STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 13-1205PL

JAMES ALEXANDER COCORES, M.D.,

Respondent.
_____/

RECOMMENDED ORDER

This case came before Administrative Law Judge Todd P. Resavage for final hearing by video teleconference on May 6, 2013, at sites in Tallahassee and West Palm Beach, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

Whether, in treating a single patient, who was actually an undercover law enforcement agent, Respondent, a medical doctor, violated sections 458.331(1)(m), (q), and (t), Florida Statutes; if so, whether (and what) disciplinary measures should be taken against Respondent's license to practice medicine.

PRELIMINARY STATEMENT

On March 13, 2013, Petitioner, Department of Health ("the Department"), issued an Administrative Complaint ("Complaint") against Respondent, James Alexander Cocores, M.D. On or about March 26, 2013, Dr. Cocores filed an Election of Rights, disputing the material facts alleged in the Complaint and requesting an administrative hearing. On April 5, 2013, the Department referred the matter to the Division of Administrative Hearings.

Administrative Law Judge John G. Van Laningham was assigned to the matter, and the final hearing was scheduled for May 6, 2013. On May 3, 2013, this case was transferred to the undersigned for all further proceedings.

The parties entered into a Joint Pre-hearing Stipulation and stipulated to certain facts contained in Section E of the Joint Pre-hearing Stipulation. To the extent relevant, those facts have been incorporated in this Recommended Order.

Both parties were represented by counsel at the hearing, which went forward as planned. The Department presented the testimony of Detective Ian Stuffield and Petitioner's Exhibits 1-3, 5, 7-8, 12, and 14 were admitted without objection. Petitioner also offered Exhibits 4 and 13, which were admitted over objection. The Department's exhibits included the deposition transcripts of Edward Dieguez, Jr., M.D., Scott Teitelbaum, M.D., and L.D. Respondent presented the testimony of four witness, E.L.T., E.H.H., Jr., C.D., and M.A.C.

The final hearing Transcript was filed on May 22, 2013. The Department and Dr. Cocores timely filed proposed recommended orders, which were considered in preparing this Recommended Order.

Unless otherwise indicated, all rule and statutory references are to the versions in effect at the time of the alleged violations.

FINDINGS OF FACT

The Parties

1. At all times relevant to this case, James Alexander Cocores, M.D., was licensed to practice medicine in the state of Florida, having been issued license number ME 76635.

2. The Department has regulatory jurisdiction over licensed physicians such as Dr. Cocores. In particular, the Department is authorized to file and prosecute an administrative

complaint against a physician, as it has done in this instance, when a panel of the Board of Medicine has found that probable cause exists to suspect that the physician has committed a disciplinable offense.

3. Here, the Department alleges that Dr. Cocores committed three such offenses. In Count I of the Complaint, the Department charged Dr. Cocores with the offense defined in section 458.331(t), alleging that he committed medical malpractice in the treatment of fictitious patient, L.D. In Count II, Dr. Cocores was charged with prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of his professional practice, an offense under section 458.331(1)(q). In Count III, the Department charged Dr. Cocores with the offense defined in section 458.331(1)(m), alleging that he failed to keep legible medical records that justified L.D.'s course of treatment.

Background and Initial Appointment

4. This matter had its genesis in July 2010, following an anonymous complaint that Dr. Cocores was prescribing Roxicodone (oxycodone hydrochloride), Oxycontin (oxycodone hydrochloride controlled release), and other controlled substances, in exchange for a fee, and without conducting an exam. The complainant further alleged that Dr. Cocores would leave

prescriptions for controlled substances at the reception desk of his office without seeing the patient.

5. Based on these allegations, the Palm Beach County Sheriff's Office initiated a criminal investigation. Initially, an undercover agent attempted to obtain an appointment with Dr. Cocores for pain management; however, he advised that he was not taking on any new patients for pain management. Thereafter, an undercover officer (hereinafter referred to as L.D.) sought to establish herself as a new patient in need of psychiatric treatment. This strategy was successful, and L.D. obtained an appointment with Dr. Cocores for August 10, 2011.

