methadone. Pt. O appeared teary and depressed at this visit. She denied suicidal ideation. She wanted full pain control from her medications. Dr. Ogoke gave a physical examination. He assessed her with: atypical facial pain; facial neuritis with neuropathic pain; right knee pain, rule out meniscal tear; and, right ankle sprain acute,

resolved. Dr. Ogoke prescribed Methadone 10 mg. (45), Effexor XR 150 mg. (30), Duragesic Patch 100 mcg. (10), and Neurontin 800 mg. (120). He wrote in the report of this visit;

Will hold off on tricyclic antidepressant (Doxepin) and continue the patient on Effexor XR, since the patient is also receiving Effexor XR from her psychiatrist at this point for treatment of her ongoing depression.

(Ex. 43: 104-107/4423-4426; 196/4515 & 198-199/4517-4518. Testimony of Dr. Ogoke, Vol. VIII, 1604-1606.)

18. Dr. Trescot opined that under the circumstances, Dr. Ogoke was practicing pain management medicine within the standard of care for treating chronic pain patients like Pt. O by adding for break-through pain the Methadone and discontinuing the Oxy IR. In particular, Dr. Trescot opined that Methadone was a better choice for the nerve/neuropathic pain Pt. O suffered from. She thought that Dr. Ogoke and Dr. Listerud were working together sufficiently on prescribing Pt. O her needed medications. (Testimony of Dr. Trescot, Vol. XV, 2995-2998.)

19. Pt. O was seen by Dr. Ogoke on June 13, 2002. She was given a physical examination. Dr. Ogoke found Pt. O to be "anxious but cooperative." She reported a left jaw pain level of 8-9/10. She had run out of Methadone. Dr. Ogoke put in the report of this visit, his opinion that, because Pt. O could take the Methadone for break-through pain, that she could have been out of the Methadone for a few days by this time if she had been taking the it properly. She received prescription refills of Methadone 10 mg. (60), Neurontin 800 mg. (120), Duragesic Patch 100 mcg. (10), and Effexor XR 150 mg. (30). The Effexor XR, Neurontin, and Duragesic Patch were to be filled on June 19, 2002. Pt. O also complained at this visit of some hip and knee pain. She was being followed for these conditions by another physician. Dr. Ogoke told her to continue care with that physician. She was to be seen in follow-up at Dr. Ogoke's office in about a month to monitor her prescription pattern and to have her pain medications filled on a

month to month basis. Dr. Ogoke remarked in the report of this visit that Pt. O was having good pain control on her medication regimen. Pt. O was seen in follow-up on July 1, 2002 by Dr. Ogoke. He remarked in the report of this visit:

[Pt. O] ... feels that her current medication seems to allow her to function at near normal capacity with improvement of her pain control. She has stopped taking Effexor from me and is getting all her psychothropic medications from her psychiatrist, and I agree with this plan. She is still taking Methadone, Neurontin and Duragesic Patch. Methadone is used for p.r.n. [as needed] pain relief.

At this visit, Dr. Ogoke wrote her prescriptions for Neurontin 800 mg. (120), Duragesic Patch 100 mcg. (10), and Methadone 10 mg. (60). Pt. O was seen on July 23, 2002 by Dr. Ogoke. Pt. O reported pain in her jaw area at a 7-8/10 level. She needed a refill of her Methadone. Dr. Ogoke gave a physical examination and prescribed Methadone 10 mg. (90) to take for her breakthrough pain, Neurontin 800 mg. (120) to take 3 times a day, and Duragesic Patch 100 mcg. (10). All the prescriptions, except the Methadone, were not to be filled until July 30, 2002. (Ex. 43: 98-103/4417-4422; 194-195/ 4513-4514 & 197/4516.)

20. Pt. O was seen by Dr. Ogoke on August 21, 2002 although she was scheduled for the follow-up visit on August 27, 2002. She had run out of Methadone again. Pt. O told Dr. Ogoke that she had a visiting nurse dispensing daily all her medications. She described pain when chewing solid foods. Pt. O reported that she was receiving Effexor XR 75 mg., to take 2 per day, from Dr. Listerud. Dr. Ogoke gave her a physical examination. He prescribed one week's worth of Methadone 10 mg. (21) to take every 8-12 hours, to reach the August 27th follow-up visit. At her August 27, 2002 visit with Dr. Ogoke, Pt. O reported a pain level in her jaw area of 10/10. Dr. Ogoke wrote in the report of this visit that the goal was to have the medications all needing refills in one month's time to coincide with her follow-up visits. Dr. Ogoke gave a physical examination and found her cooperative and not anxious. He prescribed a Duragesic Patch 100

mcg. (10), Neurontin 800 mg. (120) and Methadone 10 mg. (90), her on-going medication regimen. (Ex. 43; 93-97/4412-4416 & 243-244/4562-4563.)

21. Pt. O was seen by Dr. Ogoke on September 27, 2002. She had found that the medication regimen for her left jaw area was good for controlling her pain, but she was experiencing a 10/10 pain level in her right hip and right knee. She was going for x-rays for the hip and knee ordered by her primary care physician (PCP). She informed Dr. Ogoke that she had not suffered any new injury or fall impacting her knee and hip. Dr. Ogoke gave a physical examination and detected "some tenderness" in the knee and hip. He diagnosed: right hip and right knee arthritis; right ankle sprain; atypical facial pain; and, facial neuritis with neuropathic pain. Once the radiographic studies were reviewed, if conservative care was not resolving Pt. O's pain, Dr. Ogoke wrote in his report of this visit that a knee MRI and other treatments could be done such as "intra-articular knee injection using steroids or hyaluronic acid preparation ... Hyalgan." Dr. Ogoke renewed Pt. O's medications. He prescribed Neurontin 800 mg. (120), Duragesic Patch 100 mcg. (10), and Methadone 10 mg. (90), Pt. O's on-going medication regimen. Right hip x-rays done on September 27th were negative. The right knee x-rays showed "slight narrowing of the medial aspect of the femorotibial joint. No other abnormalities noted." Pt. O was seen by Dr. Ogoke on October 28, 2002. She reported jaw pain at a 7/10 level although well controlled on her oral medications. Dr. Ogoke gave her a physical examination. He diagnosed: atypical facial pain; facial neuritis with neuropathic pain; right hip and right knee arthritis; and, right ankle sprain. He renewed her prescriptions for Methadone 10 mg. (90), Neurontin 800 mg. (120) and Duragesic Patch 100 mcg. (10). Dr. Ogoke had not yet received the results from the x-rays done on the right hip and knee. Pt. O was seen by Dr. Ogoke on November 27, 2002. She complained of a pain level in her jaw at a 6-7/10 level, and reported

