www.usitc.gov). The public record for this investigation may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov*.

SUPPLEMENTARY INFORMATION:

Background.—These investigations are being instituted in response to a petition filed on June 5, 2012, by CP Kelco US, Atlanta, GA.

Participation in the investigations and public service list.—Persons (other than petitioners) wishing to participate in the investigations as parties must file an entry of appearance with the Secretary to the Commission, as provided in sections 201.11 and 207.10 of the Commission's rules, not later than seven days after publication of this notice in the **Federal Register**. Industrial users and (if the merchandise under investigation is sold at the retail level) representative consumer organizations have the right to appear as parties in Commission antidumping investigations. The Secretary will prepare a public service list containing the names and addresses of all persons, or their representatives, who are parties to this investigation upon the expiration of the period for filing entries of appearance.

Limited disclosure of business proprietary information (BPI) under an administrative protective order (APO) and BPI service list.—Pursuant to section 207.7(a) of the Commission's rules, the Secretary will make BPI gathered in this investigation available to authorized applicants representing interested parties (as defined in 19 U.S.C. 1677(9)) who are parties to the investigations under the APO issued in the investigation, provided that the application is made not later than seven days after the publication of this notice in the **Federal Register**. A separate service list will be maintained by the Secretary for those parties authorized to receive BPI under the APO.

Conference.—The Commission's Director of Investigations has scheduled a conference in connection with this investigation for 9:30 a.m. on June 26, 2012, at the U.S. International Trade Commission Building, 500 E Street SW., Washington, DC. Requests to appear at the conference should be filed with the Office of the Secretary (*William.bishop@usitc.gov and Sharon.bellamy@usitc.gov*) on or before June 22, 2012. Parties in support of the imposition of antidumping duties in these investigations and parties in opposition to the imposition of such duties will each be collectively allocated one hour within which to make an oral presentation at the conference. A nonparty who has testimony that may aid the Commission's deliberations may request permission to present a short statement at the conference.

Written submissions.—As provided in sections 201.8 and 207.15 of the Commission's rules, any person may submit to the Commission on or before June 29, 2012, a written brief containing information and arguments pertinent to the subject matter of the investigations. Parties may file written testimony in connection with their presentation at the conference no later than three days before the conference. If briefs or written testimony contain BPI, they must conform with the requirements of sections 201.6, 207.3, and 207.7 of the Commission's rules. Please be aware that the Commission's rules with respect to electronic filing have been amended. The amendments took effect on November 7, 2011. See 76 FR 61937 (Oct. 6, 2011) and the newly revised Commission's Handbook on E-Filing, available on the Commission's Web site at *http://edis.usitc.gov.*

In accordance with sections 201.16(c) and 207.3 of the rules, each document filed by a party to the investigation must be served on all other parties to the investigation (as identified by either the public or BPI service list), and a certificate of service must be timely filed. The Secretary will not accept a document for filing without a certificate of service.

Authority: This investigation is being conducted under authority of title VII of the Tariff Act of 1930; this notice is published pursuant to section 207.12 of the Commission's rules.

By order of the Commission.

Issued: June 6, 2012.

Lisa R. Barton,

Acting Secretary to the Commission.

[FR Doc. 2012–14158 Filed 6–11–12; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[Docket No. 10–58]

Darryl J. Mohr, M.D.; Affirmance of Immediate Suspension Order

On January 20, 2011, Administrative Law Judge (ALJ) Timothy D. Wing issued the attached recommended decision (also ALJ). Thereafter, Respondent filed exceptions to the decision.

Having reviewed the entire record including the ALJ's recommended decision[1] and Respondent's exceptions, I have decided to adopt the ALJ's rulings, findings of fact and conclusions of law, except as noted below.[2] However, because Respondent's registration expired shortly after the ALJ issued his decision and Respondent did not file a renewal application, I reject the ALJ's recommendation that I revoke his registration and deny any pending application.[3] While there is neither a registration, nor an application, to act upon, I affirm the immediate suspension order.

In his exceptions, Respondent contends that the ALJ's decision should be rejected because it is based on an unsupported assumption that ''Respondent [can] not be trusted to avoid repeating his mistakes.'' Exc. at 2. Respondent further contends that the State Board has placed him on probation and imposed various conditions, including that within six months of the State Order, he ''attend an

[1] All citations to the ALJ's decision are to the slip opinion as issued on January 20, 2011.