6. Prior to the first session, an Office-Based Opioid Treatment Order (OBOT Order) was obtained that allowed law enforcement to create undercover audio and video recordings of the sessions by and between L.D. and Dr. Cocores.

7. On August 20, 2011, L.D. presented to Dr. Cocores. As is customary, L.D. completed a lengthy medical questionnaire. In response to the "Presenting Problems" section, L.D. noted "not feeling like me anymore." She further noted, inter alia, that she (1) fatigued easily, (2) was easily distracted, (3) had problems focusing or concentrating, (4) had memory difficulties, (5) believed she was depressed, (6) sometimes had disorganized thinking, social isolation, binged or purged food, anxiety/panic attacks, (7) had trouble sleeping and often wakes during the

night, (8) experienced weekly headaches, (9) had mood swings, and (10) was having financial problems.

8. L.D.'s questionnaire further noted that she felt distant from her husband at times and attributed the same to the loss of her brother. Concerning her physical condition, L.D. noted that her last physical exam was approximately two weeks prior and that she had fallen off of a horse in February 2011. Absent from the questionnaire was any indication of pain.

9. L.D. further documented in the questionnaire that she had not had any previous psychiatric or chemical dependence treatment and that there was no family psychiatric history. She also noted daily use of caffeine, alcohol, codeine, pain killers, and sleeping pills (six months prior). L.D. listed Roxicodone, Xanax (alprazolam), and ibuprophen, as her current medications.

10. During the initial consultation, L.D. explained that her issues stemmed from her decision to remove her brother from life support following a motorcycle accident around Christmas of 2010. L.D. advised Dr. Cocores that subsequent to the accident "things just aren't right any more" and that she felt numb and was "just going through the motions."

11. In addition to providing pertinent family history, L.D. discussed her sleeping problems. When Dr. Cocores inquired into the horse accident, L.D. advised she had been under the

care of a chiropractor, as well as a pain management physician who was prescribing her oxycodone, Xanax, and ibuprophen. During this initial session, L.D. did not request any medications and none were suggested or prescribed by Dr. Cocores.

12. The initial session included discussions on nutritional counseling, guidelines for bereavement, techniques for mitigating pain in her back, and talk-therapy. At the conclusion of the first session, L.D. and Dr. Cocores agreed to reduce further sessions from one hour to a half-hour, due to her financial hardship.

13. Dr. Cocores's medical notations for the first session are less than one page and reflect that the next discussion will focus upon the decision to remove her brother from life support.

September 7, 2011 Session

14. On September 7, 2011, L.D. presented to Dr. Cocores for a follow-up visit. L.D. and Dr. Cocores returned to the topic of removing L.D.'s brother from life-support. L.D. advised Dr. Cocores that she had discussed the same with her pastor, and a discussion followed generally concerning guilt and anger.

15. L.D. initiated a conversation concerning her sleep issues. She advised Dr. Cocores that she had been without Xanax for approximately three weeks, and, therefore, she had been

taking her husband's Ambien at night. She explained that her pain management physician had been "shut down by the DEA or something."

16. L.D. advised Dr. Cocores that her pain management physician possessed a former MRI from an automobile injury, as well as X-rays; however, she was not sure she could "get all that." When L.D. inquired as to whether Dr. Cocores could help her, the following dialogue transpired:

> DR. COCORES: Well, Xanax, I can do. And [the pain management physician] wasn't supposed to be writing this—that oxycodone unless he's a psychiatrist.
>
> L.D.: Oh, really?
>
> DR. COCORES: Yeah. And then once—
>
> L.D.: He didn't say that to me. Maybe (Inaudible)
>
> DR. COCORES: (Inaudible.)
>
> L.D.: Well, apparently, they were after him.
>
> DR. COCORES: They came after me, and I had to change my ways. And—but I am the psychiatrist. So they, so far, are not bothering me. So I can –I –so he wasn't a psychiatrist. He – one of the reasons he might have gotten busted is because he was giving out psychiatric meds with pain medication. You aren't supposed to do that unless you are a psychiatrist. And, basically anyone that writes oxycodone is subject to investigation. And so I stopped writing oxycodone since the DEA was last here in February. And so – and they know I'm not taking any new pain people. But