that the medication prescribed for this pain was good for controlling the pain. She reported a pain level in her right knee of 9/10, the condition that now an orthopedist, Dr. Kane, was addressing for her. She reported having had a recent fall, and Dr. Kane was ordering a bone scan. Dr. Ogoke gave a physical examination, and made no changes in his diagnoses. He renewed her prescriptions for Methadone 10 mg. (90), Neurontin 800 mg. (120), and Duragesic Patch 100 mcg. (10). He did not mention what the right hip and knee x-rays from September 27, 2002 had shown. Pt. O was seen at Dr. Ogoke's office on December 24, 2002. She reported jaw pain at a 7/10 level with the medications helping to control the pain. She was given a physical examination. The assessments listed in the report of this visit were: atypical facial pain; facial neuritis with neuropathic pain; right hip osteoarthritis and right knee arthritis; and, right ankle sprain. Pt. O's medications were renewed. She was prescribed Neurontin 800 mg. (120), Duragesic Patch 100 mcg. (10) and Methadone 10 mg. (90). (Ex. 43: 84-92/4403-4411; 226/4545 & 239-242/4558-4561.)

22. Pt. O was seen at Dr. Ogoke's office on January 23, 2003 complaining of jaw area pain at a 7/10 level, and right knee pain at an 8-9/10 level. She was seeking renewals of her pain medicine. Dr. Kane continued to be treating her knee, and had determined that she might be a candidate for surgery. She was given a physical examination. Tenderness was detected at the left jaw area and at the right knee. Her medications for the jaw pain were renewed of Methadone 10 mg. (90), Neurontin 800 mg. (120), and Duragesic Patch 100 mcg. (10). She was also given a prescription for a knee brace for osteoarthritis. Pt. O was seen at Dr. Ogoke's office on February 19, 2003. She sought refills of pain medication for her jaw pain that was at a 7/10 level. She also complained of a pain level of 8/10 in her right knee. She was scheduled to see Dr. Kane about having knee surgery. She further complained of low back right sciatica pain, something

she had not experienced before. She had not suffered any recent injury or fall. She was given a physical examination. She had tenderness over the left jaw area and the right knee. No sciatica related clinical findings were made from this physical examination. The assessments reached were: atypical facial pain; facial neuritis with neuropathic pain; right hip and right knee osteoarthritis; right ankle sprain; and, possible sciatica. Her pain medications were renewed of Methadone 10 mg. (90), Neurontin 800 mg. (120) and Duragesic Patch 100 mcg. (10). She was also prescribed Celebrex and Zanaflex 4 mg. (90). She was instructed to do follow-up with Dr. Kane. Pt. O was seen by Dr. Ogoke on March 17, 2003. She complained of jaw pain at a 6-7 level that was now on both sides of her face. She reported her current medications were not doing as well as they had been in controlling her pain. She was given a physical examination. Dr. Ogoke found her jaw condition remained unchanged. Straight leg raising was positive to 45 degrees, both sides, in a sitting position. Pt. O's medications were renewed, and she was prescribed Methadone 10 mg. (90), Neurontin 800 mg. (190), Duragesic Patch 100 mcg. (10), and Zanaflex 4 mg. (90). For her persisting knee and sciatica complaints, Dr. Ogoke considered prescribing her a walker to use if the sciatica symptoms continued. (Ex. 43; 77-83/4396-4402 & 235-238/ 4554-4557.)

23. Pt. O was seen by Dr. Ogoke on April 16, 2003 with the same complaints about her jaw pain, and with no new findings on physical examination. She continued to complain of right knee and right sciatica pain at an 8/10 level. Dr. Ogoke wrote in this report:

[Pt. O has] low back area pain ... which has been persistent for some time now. The initial complaint came ... in March. Despite the patient being on narcotics, she still continues to complain of low back area pain. It has gotten progressively worse. She denies any new fall, accidents or injuries ... [T]he patient had lumbar surgery about seven years ago ... Further workup appears to be indicated at this point.

Dr. Ogoke did a review of systems and gave a physical examination. He made the following assessments: new onset of lumbar radiculopathy, rule out herniation versus epidural scarring with post laminectomy syndrome; sacroiliitis; right hip and right knee osteoarthritis; right ankle sprain; atypical facial pain; and, facial neuritis with neuropathic pain. Dr. Ogoke ordered an MRI of the lumbar spine, and scheduled Pt. O for a sacroiliac joint (SI) injection along with consideration of lumbar epidural steroid injections (ESI). He prescribed Ativan 2 mg. (2) for the SI injection, Methadone 10 mg. (90), Neurontin 800 mg. (120), Duragesic Patch 100 mcg. (10), and Zanaflex 4 mg. (90). Pt. O had a lumbar spine MRI on May 12, 2003 that showed no fractures or dislocations. The impression reached was:

New Grade I spondylolisthesis of L3-4 and well established degenerative end-plate, disc and facet joint changes including a moderate-size pseudo-disc bulge. Overall there is mild central spinal canal stenosis as well as inferior neural foraminal narrowing without definite impingement on the neural foramina without definite impingement on the nerve roots within the neural foramina.