[2] The ALJ found that Respondent materially falsified his January 2008 renewal application by failing to disclose that in 2001, the Arizona Medical Board had placed him on probation based on his having prescribed Viagra to an FDA undercover agent without having conducted a physical examination and determining whether the drug was clinically indicated or contraindicated for the patient. *See* ALJ at 37; *see also* GX 2, at 3–4. The State Board also found that Respondent had been named as a defendant in a lawsuit brought by the Attorney General of Illinois which had alleged that he engaged ''in the use of electronic internet communication for the prescribing and dispensing of prescription medications'' in violation of the Illinois Consumer Fraud and Deceptive Business Practices Act; Pharmacy Practice Act of 1987, and Medical Practice Act of 1987; Respondent accepted a settlement in which he did not admit to any illegality ''but agreed not to engage in the internet prescribing or dispensing of prescription medication in Illinois.'' GX 2, at 3–4. The State did not, however, suspend or revoke his medical license.

Viagra is not, however, a controlled substance and the Government did not offer any evidence that Respondent had engaged in the internet prescribing of controlled substances. Moreover, the Government did not offer any evidence explaining why Respondent's Internet prescribing of Viagra was ''capable of influencing the decision'' of the Agency as to whether to grant his application. *See Scott C. Bickman,* 76 FR 17694, 17701 (2011) (quoting *Kungys* v. *United States,* 485 U.S. 759, 770 (1988) (other citations omitted)). Nor did the Government cite to any decision of this Agency holding that an application for registration may be denied on the ground that the applicant had prescribed a non-controlled substance inappropriately. Accordingly, while Respondent falsified his application, the falsification was not material. I thus do not adopt the ALJ's finding that Respondent materially falsified his renewal application.

[3] Both the Government and Respondent nonetheless maintain that this case is not moot under the collateral consequences doctrine. *See* Gov. Note. Regarding Resp.'s DEA Registration, at 1–2 (citing *William Lockridge,* 71 FR 77,791 (2006)); Resp. Exceptions at 2 n.1. Neither party explains what collateral consequences attach in this case.

intensive education program regarding medical recordkeeping and the prescribing of controlled substances,'' and that upon completion of the program, he submit his charts to a Board-approved contractor who is to review his documentation and prescribing practices. *Id.* at 3.

In Respondent's view, the ALJ's finding that he did not accept responsibility for his misconduct is erroneous because the ALJ placed excessive weight on Respondent's failure to implement the monitoring program required by the Board's Order. *Id.* at 4. According to Respondent, the ALJ erroneously assumed that he was required to have ''the monitoring program * * * up and running as of the time of the hearing'' when the Board's Order does not require ''that the monitoring itself would * * * take place until *after* he had completed the PACE education program.'' *Id.* Respondent further maintains that he cannot be faulted for failing to implement the monitoring program because the ''program was to assess prescribing and documentation in the context of [his] prescribing [of] controlled substances,'' which he is unable to do because his registration was immediately suspended. *Id.*

However, subsequent to the ALJ's issuance of his decision, on February 25, 2011, the Arizona Medical Board issued to Respondent an Interim Order For Practice Restriction And Consent To The Same. I take Official Notice of the Board's Order.[4] Therein, the Board found that Respondent had failed to complete ''either the PACE prescribing course or the Pace medical recordkeeping course.'' Interim Order, at 2. The Board further found ''that a practice restriction is needed in order to protect the public.'' *Id.* The Board therefore placed Respondent ''on a practice restriction that prohibits him from prescribing, administering, or dispensing any Controlled Substances until he applies to the Board and receives permission to do so.'' *Id.* at 3.

Accordingly, Respondent no longer has authority under Arizona law to prescribe controlled substances and is not entitled to be registered under the Controlled Substances Act. *See* 21 U.S.C. 802(21) (''[t]he term 'practitioner' means a physician * * * licensed, registered, or otherwise permitted, by * * * the jurisdiction in which he practices * * * to * * * dispense * * * a controlled substance in the course of professional practice''). *See also id.* § 823(f) (The Attorney General shall register practitioners * * * to dispense * * * controlled substances * * * if the applicant is authorized to dispense * * * controlled substances under the laws of the State in which he practices.''); *id.* § 824(a)(3) (authorizing the revocation of a registration ''upon a finding that the registrant * * * has had his State license or registration suspended [or] revoked * * * and is no longer authorized by State law to engage in the * * * distribution [or] dispensing of controlled substances''). Thus, even if Respondent had filed a renewal application and prevailed in this proceeding, he would not be entitled to be registered. *See, e.g., Jovencio L. Raneses, M.D.,* 75 FR 11563 (2010).