> what I can do is I certainly can write the Xanax, and I can certainly write the Motrin. As far as oxycodone, the only thing I could give you to replace it, is either – I would prefer Vicodin 10-milligrams if you can tolerate it and don't get sick on it. That would be best.
>
> L.D.: Right.
>
> DR. COCORES: I would rather avoid Percocet, which is oxycodone 10.
>
> L.D.: Right.

17. Thereafter, L.D. advised Dr. Cocores that she had previously taken Percocet without issue. L.D. again reiterated that she had fallen from a horse; however, she responded affirmatively to Dr. Cocores's question that she did not have surgery for that event. As a result, Dr. Cocores noted that, "[s]o then you also need to get a copy of an MRI for the next time; although, it's not as crucial with the Vicodin." He also noted that, "[w]hat's good about Vicodin is that you can get refills on it."

18. Respondent prescribed 30 dosage units of Xanax 1 mg and 120 dosage unites of Vicodin[1/] 10/325 mg to L.D. on September 7, 2011. Dr. Cocores noted that, "[w]ell, if you are going to continue with the pastor, you have enough medicines here for three months. And so that will save you some money. And you can continue with him and then if you need some spot checks for therapy, you can come in."

19. The totality of Dr. Cocores' medical notes for the September 7, 2011, session are as follows:

RX Vicodin 10/325 #120
RX Xanax 1mgLS #30

Subsequent Sessions

20. L.D. presented to Dr. Cocores on November 10, 2011, just shy of two months since her last visit. During this "spot check", L.D. and Dr. Cocores very briefly discussed artificial sweeteners and then transitioned to whether the medications were helping L.D. sleep. L.D. advised Dr. Cocores that she had been out of Xanax "for a little bit because I think you – I only got like two months."

21. L.D. advised Dr. Cocores that she didn't like the Vicodin and was hoping to get back on either oxycodone or Percocet.[2/] She informed Dr. Cocores that she didn't know who else to go to. Dr. Cocores instructed L.D. that, "we can't do oxycodone. It's just too expensive and too highly scrutinized and too unavailable." Instead, he notified L.D. that "we could do four Percocet, if you want to."

22. Dr. Cocores informed L.D. that the Xanax could be renewed; however, the Percocet could not. As such, it was agreed that L.D. would make a return appointment in one month. On this date, Dr. Cocores prescribed 30 dosage units of Xanax 1 mg and 120 dosage units of Percocet 10/325 mg to L.D.

Dr. Cocores' medical notations for the November 10, 2011, visit are as follows:

> D/C Vicodin
> Percocet 10/325
> Xanax 1mg LS #30

23. On December 8, 2011, L.D. returned to Dr. Cocores, as scheduled. After discussing various religious traditions, Dr. Cocores segued into whether the medications were working for L.D. She responded affirmatively; however, she noted that she becomes nauseous on occasion. Thereafter, the conversation primarily focused on nutrition. Dr. Cocores also inquired into her pain. L.D. responded by informing Dr. Cocores that her pain was in the thoracic lumbar area and primarily occasioned upon picking up her minor child.

24. Dr. Cocores prescribed 30 dosage units of Xanax 1 mg and 120 dosage units of Percocet 10/325 mg to L.D. Dr. Cocores' medical notes for the December 8, 2011, visit are as follows:

> Percocet 10/325 #120
> Xanax 1mg #30

25. L.D.'s next spot check with Dr. Cocores occurred on January 4, 2012. On this occasion after L.D. wished Dr. Cocores a Happy New Year and apologized for being 15 minutes late, Dr. Cocores immediately stated, "Well, I'll try to get that—what you need; I guess you just need a refill?" L.D. then advised

Dr. Cocores that she was leaving for a ski trip and requested something stronger like "the oxies that I used to take." Dr. Cocores refused this request noting that "they're unobtainable and they're extremely expensive." He further noted that, "there's just too much scrutiny around those medicines."