Pt. O was seen at Dr. Ogoke's office on May 16, 2003. She continued to complain of jaw area pain at a 7-9/10 level, although she acknowledged that the pain medications helped control the pain, especially the Duragesic Patch. She reported low back pain at a 9/10 level that had worsened and now radiated to the right side and right leg above the knee with no numbness and tingling. She was given a physical examination. Tenderness was detected to palpation in the lumbar spine and along the sacroiliac joints bilaterally. The results of the May 12, 2003 MRI were not known at this time. The impressions reached were: new onset lumbar radiculopathy, rule out herniation versus epidural scarring with post laminectomy syndrome; sacroiliitis; right hip and right knee osteoarthritis; right ankle sprain; atypical facial pain; and, facial pain with neuritis and neuropathic pain. Physical therapy treatments were ordered for the lumbar region. Pt. O's medications were renewed of Methadone 10 mg. (90), Neurontin 800 mg. (120),

Duragesic Patch 100 mcg. (10), and Zanaflex 4 mg. (90). At a May 29, 2003 visit at Dr. Ogoke's office, Pt. O continued to complain of jaw area pain at a level of 7/10, but also of low back and left hip area pain at a level of 9/10. The treatment plan was to have the SI injection and lumbar ESIs. At this visit, she was prescribed a Duragesic Patch 25 mcg. (10) and Percocet 5/325 mg. (90). (Ex. 43: 134-140/4453-4459; 224-225/4543-4544 & 227-234/4546-4553.)

24. Pt. O was seen by Dr. Ogoke's office on June 16, 2003. She reported a 10/10 pain level in the back and hips. She was given a physical examination that detected tenderness in the hips, lumbar spine, and sacroiliac joints. She was assessed with a new condition to add to her existing conditions, trochanteric bursitis on the right more than the left. At this visit, Dr. Ogoke gave Pt. O a lumbar ESI with fluoroscopy at the L4-5 level. The treatment plan was to continue physical therapy and to schedule an SI injection. She was prescribed Duragesic Patch 100 mcg. (10), Methadone 10 mg. (90), Neurontin 800 mg. (120), Zanaflex 4 mg. (90), and Percocet 5/325 mg. (90). On June 24, 2003, Dr. Ogoke's office prescribed Oxcarbazipine 150 mg. (14) and 300 mg. (14). On June 28, 2003, Dr. Ogoke gave Pt. O a bilateral SI injection with fluoroscopy for sacroiliitis. She reported a pain level of 8/10. On July 14, 2003, Pt. O called Dr. Ogoke's office to report her back pain felt worse. Dr. Ogoke's office explained that it would take a few injection treatments to experience significant improvement in pain. Pt. O received a refill prescription for her Percocet.¹⁷⁰ On July 16, 2003, Dr. Ogoke gave Pt. O a lumbar ESI with fluoroscopy at the L5-S1 level. At this visit, she reported that the first lumbar ESI had helped her pain, but reported her current low back pain was at a 9/10 pain level. Dr. Ogoke gave Pt. O a lumbar ESI with fluoroscopy at the L5-S1 level. Pt. O was seen on August 6, 2003 at Dr. Ogoke's office. She reported a pain level of 9/10 in the low back. She received a lumbar

¹⁷⁰ The visit report for July 14, 2003 notes that Pt. O received a refill for Percocet, but I could not locate a copy of a prescription written on July 14, 2003 in Pt. O's medical records (Exhibit 43).

physical therapy order. Pt. O was seen at Dr. Ogoke's office on August 14, 2003. She reported that since her last lumbar ESI, her pain was at an 8/10 level in her low back with pain that radiated into her right leg to her ankle, although the last lumbar ESI had helped with pain relief. She was given a physical examination. The assessments made were: lumbar strain; lumbar radiculopathy; spondylolisthesis at L3-4; lumbar facet arthropathy; disc bulge at L3-4; spinal stenosis; osteoarthritis in the right hip and right knee; a resolved right ankle sprain; and, atypical facial pain and facial neuritis with neuropathic pain. Pt. O received prescriptions at this visit for Oxcarbazepine 300 mg. (60) and Methadone 10 mg. (90). The treatment plan was to schedule Pt. O for a lumbar facet joint injection, continue physical therapy, and consider doing a lysis of adhesion treatment. Pt. O was seen at Dr. Ogoke's office on August 28, 2003. She reported a pain level 9/10 in the right low back with pain radiating into the right leg. Dr. Ogoke gave her a lumbar bilateral facet joint injection with fluoroscopy at levels L2-3, L3-4, L4-5 and L5-S1. (Ex. 43: 24/4343; 114-120/4433-4439; 122-133/4441-4452; 221-223/4540-4542 & 278-288/4597-4607.)

25. Pt. O was seen at Dr. Ogoke's office on September 12, 2003. Although the low back radiating pain symptoms had improved by about 20% since her injection procedure on August 28th, Pt. O complained of a pain level of 8/10. She was given a physical examination, and the assessments made were: trochanteric bursitis right greater than left; lumbar strain; lumbar radiculopathy, lumbar spondylolisthesis; lumbar stenosis at L3-4; lumbar disc bulge at L3-4; lumbar degenerative disc and joint disease; post laminectomy syndrome of the lumbar spine; sacroiliitis; osteoarthritis in the right hip and right knee; a resolved right ankle sprain; and, atypical facial pain and facial neuritis with neuropathic pain, both improved. The treatment plan was to start lumbar spine physical therapy treatments and to do another lumbar facet joint

injection if needed. Pt. O was prescribed Roxicet (Percocet) 5/325 mg. (240), EC Naprosyn 375 mg. (60), Zanaflex 4 mg. (90), Duragesic Patch 25 mcg. (10) and 100 mcg. (10), and Lidoderm Patch 5% (15).¹⁷¹ Pt. O was seen at Dr. Ogoke's office on October 10, 2003. She reported a pain level of 8/10 in her low back that radiated down her right leg. She was given a physical examination, and the same impressions were reached. She was prescribed a Duragesic Patch 100 mcg. (10), Zanaflex 4 mg. (90), Methadone 10 mg. (90), EC Naprosyn 375 mg. (6). (Ex. 43: 20-23/4339-4342 & 267-269/4586-4588.)