Moreover, even assuming that Respondent intends to remain in professional practice, *cf.* Resp. Exc. n.1., contrary to Respondent's understanding and notwithstanding the collateral consequences doctrine, his challenge to the ALJ's finding that he did not accept responsibility for his misconduct is now moot. As DEA's case law makes clear, the issue of whether a registrant has accepted responsibility for his misconduct and has demonstrated that he will not engage in future misconduct is in play in only two circumstances: (1) In determining whether a registrant's continued registration is consistent with the public interest, *see* 21 U.S.C. 824(a)(4); and (2) in determining whether granting an applicant's application for registration is consistent with the public interest. *Id.* § 823(f). However, where, as here, a registrant allows his registration to expire, and does not file a renewal application, there is neither a registration nor an application to act upon and the issue of whether a registrant's continued registration is consistent with the public interest is off the table. *Ronald J. Reigel,* 63 FR 67132, 67133 (1998). While this Agency has recognized that because an immediate suspension order involves the exercise of summary process, it is reviewable in a proceeding under 21 U.S.C. 824, even where collateral consequences exist, review of the order is limited to challenging its factual and legal basis. Whether a former registrant has accepted responsibility for his misconduct has no bearing on the validity of the suspension order.

As the ALJ found (and as the Government's Expert testified), Respondent prescribed narcotic controlled substances to the two undercover patients even though he did not obtain a patient history or perform a bona fide physical exam during any of the four undercover visits, ALJ at 48, notwithstanding that Arizona law explicitly provides that it is ''[u]nprofessional conduct'' to ''fail[] or refus[e] to maintain adequate records on a patient'' or to ''[p]rescrib[e], dispens[e] or furnish[] a prescription medication * * * to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship.'' *Id.* at 52 (quoting Ariz. Rev. Stat. § 32–1401(27)(e) & (ss)).

As the Government's Expert testified, Respondent's records for the two undercover patients ''showed no substantiation for a diagnosis, a plan, or a treatment with opioid medication.'' *Id.* at 48 (quoting Tr. 416). Indeed, at their initial visits, both undercover patients had indicated on their intake form (''Opioid Flow Sheet) that they had a pain level of ''0'' on a scale of 0 to 10. GX 15, at 2 (K.R. visit of 11/13/09); GX 16, at 2 (B.K. visit of 11/18/09).[5] Respondent did not discuss a treatment plan with either undercover patient.

Moreover, there is ample evidence establishing that Respondent knew that the undercover officers were not legitimate patients but were seeking the controlled substances to abuse them. At her first visit, K.R. told Respondent that she had been using her father's Percocet and did not make any claim of being in pain in her conversation with Respondent. GX 21, at 144. During K.R.'s visit, Respondent told her that ''[t]he only place you can get these medications from is me,'' which K.R. then acknowledged with ''o.k.'' GX 21, at 147. Respondent then stated: ''You

[4] Under the Administrative Procedure Act (APA), an agency ''may take official notice of facts at any stage in a proceeding-even in the final decision.'' U.S. Dept. of Justice, *Attorney General's Manual on the Administrative Procedure Act* 80 (1947) (Wm. W. Gaunt & Sons, Inc., Reprint 1979). In accordance with the APA and DEA's regulations, Respondent is ''entitled on timely request, to an opportunity to show to the contrary.'' 5 U.S.C. 556(e); *see also* 21 CFR 1316.59(e). Respondent can dispute the facts of which I take official notice by filing a properly supported motion for reconsideration within twenty days of service of this Order, which shall begin on the date it is mailed.

[5] With respect to the undercover visitors, Respondent asserted that this did not give reason for concern because ''0'' on the flow sheet indicated that this was their pain score ''with medications.'' Resp. Proposed Findings of Fact and Conclusion of Law, at 7 (¶ 22) & 10 (¶ 34). During K.R.'s visit, Respondent asked her how long it had been since she had taken medication. GX 21, at 144. In response, K.R. stated that she had used her father's Percocet and that it had been several weeks since she had done so. GX 21, at 142–45. K.R. did not represent that she was currently in pain. *See id.*

What is obvious is that no matter what number on the pain scale was circled, this form would always provide justification to prescribe controlled substances. If, as in K.R.'s visit, the patient circled ''0,'' Respondent could claim that this was because of the medications the patient was on. Notably, during the visit, Respondent did not ask K.R. to rate her pain level without medications.

can't, you go, you can't go to me and then another doctor and another doctor cause they you're gonna, it's all computerized, so your gonna get red-flagged and they're gonna call you a drug addict and a doctor shopper and then all of a sudden no pharmacy is gonna give you any medication.'' *Id.* Respondent was also well aware of the ''high street value'' of both Percocet and OxyContin. *Id.* at 147–48.