26. After discussing vacation plans, a follow-up appointment was scheduled. Dr. Cocores again prescribed 30 dosage units of Xanax 1 mg and 120 dosage units of Percocet 10/325 mg to L.D. On this occasion, Dr. Cocores' medical notes simply provide: "Rxs."

27. On February 1, 2012, L.D. returned to Dr. Cocores. Again, Dr. Cocores prescribed 30 dosage units of Xanax 1 mg and 120 dosage units of Percocet 10/325 mg to L.D. Again, his medical notes for this visit provide: "Rxs."

28. L.D. returned to Dr. Cocores on February 29, 2012. After discussing L.D.'s clothing accessories, Dr. Cocores inquired if the two medicines were "working out all right." L.D. responded that things were going really well and she was staying busy with her child. He further asked if she was still attempting to minimize the daily damage to her spine based on correct posture. She noted that she walks big dogs, and picks up her child.

29. Dr. Cocores confirmed that the Percocet and Xanax were not impairing her ability "to drive or be safe." In response,

L.D. noted that she gets a foul stomach every once in awhile. Dr. Cocores opined that he thought it was the Tylenol more than the Percocet. L.D. agreed and explained that was why she would rather just have the oxycodone. Dr. Cocores replied to this request by stating, "Is that what you want to do?"

30. Thereafter, Dr. Cocores prescribed 30 dosage units of Xanax 1 mg and 75 dosage units of oxycodone 15 mg to L.D. on February 29, 2012. His medical records for that occasion simply provide: Δ (change) Perc→Oxy 15 #75.

31. On March 28, 2012, L.D. returned to Dr. Cocores. After initial greetings, Dr. Cocores confirmed that L.D. had switched to oxycodone from Percocet and inquired as to where she obtained the prescription. He then confirmed that L.D. was "trying to minimize the injury that you inflict upon yourself every day with physical exercise." Dr. Cocores then proceeded to request an updated MRI "or else I can't prescribe it anymore because they're getting very strict with that stuff."

32. L.D. also advised that she needed additional Xanax and Dr. Cocores confirmed through L.D. that the Xanax did not interefere with her functionality. He also asked L.D. whether the oxycodone interfered with her ability to drive or her coordination, to which she said it did not.

33. Dr. Cocores prescribed 30 dosage units of Xanax 1 mg and 75 dosage units of oxycodone 15 mg to L.D. on February 29, 2012. His medical records for that occasion simply provide:

> Rx Oxy 15 #75
> Rx Xanax 1mg #30

34. L.D.'s last visit to Dr. Cocores occurred on April 25, 2012. Dr. Cocores asked, "So how is the oxycodone and the Xanax working for you, okay? L.D. replied, "I mean, I – I guess I've been doing pretty good, you know." Again, Dr. Cocores asked her whether it interfered with her coordination or driving. L.D. confirmed that she does "okay." Dr. Cocores also confirmed that L.D. had not reinjured her back. L.D. replied that she had not but still lifts her child and walks big dogs and that she gets by.

35. There is no evidence that L.D. provided an updated MRI at any point during this session. Notwithstanding Dr. Cocores's previous demand of an updated MRI as a condition precedent to further prescriptions for oxycodone, he prescribed 30 dosage units of Xanax 1 mg and 75 dosage units of oxycodone 15 mg to L.D. on April 25, 2012. With the exception of writing the date, Dr. Cocores did not author any medical records or notations for this visit.