26. On October 14, 2003, Pt. O's visiting nurse who was dispensing daily to Pt. O her medications, called Dr. Ogoke's office to learn which of her medications were discontinued. This was because Pt. O seemed to have a lot of narcotics, but had diminishing pain symptoms. The Duragesic Patch 25 mcg. was discontinued as was the Roxicet (Percocet). Pt. O was still taking Methadone for break-through pain. In a note in Pt. O's medical records about this call, Dr. Ogoke's office mentioned that there might be a need to address addiction and dependence issues with Pt. O, and to use interventional treatments instead of narcotics for pain relief. Dr. Ogoke's office provided a revised list of Pt. O's medications to the visiting nurse. On October 20, 2003, Dr. Ogoke gave Pt. O a lumbar epidurogram with fluoroscopy due to her persisting back pain and radiating pain complaints. At this visit, Pt. O was given a referral to Dr. Kishore, an addiction specialist, and provided medical records to Dr. Kishore to assess Pt. O's long-term use of narcotics for pain control and concerns about addiction or dependence. Dr. Ogoke remarked on the treatment plan in the visit report:

The patient will be followed up and reviewed ... and be seen at addiction medicine for her to be considered for detoxification and re-evaluation for possible drug addiction in view of increasing drug seeking behavior.

¹⁷¹ The report of this visit did not provide an explanation within the visit report for why the Lidoderm Patch was prescribed.

Pt. O was seen on October 29, 2003 by Dr. Kishore, the addiction specialist. Dr. Kishore reported back to Dr. Ogoke. Dr. Kishore did not find Pt. O to be at “an exceptional risk for abuse” of her prescribed medications, noting she had a visiting nurse who was dispensing daily to Pt. O all her medications, and also, because Pt. O was seeking further interventional injection treatments because they helped her. Dr. Kishore relied on Pt. O’s statements as being accurate, but checked with her pharmacy to learn the medications she was taking. Pt. O told Dr. Kishore over the prior two weeks, she had not experienced any withdrawal symptoms. Pt. O reported having more right hip and leg break-through pain, “relieved by laying down.” Pt. O reported to Dr. Kishore that she had the visiting nurse dispensing daily to her all her medications, not because she had abused her medications, but because she could not easily leave her home. Pt. O reported that her mother would agree with her account. (Ex. 43: 15-19/4334-4338; 259-260/4578-4579 & 262-266/4581-4585.)

27. Based on a review of Pt. O’s medical records up to this point, Dr. Satwicz opined that Pt. O was at risk for opioid abuse. He explained his concerns about Dr. Kishore’s assessment:

This note baffles me. You have in the consultant’s note ... she has not abused any medications. Well, we have two in Dr. Ogoke’s notes ... two prescription overdoses. And then its underlined, “If she has been honest.” I just don’t know how to interpret that ... [A]nd how [Dr. Kishore concludes], “I don’t believe she is at exceptional risk for abuse.” This is a woman who has demonstrated very poor self-control, hospitalized with two overdoses, yet gets continued on high dose opioid prescriptions. This [assessment] doesn’t make sense to me.

Dr. Satwicz thought it was a lack of adequate monitoring by Dr. Ogoke that Pt. O’s medical records until the end of her care, did not show she was subject to on-going urine drug screen (UDS) tests. (Testimony of Dr. Satwicz, Vol. XII, 2282-2289.)

28. Dr. Ogoke and Dr. Trescot agreed with Dr. Kishore’s opinion that Pt. O was not at an

exceptional risk for addiction because: Dr. Ogoke was monitoring Pt. O's use of her medications; she was having interventional procedures for her pain control; a visiting nurse was coming daily to her home to dispense her medications; and, Pt. O's mother acknowledged Pt. O was following this treatment plan. Dr. Ogoke understood that the hospitalizations for overdoses had not involved his prescriptions, but he wanted a second opinion from Dr. Kishore whether Pt. O was a "full-blown addict or whether ... [she was] just dependent on medication, has taken it for a long time, and the body has adjusted to it." Dr. Trescot did not think Dr. Kishore was shirking from his responsibility as an addiction expert in his assessment. She testified that pain management specialists rely on the honesty of their patients in addressing their pain complaints. She opined that Dr. Ogoke had not violated the standard of care in the practice of pain management medicine by continuing to prescribe the opioid medications he did for Pt. O. He relied, appropriately, on Dr. Kishore's assessment and his own on-going monitoring of Pt. O's use of her prescribed medications. (Testimony of Dr. Ogoke, Vol. VIII, 1602-1612 & Dr. Trescot, Vol. XV, 2998-3002, 3015-3019.)

29. Pt. O was seen at Dr. Ogoke's office on November 14, 2003. She continued to report low back pain at a 9/10 level that radiated down the right leg to the knee. She was seeking medication refills. A physical examination was given. The treatment plan was to discontinue the Duragesic Patch and to schedule a lysis of adhesion procedure. She was prescribed Methadone 10 mg. (84), EC Naprosyn 375 mg. (60), and Zanaflex 4 mg. (90). On December 2, 2003, Dr. Ogoke gave Pt. O a bilateral lumbar facet joint injection with fluoroscopy at levels L3-4, L4-5 and L5-S1. She came to this visit with a 10/10 pain level in her back radiating down her right leg. She was prescribed EC Naprosyn 375 mg. (60), Zanaflex 4 mg. (90), and Methadone 10 mg. (180). (Ex. 43; 11-14/4330-4333 & 253-258/4572-4577.)

30. On December 8, 2003, Pt. O's visiting nurse again contacted Dr. Ogoke's office concerning Pt. O's medications. Her concerns that Pt. O was engaging in drug seeking behaviors was described in Pt. O's medical records. The discussion involved what the nurse referred to as Pt. O engaging in narcotic seeking behavior.¹⁷² On December 18, 2003, Pt. O was seen at Dr. Ogoke's office. She reported low back and right leg pain at a 10/10 level. The treatment plan was to schedule a lysis of adhesion procedure and after that a lumbar transforaminal procedure, increase the dose of the Methadone, and do TPI injections for the bursitis and in the right knee. Pt. O was prescribed Ativan 2 mg. (2) for interventional procedures, Zanaflex 4mg. (90), EC Naprosyn (60), and Methadone 40 mg. (60). There was no discussion within this visit report in reaction to the nurse's concern that Pt. O had shown drug seeking behaviors. (Ex. 43; 10/4329 & 251-252/4570-4571.)