Expert Testimony

A. Medical Malpractice and Recordkeeping

36. Petitioner offered the deposition of Dr. Edward Dieguez, Jr., M.D., as an expert in pain management. Dr. Dieguez is a diplomate of the American Academy of Pain Management, an anesthesiologist, and chronic pain management specialist. Dr. Dieguez opined that Dr. Cocores fell below the standard of care for the use of controlled substances for the treatment of L.D.'s pain, as set forth in Florida Administrative Code Rule 64B8-9.013.[3/]

37. Dr. Dieguez opined that Dr. Cocores was deficient in every respect of the rule. Specifically, Dr. Dieguez testified that Dr. Cocores failed to comply with the standard of care in the following respects: 1) failed to perform and document a history and physical examination appropriate for a patient with pain; 2) failed to establish sound clinical grounds to justify the need for the therapy instituted; 3) failed to establish a treatment plan, delineating any objectives that he used to determine treatment success, such as pain relief and improved physical and psychological function; 4) failed to use any other modalities of treatment such as interventional techniques, and failed to request consultations with other specialists such as interventions, orthopaedic surgeons, neurosurgeons, or pain specialists; 5) failed in attempting to prevent drug abuse and

diversion; 6) failed to document evidence to support any diagnostic impression for the therapy instituted and; 7) failed to properly document the medications prescribed including the strength, number, frequency, and date of issuance.

38. Dr. Dieguez also opined that the medical records relating to Dr. Cocores's treatment of L.D. were deficient. Dr. Dieguez succinctly opined that, "there was basically no medical records."

39. The undersigned finds that the testimony of Dr. Dieguez is credible. The undersigned concludes, and Dr. Cocores concedes, that the Department presented sufficient evidence to establish that Dr. Cocores breached the prevailing professional standard of care in prescribing pain medication to L.D., as set forth in rule 64B8-9.013, thus violating section 458.331(1)(t)(1)(Count I), and that Dr. Cocores failed to keep appropriate medical records as required by section 458.331(1)(m)(Count III).

40. The Department also presented the testimony of its second expert witness, Scott Teitelbaum, M.D., by deposition transcript. Dr. Teitelbaum, is certified by the American Board of Pediatrics and the American Board of Addiction Medicine. He is an associate professor at the University of Florida, and is the Vice-Chairman of the Department of Psychiatry. Dr. Teitelbaum practices psychiatry on a daily basis.

41. Dr. Teitelbaum confirmed that rule 64B8-9.013 applies to physicians who practice psychiatry in the state of Florida when those physicians prescribe controlled substances for the treatment of their patients' pain. He further opined that Vicodin, Percocet, and oxycodone are not medications used to treat psychiatric disorders or conditions, and, therefore, Dr. Cocores would have breached the standard of care in prescribing the same in the treatment of any psychiatric condition or mental health disorder.

42. Dr. Teitelbaum testified that Dr. Cocores prescribed Xanax to L.D. for sleep issues. In his opinion, Dr. Cocores breached the standard of care in this regard, because he did not obtain a proper history, which would provide the appropriate rationale for the prescription. Additionally, Dr. Teitelbaum opined that Dr. Cocores breached the standard of care in failing to document and monitor the efficacy of the Xanax prescription.

43. Dr. Teitelbaum also opined that the combination of Xanax (benzodiazepine) with an opioid (such as oxycodone) can create a great risk for adverse medical consequences. He explained that a physician prescribing such a combination must complete a thorough assessment of any substance abuse disorder; conduct drug testing and document the use or non-use of other drugs the patient may be taking; and inquire regarding the patient's alcohol usage.

44. Dr. Teitelbaum opined that Dr. Cocores did not take the above-noted precautionary measures, and, therefore breached the standard of care in prescribing Xanax and oxycodone contemporaneously. The undersigned finds Dr. Teitelbaum's testimony to be credible and that it supports an additional and independent basis for finding that Dr. Cocores violated section 458.331(1)(t)(1)(Count I).

B. Course of Physician's Professional Practice

45. Dr. Dieguez further testified that Dr. Cocores was not practicing medicine during the sessions with L.D. Dr. Deiguez's testimony in this regard is rejected. Dr. Dieguez is not a psychiatrist, has never practiced psychiatry, and conceded that he could not testify regarding whether the interactions by and between Dr. Cocores and L.D. met or breached the standard of care from a psychiatric point-of-view.

46. Although Dr. Teitelbaum testified that he was unclear as to "what was being addressed with respect to the medications that were being prescribed," he did not offer an opinion that Dr. Cocores was not practicing medicine. The undersigned finds, as a matter of ultimate fact, that Dr. Cocores's conduct did not occur outside the practice of medicine, and, therefore, he is not guilty of violating section 458.331(1)(q).

Mitigation

47. Dr. Cocores presented the testimony of four current or former patients to testify on his behalf. All four indicated that Dr. Cocores is a trustworthy and effective physician that they would recommend to other patients.

48. No evidence was presented that Dr. Cocores has been previously disciplined.

CONCLUSIONS OF LAW

49. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this cause, pursuant to section 120.57(1), Florida Statutes.

50. This is a disciplinary proceeding in which the Department seeks to discipline Dr. Cocores's license to practice medicine. Accordingly, the Department must prove the allegations contained in the Administrative Complaint by clear and convincing evidence. Dep't of Banking & Fin., Div. of Secs. & Investor Prot. v. Osborne Sterne, Inc., 670 So. 2d 932, 935 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292, 294 (Fla. 1987).

51. Regarding the standard of proof, in Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983), the Court developed a "workable definition of clear and convincing evidence" and found that of necessity such a definition would

need to contain "both qualitative and quantitative standards." The Court held that:

> [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Id. The Florida Supreme Court later adopted the Slomowitz court's description of clear and convincing evidence. See In re Davey, 645 So. 2d 398, 404 (Fla. 1994). The First District Court of Appeal also has followed the Slomowitz test, adding the interpretive comment that "[a]lthough this standard of proof may be met where the evidence is in conflict . . . it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., Inc., 590 So. 2d 986, 988 (Fla. 1st DCA 1991); rev. denied, 599 So. 2d 1279 (Fla. 1992)(citations omitted).

52. Section 458.331(1), Florida Statutes, authorizes the Board of Medicine to impose penalties ranging from the issuance of a letter of concern to revocation of a physician's license to practice medicine in Florida if a physician commits one or more acts specified therein.

53. In its Complaint, the Department alleges that

Dr. Cocores is guilty of: committing medical malpractice (Count I); prescribing a legend drug other than in the course of his professional practice (Count II); and failing to keep sufficient medical records (Count III).

54. In Count I of the Administrative Complaint, Petitioner contends that Respondent violated section 458.331(1)(t)(1), which provides:

> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (t) Notwithstanding s. 456.072(2) but as specified in s. 456.50(2):
>
> 1. Committing medical malpractice as defined in s. 456.50. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. Medical malpractice shall not be construed to require more than one instance, event, or act.
>
> * * *
>
> Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross medical malpractice," "repeated medical malpractice," or "medical malpractice," or any combination thereof, and any publication by the board must so specify.

55. This is a case of medical malpractice, not gross medical malpractice or repeated medical malpractice. Section 456.50(1)(g) defines "medical malpractice" as:

> [T]he failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. . . .

56. Section 456.50(1)(e) provides: "Level of care, skill, and treatment recognized in general law related to health care licensure" means the standard of care specified in s. 766.102." Section 766.102(1), in turn, provides:

> The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

57. The Department contends the following acts or omissions on behalf of Dr. Cocores constitute failures in the prevailing standard in care: failing to conduct a history and physical examination on L.D. at any time; failing to order appropriate diagnostic or objective tests for L.D.; prescribing controlled substances to L.D. without medical justification; prescribing inappropriate quantites of controlled substances to L.D.; failing to establish a treatment plan for the treatment of L.D.'s pain; failing to employ other modalities for the treatment of L.D.'s pain; failing to request consultations with

other specialists for the treatment of L.D.'s pain; and failing to monitor L.D. for drug abuse and/or diversion of the medications which he prescribed to her.