31. On January 9, 2004, Pt. O was seen at Dr. Ogoke's office with a pain level at 10/10 in her lower back and right knee. The lysis of adhesion procedure planned for today had to be rescheduled. Pt. O was given a physical examination. In addition to the lysis of adhesion procedure, Pt. O's treatment plan included consideration of further lumbar injection treatments. She was prescribed EC Naprosyn 500 mg. (60), Zanaflex 4 mg. (90), and Methadone 40 mg. (60) to be filled on January 17, 2004. She was also given an order for physical therapy. On January 15, 2004, Dr. Ogoke gave Pt. O the lysis of adhesion procedure with fluoroscopy. The indications for doing this procedure were; the post-lumbar laminectomy syndrome, lumbar radiculopathy, and epidural fibrosis in the lumbar spine region. She received prescriptions that day for Trileptal (Oxcarbazepine) 300 mg. (60)¹⁷³ and a Lidoderm Patch 5% (30). Pt. O was

¹⁷² The note of the visiting nurse's call was hard to decipher. (Ex. 43, 13/4332.)

¹⁷³ Tripeltol and Oxcarbazepine appear to be the same medication from my google search.

seen at Dr. Ogoke's office on January 27, 2004. She reported better mobility after having the lysis of adhesion procedure, but no lessening of the low back area pain. She reported that the visiting nurse found only one Methadone tablet left. The plan was for scheduling a second lysis of adhesion procedure and to continue physical therapy. At this visit, she was prescribed MSIR 15 mg. (60)¹⁷⁴ and Ativan 2mg. (2) for the procedure. (Ex. 43: 5-8/4324-4327; 166-168/4485-4487; 170-173/4489-4492 & 249-250/4568-4569.)

32. On February 12, 2004, Pt. O was seen at Dr. Ogoke's office complaining of back pain at an 8/10 level. She was prescribed MSIR 15 mg. (60), Ativan 2 mg. (2), Trileptol 300 mg. (60), Zanaflex 4 mg. (90), Methadone 40 mg. (60) to fill February 17, 2004, EC Naprosyn 500 mg. (60), and a Lidoderm Patch 5% (30). On February 19, 2004, Dr. Ogoke gave Pt. O another lysis of adhesion procedure with fluoroscopy. (Ex. 43; 4/4323; 152-154/4471-4473 & 163-165/4482-4484.)

33. On February 20, 2004, Pt. O reported to the local police that her visiting nurse lost her Methadone medication. Pt. O had secured a police report. She came to Dr. Ogoke office with the police report asking for a substitute Methadone prescription. She acknowledged the narcotics agreement would not permit a narcotic prescription to be replaced without a police report. Dr. Ogoke's office wrote Pt. O a prescription for Methadone 40 mg. (20). (Ex. 43, 323-325/4642-4644.)

34. Pt. O was seen by Dr. Ogoke on February 25, 2004. Pt. O reported back pain at a level of 8/10 that radiated down the right leg, and "significant" right knee pain that was recurrent after she stepped into a pothole two years ago. She reported a good result from the recent lysis of adhesion procedure, with an ability to engage in activities she had not been able to do previously, although she still had back pain radiating down her right leg. Dr. Ogoke remarked in

¹⁷⁴ A google search labeled MSIR as a morphine based short-acting opioid medication.

this visit report that Pt. O might benefit from a discogram, something she had not undergone. He opined that it would be a diagnostic procedure “to make a determination as to whether there is a degenerative disc disease or discogenic pain that is contributing to her current pain problems in the low back. The low back pain remains significant.” He opined that the two lysis of adhesion procedures had helped her. Dr. Ogoke gave a physical examination with clinical findings that were close to her baseline. His treatment plan included scheduling a right knee MRI as soon as possible, and consider doing a discogram. She was to do physical therapy and to take her medications as prescribed. Dr. Ogoke noted there was monitoring of Pt. O’s progress in place. She was prescribed medications of a Lidoderm Patch 5% (30) and Oxy IR 15 mg. (60) at this visit. (Ex. 43: 149-151/4468-4470; 318-319/4637-4638 & 321/4640.)

35. On March 1, 2004, Dr. Ogoke gave Pt. O a discogram with fluoroscopy at the L2-3 and L3-4 levels. She had no complications from the procedure. She had no reproduction of pain at these levels. She was given a prescription for Levaquin 500-mg. (3) to use for three days. The discogram was done due to Pt. O being “poorly responsive” to epidural steroid injections, facet joint injections, and SI injections to gain adequate pain control for her low back and right leg pain. (Ex. 43: 146-148/4465-4467; 306/4625 & 313-317/4632-4636.)

36. On March 11, 2004, Pt. O had an MRI of her right knee. No meniscal tear was detected. The MRI showed: “Minimal Grade I degeneration posterior horn medial meniscus, otherwise unremarkable MRI right knee.” (Ex. 43; 303/4622 & 305/4624.)