58. Rule 64B8-9.013(3) defines, to the extent of its reach, the standard of care for a physician's use of controlled substances:

> (3) Standards. The Board has adopted the following standards for the use of controlled substances for pain control:
>
> (a) Evaluation of the Patient. A complete medical history and physical examination must be conducted and documented in the medical record. The medical record shall document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also shall document the presence of one or more recognized medical indications for the use of a controlled substance.
>
> (b) Treatment Plan. The written treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician shall adjust drug therapy, if necessary, to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

(c) Informed Consent and Agreement for Treatment. The physician shall discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is incompetent. The patient shall receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician shall employ the use of a written agreement between physician and patient outlining patient responsibilities, including, but not limited to:

1. Urine/serum medication levels screening when requested;

2. Number and frequency of all prescription refills; and

3. Reasons for which drug therapy may be discontinued (i.e., violation of agreement).

(d) Periodic Review. Based on the individual circumstances of the patient, the physician shall review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy shall depend on the physician's evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the physician shall reevaluate the appropriateness of continued treatment. The physician shall monitor patient compliance in medication usage and related treatment plans.

(e) Consultation. The physician shall be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention must be given to those pain patients who are at risk for misusing

their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation, and may require consultation with or referral to an expert in the management of such patients.

(f) Medical Records. The physician is required to keep accurate and complete records to include, but not be limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence, as appropriate;

2. Diagnostic, therapeutic, and laboratory results;

3. Evaluations and consultations;

4. Treatment objectives;

5. Discussion of risks and benefits;

6. Treatments;

7. Medications (including date, type, dosage, and quantity prescribed);

8. Instructions and agreements;

9. Drug testing results; and

10. Periodic reviews. Records must remain current, maintained in an accessible manner, readily available for review, and must be in full compliance with Rule 64B8-9.003, F.A.C, and Section 458.331(1)(m), F.S. Records must remain current and be maintained in an accessible manner and readily available for review.

(g) Compliance with Controlled Substances Laws and Regulations. To prescribe,

> dispense, or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual: An Informational Outline of the Controlled Substances Act of 1970, published by the U.S. Drug Enforcement Agency, for specific rules governing controlled substances as well as applicable state regulations.

59. As detailed in the findings of fact above, the undersigned concludes, and Dr. Cocores concedes, that the Department has proved standard-of-care violations in prescribing pain medications to fictitious patient, L.D., in violation of section 458.331(1)(t).

60. In Count II of the Administrative Complaint, the Department avers that Dr. Cocores violated section 458.331(1)(q), which provides:

> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (q) Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional

practice, without regard to his or her intent.

61. As concluded in the preceding section of this Recommended Order, Dr. Cocores breached the applicable standard-of-care in prescribing controlled substances to fictitious patient, L.D. The undersigned cannot conclude, however, that his conduct occurred outside the practice of medicine, a required element of a section 458.331(1)(q) violation.

62. As detailed in the findings of fact, the only credible evidence presented on this issue was provided by Dr. Teitelbaum. Although understandably unclear as to "what was being addressed with respect to the medications that were being prescribed," Dr. Teitelbaum did not go so far as to opine that Dr. Cocores was not practicing medicine.

63. The undersigned concludes that a reasonable interpretation or characterization of the first two sessions by and between Dr. Cocores and L.D. would be that of talk-therapy. The balance of the "spot check" sessions, admittedly short in duration, may be properly viewed as potential prescription adjustment sessions. The Department failed to present any evidence that the brief consultations with L.D. were incongruous with the psychiatric profession.

64. Assuming, arguendo, that Dr. Cocores's conduct occurred outside the practice of medicine, he could not be

convicted, in connection with the same underlying behavior, of failing to practice medicine in accordance with the applicable standard of care. See Dep't of Health, Bd. of Chiropractic Med. v. Christensen, M.D., Case No. 11-5163PL, 2012 Fla. Div. Adm. Hear. LEXIS 136 (Fla. DOAH Mar. 16, 2012)(concluding that physician cannot be convicted, in connection with the same underlying behavior, of failing to practice medicine in accordance with the applicable standard of care and simultaneously for conduct occurring outside the practice of medicine).

65. For the reasons expressed above, Dr. Cocores is not guilty of violating section 458.331(1)(q).

66. The Department further contends, in Count III of the Complaint, that Dr. Cocores has violated Section 458.331(1)(m), which provides:

> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (m) Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination

> results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

67. As set forth in the discussion of Count I, rule 64B8-9.013(3)(f) requires that the medical records contain a complete medical history and physical examination, including history of drug abuse or dependence (as appropriate); diagnostic, therapeutic, and laboratory results; evaluations and consultations; treatment objectives; discussion of risks and benefits; and medications (including date, type, dosage, and quantity prescribed), among other things. For the most part, Dr. Cocores's records contained none of these required elements and generally failed to justify the course of treatment.

68. The undersigned concludes, and Dr. Cocores concedes, that the Department has satisfying its burden that Dr. Cocores failed to maintain legible medical records justifying the course of treatment to L.D., in violation of section 458.331(1)(m).

69. The Board of Medicine imposes penalties upon licensees in accordance with the disciplinary guidelines prescribed in Florida Administrative Code Rule 64B8-8.001. As it relates to Dr. Cocores's violation of section 458.331(1)(t), rule 64B8-8.001(2)(t) provides for a penalty range (for a first offense) of one year probation, 50 to 100 hours of community service, to revocation and an administrative fine from $1,000 to $10,000.

With respect to the violation of section 458.331(1)(m), rule 64B8-8.001(2)(m) provides a penalty range (for a first offense) from a reprimand to a two year suspension followed by probation, 50 to 100 hours of community service, and an administrative fine from $1,000 to $10,000.

70. Rule 64B8-8.001(3) provides that, in applying the penalty guidelines, the following aggravating and mitigating circumstances shall be considered:

> (a) Exposure of patient or public to injury or potential injury, physical or otherwise: none, slight, severe, or death;
>
> (b) Legal status at the time of the offense: no restraints, or legal constraints;
>
> (c) The number of counts or separate offenses established;
>
> (d) The number of times the same offense or offenses have previously been committed by the licensee or applicant;
>
> (e) The disciplinary history of the applicant or licensee in any jurisdiction and the length of practice;
>
> (f) Pecuniary benefit or self-gain inuring to the applicant or licensee;
>
> (g) The involvement in any violation of Section 458.331, F.S., of the provision of controlled substances for trade, barter or sale, by a licensee. In such cases, the Board will deviate from the penalties recommended above and impose suspension or revocation of licensure.

(h) Where a licensee has been charged with violating the standard of care pursuant to Section 458.331(1)(t), F.S., but the licensee, who is also the records owner pursuant to Section 456.057(1), F.S., fails to keep and/or produce the medical records.

(i) Any other relevant mitigating factors.

71. Having considered the potential aggravating and mitigating factors, the undersigned does not find compelling reasons to deviate from the guidelines and, therefore, recommends that the Board of Medicine impose a penalty that falls within the recommended range.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Medicine enter a final order:

1. Finding that Dr. Cocores violated sections 458.331(1)(t) and (m), Florida Statutes, as Charged in Counts I and III of the Complaint;

2. Dismissing Count II of the Complaint;

3. Imposing $10,000 in administrative fines, suspending Dr. Cocores from the practice of medicine for two years, requiring 200 hours of community service, five years of probation after completion of the suspension, and such restrictions on his license thereafter as the Board of Medicine deems prudent and for as long as the Board of Medicine deems

prudent, and such educational courses in the prescription of controlled substances, as the Board of Medicine may require.

DONE AND ENTERED this 24th day of June, 2013, in Tallahassee, Leon County, Florida.

TODD P. RESAVAGE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 24th day of June, 2013.

ENDNOTES

[1/] Vicodine contains a combination of acetaminophen and hydrocodone.

[2/] Percocet contains a combination of acetaminophen and oxycodone.

[3/] The text of rule 64B8-9.013 is set forth in full in the Conclusions of Law section of this Recommended Order.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.