37. On March 12, 2004, Pt. O was seen at Dr. Ogoke’s office. She reported continuing low back pain at an 8/10 level radiating into the right leg and knee, but at this time, it was the right knee condition that was most significant in terms of pain issues for Pt. O, and “interfering with her quality of life.” A review of systems was done and she received a physical

examination. The assessments added to her on-going list of assessments/diagnoses were Grade I degeneration of the posterior horn of the medial meniscus and negative lumbar discogram at all levels. Pt. O was given a referral to an orthopedic surgeon, Dr. Corsetti, for an evaluation of her right knee. Dr. Ogoke's treatment plan for Pt. O was to have a third lysis of adhesion procedure because the prior two procedures had provided pain relief, and to start physical therapy as soon as possible. Her Methadone dose level was increased. She was prescribed Ativan 2 mg. (2) for the procedure, MSIR 15 mg. (90), Methadone 40 mg. (60) and 10 mg. (60), Lidoderm Patch 5% (90), Trileptol 300 mg. (60), Celebrex 200 mg. (60), and Zanaflex 4 mg. (90). On April 7, 2004, Pt. O was seen at Dr. Ogoke's office reporting a pain level of 9/10 in her back and right leg. She had an appointment with Dr. Corsetti for May 6, 2004. She was given a physical examination. She was prescribed Gabitril 4 mg. (10), MSIR 15 mg. (90), Methadone 40 mg. and 10 mg. (60) to be filled April 11, 2004, Lidoderm Patch 5% (90), Celebrex 200 mg. (60), Zanaflex 4 mg. (90), and Trileptol 300 mg. (60). (Ex. 43: 141-145/ 4460-4464; 293-295/4612-4614; 301-302/ 4620-4621.)

38. On February 9, 2005, Pt. O's visiting nurse contacted Dr. Ogoke's office to get short-term prescriptions for Methadone 40 mg. and 10 mg. as a bridge until Pt. O secured refills of her scheduled medications. A UDS test from an August 17, 2006 specimen was positive for Oxycodone from an Oxycodone screen. (Ex. 43, 289-291/4608-4610.)¹⁷⁵

Conclusion and Recommendation

The Statement of Allegation alleged that Dr. Ogoke practiced pain management medicine in violation of the standard of care by having inappropriately prescribed high doses of opioid medication to Pt. O who had a history of opioid abuse and had shown on-going drug seeking

¹⁷⁵ There is a gap in medical records (Exhibit 43) for Pt. O from the visit on April 7, 2004 to the minimal record from February 9, 2005, and then there is no medical record until the August 17, 2006 UDS result.

behavior. The BORM has not proven its charges.

To determine whether the BORM had proven its charges, I had to uncover the course of care that Pt. O received from Dr. Ogoke. This was often challenging due to a number of copies of medical records that were faint or not copied fully, making some medical records hard to decipher.¹⁷⁶ In addition, not having each patient's medical records in any useful order within Exhibit 43 made the process of determining the course of care very time-consuming. Nevertheless, a course of care was produced and relied upon in reaching my conclusions about Dr. Ogoke's opioid prescribing practices to Pt. O.

Over Dr. Ogoke's course of care of Pt. O, there were three conditions that caused her high pain levels that overlapped in time. She had severe and constant jaw area pain. After that pain was under adequate pain control with a medication regimen, she developed low back pain that radiated into her right leg. Treating the pain from that condition involved diagnostic tests, interventional procedures, and pain medication. The medical records showed this source of pain was relieved by Dr. Ogoke's treatment even if the pain relief was not long-lasting. Pt. O suffered a fall into a pothole that led to knee pain that was also a source of pain. The knee condition was addressed by an orthopedist, although Dr. Ogoke prescribed pain medication for this. Pt. O came to Dr. Ogoke in late 2000 with mental health issues and in the care of a psychiatrist. The BORM did not allege that Dr. Ogoke misdiagnosed Pt. O's underlying conditions, or did interventional procedures improperly. The BORM relied on the opinions of Dr. Satwicz to support its charges.

In terms of the jaw area pain, this was the initial reason that Pt. O sought care with Dr. Ogoke in November 2000. Pt. O had frequent evaluations and was prescribed some opioid and

¹⁷⁶ This was an issue not unique to Pt. O in terms of the quality of the medical records the BORM provided, mostly within the disc, Exhibit 43. It was an issue for all the patients addressed by the Statement of Allegations who had their medical records copied onto the disc and even some medical records copied as paper documents.

non-opioid medications to provide adequate pain relief. Her symptoms were described in the medical records as quite debilitating, including pain with chewing food. She had surgeries prior to treating with Dr. Ogoke, with on-going conditions that involved evaluations by oral surgeon specialists for consideration of with further surgery. By September 2002, Pt. O reported the pain medications were helping to address her jaw area pain, although she continued to be prescribed medication for pain levels that could reach 7/10 at times in her jaw area. Treatment for this condition did not include any interventional procedures.

The right knee condition that was the result of the fall in the pothole, started in October 2001. Pt. O had diagnostic tests to determine what her right knee condition showed, and she was seen by orthopedic physicians. In terms of her low back and right leg pain complaints, those started in January 2003 and continued into April 2004. Dr. Ogoke ordered diagnostic tests to uncover the conditions that were causing Pt. O's high pain levels in her low back that radiated into her right leg. He gave Pt. O interventional procedures to try to target pain medicine to the areas of the lumbar spine generating her pain. He prescribed medications to provide Pt. O with pain relief that the interventional procedures did not sufficiently address. Pt. O's medical records contained no on-going visit reports and prescriptions after April 2004, but the low back radiating pain into the right leg did not resolve by the time the medical records stopped.

The medical records showed that Pt. O came to Dr. Ogoke in the care of a psychiatrist, Dr. Sewell, as early as December 2000. By March 2002, Dr. Ogoke was in contact with Dr. Listerud, a treating psychiatrist. They agreed that Dr. Ogoke would only prescribe medication for Pt. O's pain issues, and Dr. Listerud would prescribe medications for her mental health conditions. During the time Dr. Ogoke treated Pt. O, she was also taking medications prescribed by her treating psychiatrist. During this time, there were red flag situations of concern about

whether Pt. O was being compliant in taking her prescribed medications, and whether Pt. O had been abusing opioids and engaging in drug seeking behaviors. Soon after Pt. O began care with Dr. Ogoke, Pt. O began to have a visiting nurse dispense daily all her medications to her. Both Dr. Ogoke and Dr. Listerud approved of this monitoring. There were various episodes when Pt. O engaged in conduct that lead to hospitalizations for overdoses of medications taken with alcohol, and there were occasions when Pt. O sought substitute opioid prescriptions for lost or mistakenly discarded scripts. The visiting nurse contacted Dr. Ogoke's office at times with concerns about drug seeking behavior. These episodes and her conduct were addressed with Pt. O by Dr. Ogoke.

Soon after Dr. Ogoke began to treat Pt. O, on December 7, 2000, Pt. O reported that her pocketbook had been lost and that she needed a substitute prescription from Dr. Ogoke. She had come to Dr. Ogoke in November 2000 having started Oxycontin at a 20 mg. dose. By this time, Dr. Ogoke had added Percocet 5 mg. (120) for her break-through pain. Dr. Ogoke prescribed Oxycontin 20 mg. (42) to cover this medication until her next scheduled visit with him. Dr. Ogoke later learned that Pt. O had been hospitalized in December 2000 for overdosing on drugs that she claimed she had received from someone, and that she had taken the drugs with alcohol. There was also information that instead, she had overdosed on her anti-depression medication taken with alcohol. This hospitalization resulted by January 2001 with Pt. O was having all her medications dispensed daily by a visiting nurse. In March 2001, the visiting nurse contacted Dr. Ogoke's office and explained that in cleaning out Pt. O's medicine cabinet, she had accidentally thrown out a script for Oxycontin 20 mg. (28) from February 21, 2001. Because by this time, that initial script was too old to fill, a new prescription for Oxycontin was written, at 40 mg. with a discussion with Pt. O to be sure that she would take all her medications properly. By June 1,

2001, the Oxycontin dose was reduced to 20 mg. At a meeting with Dr. Ogoke on this date, he spent fifteen minutes discussing her need to be compliant in taking her medications. On June 18, 2001 after the visiting nurse reported to Dr. Ogoke office that Pt. O had become nauseous with diarrhea, Dr. Ogoke discontinued her prescription for Zonegran as the source of that symptom. He increased her Oxycontin dose level to 40 mg. But, on June 28, 2001, the Oxycontin dose level was decreased to 30 mg. Dr. Ogoke's office kept Pt. O's visiting nurse informed of these changes.

When Pt. O fell in the pothole in October 2001 and experienced right knee pain, she wanted pain medication for this new pain. Pt. O went to an emergency room for pain relief between November 20 and December 26, 2001, and received a prescription for Percocet. Dr. Ogoke had not been informed about this event or that Pt. O had been prescribed Percocet. Pt. O had not informed Dr. Ogoke's office before going to the emergency room. This information was recorded in Pt. O's medical records.

By March 2002, Pt. O's visiting nurse asked Dr. Ogoke if Pt. O could take her Oxycontin independent from the medications the visiting nurse dispensed. Dr. Ogoke and Dr. Listerud agreed Pt. O could do this. But, Dr. Listerud contacted Dr. Ogoke in April 2002 because Pt. O had taken too many medications without supervision and was hospitalized as a result. Dr. Listerud informed Dr. Ogoke that Pt. O was now back to having all her medications dispensed daily by the visiting nurse. When Pt. O was asked about this upon seeing Dr. Ogoke after the hospitalization, she told him that she had taken someone else's medication with alcohol to get pain relief. Dr. Ogoke decided to try to wean Pt. O off Oxycontin and to increase the dose of her Duregesic Patch. On May 8, 2002, Dr. Ogoke prescribed Methadone and discontinued her other pain medications other than the Duregesic Patch. He did this because he believed that she was

not likely to overdose on the Duregesic Patch or on Methadone because both provide pain relief slowly over time. The patch releases the Fentanyl through the skin and the Methadone does not provide a “high” feeling upon its use. In June 2002, Pt. O reported that she had run out of her Methadone. Dr. Ogoke included in the visit report that Pt. O could have run out of the Methadone by the time of this visit because it was prescribed for break-through pain. She received her regular prescription for Methadone 10 mg. (60). In August 2002, Pt. O again reported that she ran out of her Methadone medication. She received another week’s worth of Methadone to reach her next visit.

On October 14, 2003, the visiting nurse contacted Dr. Ogoke’s office to learn which of Pt. O’s medications had been discontinued. The visiting nurse had observed that Pt. O seemed to have diminishing pain symptoms, but had a lot of narcotics. Dr. Ogoke included a note in Pt. O’s medical records that she may have addiction or dependence issues. He wanted to try to use interventional procedures and fewer narcotics for Pt. O’s pain relief treatments. Her Duregesic Patch was discontinued. On October 29, 2003, Pt. O was evaluated by Dr. Kishore, the addiction specialist. Dr. Kishore cleared Pt. O for continued care with her opioid medication. Dr. Kishore was aware that Pt. O had her medications dispensed daily by a visiting nurse. At her November 14, 2003 visit, Pt. O was prescribed the only opioid she was taking by then, Methadone, at her long-time 10 mg. dose level. On December 8, 2003, the visiting nurse contacted Dr. Ogoke’s office concerned that Pt. O had engaged in narcotic seeking behavior. At her visit to Dr. Ogoke’s office on December 18, 2003, Pt. O reported a 10/10 pain level in her back and right leg. Interventional procedures were planned, and Pt. O received prescriptions that included an increase in her Methadone to a 40 mg. dose level. At a January 27, 2004 visit, Pt. O had only one Methadone tablet left. Another lysis of adhesion procedure was planned because the first

one had provided pain relief. At this visit Pt. O was prescribed the short-acting morphine, MSIR 15 mg. (60), and Ativan 2mg. (2) for the procedure. The MSIR continued to be prescribed along with the Methadone prescription.

On February 20, 2004, Pt. O reported to the local police that the visiting nurse who dispensed daily her medications, had lost her Methadone medication. She received a police report that she presented to Dr. Ogoke's office. At a visit with Dr. Ogoke on February 25, 2004, the issue of the lost Methadone prescription was not discussed, but Dr. Ogoke included in the visit report that Pt. O had monitoring of her medication use in place. At this visit, she received a prescription for a Lidoderm Patch and Oxy IR 15 mg. (60). At a March 12, 2004 visit at Dr. Ogoke's office, the treatment plan was for Pt. O to undergo a lysis of adhesion procedure. She reported a pain level of 8/10. She was prescribed Methadone at an increased level of 40 mg. (60) and 10 mg. (60). She was also prescribed MSIR 15 mg. (90). On April 7, 2004, Pt. O's pain level was at 9/10 despite the increase in the amount of Methadone she received.

Dr. Trescot opined that Pt. O's course of care with Dr. Ogoke did not show he had overprescribed opioid medication; that Pt. O had difficulty to treat constant high pain levels from conditions that were capable of causing her such pain to justify such pain medication. Dr. Trescot opined that Dr. Ogoke acted appropriately in treating Pt. O with opioid pain medication to help improve her quality of life that was otherwise quite limited. Dr. Trescot noted that even though Pt. O had shown problematic behaviors that had led to drug overdoses and red flag conduct, those events were identified and addressed with her and with the kind of opioid medication that Dr. Ogoke prescribed. An example was Dr. Ogoke deciding to prescribe the Duregesic Patch and Methadone that were both less likely to be opioids she would abuse, and focusing on providing pain relief through interventional procedures such as the lysis of adhesion

procedures, lumbar ESIs, and SI injections. Dr. Trescot opined that Dr. Ogoke prescribed opioid medications to Pt. O with careful monitoring of her use of her pain medications. Pt. O was under the supervision of a visiting nurse who saw her daily to dispense her medications. She was living at home with her mother who was aware of this monitoring. She was seen frequently at Dr. Ogoke's office when she would receive a physical examination and would be questioned about whether her pain medications and injection treatments were providing pain relief. Dr. Ogoke counseled Pt. O on taking her medications properly and only as prescribed. He had her evaluated by an addictionologist to have a specialist determine if she should continue to receive opioid medication. Dr. Ogoke was in contact with the visiting nurse and with Pt. O's treating psychiatrist. For Dr. Trescot, all this demonstrated that Dr. Ogoke did not violate the standard of care in his treatment of Pt. O.

Dr. Satwicz did not place as much worth on Pt. O having her medication dispensed daily by a visiting nurse, because she was able to be out of control despite this monitoring to end up in hospitalizations for drug overdoses. He disagreed with the evaluation of the addictionologist who in his report never addressed Pt. O's hospitalizations for drug overdoses. He could not comprehend how Pt. O could have been cleared to continue to receive on-going opioid medications given her past history. Dr. Satwicz disputed that the use of a Duregesic Patch to receive the opioid Fentanyl was avoiding a risk of abuse. He opined that such patches can be a source of Fentanyl abuse. He opined that Dr. Ogoke should have been doing regular urine drug screen tests with Pt. O to uncover whether she was misusing her prescribed opioid medications. Dr. Satwicz found the monitoring of Pt. O to have been inadequate given her out of control conduct in taking her opioid medications. For Dr. Satwicz, Pt. O showed time and again, poor self-control and being at too high a risk for abuse given the many high dose opioids she received

over her course of care with Dr. Ogoke. For Dr. Satwicz, Pt. O's red flag situations should have resulted her receiving increased doses of opioids over time. Because Dr. Ogoke engaged in continued prescribing of opioids at increased dose levels over time to an out of control patient who had suffered drug overdoses and who had shown too much drug seeking behavior, he had practiced below the standard of care in pain management medicine.

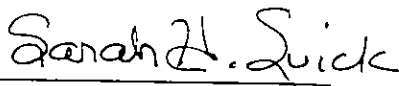
I concluded that Dr. Ogoke did not provide substandard care to Pt. O as charged by the BORM. I concluded that Dr. Trescot's expert opinion that Dr. Ogoke did not engage in a violation of standard of care outweighed Dr. Satwicz's opinion to the contrary. I concluded that Pt. O had constant high levels of pain throughout her course of care with Dr. Ogoke, and that as a result, she had a very limited quality of life. Dr. Ogoke was able to provide her with pain relief for periods of time that improved her quality of life. He was able to do this for her due to his careful prescribing and due to the interventional procedures she received. Supporting my reliance on Dr. Trescot's opinion were the frequent visits Pt. O made to Dr. Ogoke's office when she would receive physical examinations that would be consistent with her pain complaints, and the many diagnostic test results and/or medical history that confirmed Pt. O had conditions capable of causing high pain levels. I relied on Dr. Trescot's opinion that Dr. Ogoke had engaged in adequate monitoring of Pt. O's use of her opioid medications. Dr. Satwicz opined that Dr. Ogoke should have been doing frequent urine drug screens to see if Pt. O was being compliant in taking her opioid medications. In light of all the attention being paid to Pt. O's receipt of her opioid medication, I concluded that this lack of testing was not a necessary tool for Dr. Ogoke to have used to monitor Pt. O's compliance in taking her opioid medication. For instance, each time Pt. O claimed she had run out of Methadone, her visit report would explain why she would be receiving more Methadone, but only enough to reach her next scheduled

office visit. And, despite Dr. Satwicz's general opinion that the Duregesic Patch can be a source for abusing Fentanyl, I found persuasive Dr. Ogoke's reasons for prescribing it to Pt. O as medication less likely to be a drug she would abuse. I also relied on Dr. Trescot's opinion that Dr. Ogoke had acted reasonably in relying on the opinion of Dr. Kishore that Pt. O could continue to receive opioid medication in light of the on-going monitoring of her use of such medications. Dr. Satwicz's opinion to the contrary was not collaborated by testimony from any addictionologist. Dr. Kishore was not called as a witness by the BORM to allow for questioning of his opinion. Dr. Ogoke, Dr. Satwicz, and Dr. Trescot are not addiction treatment specialists. For all these reasons, I concluded that the BORM did not prove that Dr. Ogoke violated the standard of care in his treatment of Pt. O as charged.

Conclusion and Order

Having concluded that Dr. Ogoke violated the standard of care pertinent to his specialty in pain management medicine as to Pts. G, H, J and M, the BORM may discipline Dr. Ogoke as it sees appropriate.

DIVISION OF ADMINISTRATIVE LAW APPEALS



Sarah H. Luick, Esq.
Administrative Magistrate
Dated: February 24, 2017