While Respondent did a superficial examination, noting that ''I'm gonna poke you. I gotta find something out about ya,'' he had already agreed to write a prescription for K.R. *Id.* at 150–51. As this interaction demonstrates, Respondent knew that K.R. was not a legitimate patient but needed to find something to justify the prescription he had already agreed to issue. Moreover, while during the visit, K.R. had stated that she had used Percocet (which contains only 5 mg of oxycodone) or even oxycodone 10 mg, Respondent gave her a prescription for seventy tablets of oxycodone 30 mg. *See* GX 21, at 144; Tr. 207.

As for the first visit of B.K. (the second undercover patient), Respondent, immediately upon introducing himself, stated: ''Obviously you're looking for pain medication. What did you do?'' GX 22, at 159. When Respondent then asked B.K. to state the location of his pain, B.K. stated: ''You name it'' and added that he had ''basically, you know general pain.'' *Id.* at 159–60. When Respondent asked if he had been in an auto accident, B.K. stated that he had been ''[p]robably a couple years'' ago. *Id.*

Respondent then asked B.K. ''what kind of medication are you looking to get?'' *Id.* at 161. B.K. stated ''well Oxy. Probably thirties'' and added that he got them ''wherever I can.'' *Id.* When Respondent asked how B.K. got ''started on oxycodones,'' B.K. answered ''[o]h just general pain'' and ''achiness.'' *Id.* Respondent then suggested that there were ''other medications to take except a schedule II narcotic''; B.K. answered: ''[w]ell that was available to me.'' *Id.* Manifesting his recognition that B.K. was not a legitimate patient, Respondent then stated that ''the issue is * * * that I can't write for pain medication unless I have proof of injury. * * * You're not giving me proof of injury, you're just telling me you, you ache all over.'' *Id.* To this B.K. replied: ''Right.'' *Id.*

Respondent then stated:

> I mean there's other medications that you can take. Uh, you've never even been on, or whatever you're doing if you're buying this off the street, and I don't care whether you are or not, I have patients that do that. Uh, but basically that's why they're coming because they're very expensive on the street, plus they need to be evaluated and find out what their problem is. Uh, but for me just to write a script * * * for a patient that walks in the door and says, ''I'm just having general pain'' that doesn't work. I mean there's no way I'm going to lose my license.

Id. at 162.

While Respondent told B.K. that he was going to have to find another doctor, he then explained that:

> the point is, I can't write you a prescription for medication at this level without any proof of injury. So, if you're having pain, you know I can certainly give you something less than the Percocet. I can give you some Vicodin, I can give you some Darvocet, I can give you some Tyonol[sic] three's, but to give you this level * * * drug is, no, that's out.

Id.

After B.K. stated ''ok,'' Respondent added that ''[i]f you want a lesser drug I'd be more than happy to write it for you. * * * But that's up to you.'' *Id.* B.K. stated ''[t]hat'd be great'' and Respondent asked him if he had ever been on Vicodin, Darvocet or Tylenol Three. *Id.* When B.K. told Respondent that he had previously ''been on the strongest Vicodin * * * the 10–325,'' Respondent offered to write the prescription and give B.K. a thirty-day supply (120 tablets), even though he acknowledged that B.K. ''got no * * * chronic pain syndrome'' and ''no etiology.'' *Id.* at 162–63.

When B.K. then asked Respondent whether he could get another appointment, Respondent agreed that B.K. could ''come back'' on December 23rd even though he had no ''proof of injury.'' *Id.* at 165. Respondent then told B.K. that he was giving him the medication ''because you're telling me you're having pain'' (even though B.K. never identified any specific area of pain) and told him that he would have to find himself ''a primary care physician.' '' *Id.* at 166. Respondent gave B.K. a prescription for 120 Vicodin 10/325, a highly abused schedule III narcotic. Tr. 255; *see also* 21 CFR 1308.13(e)(1).

On December 23rd, B.K. returned to Respondent. Shortly after the visit commenced, B.K. stated that he was ''not better'' and Respondent stated that he was going to give him the medication, but that he did not think that B.K. would ''find anybody that's really gonna give you these narcotic medications just because you're stating that you're not better.'' GX 23, at 171. While Respondent recommended that B.K. get insurance and see a rheumatologist and stated that he would give B.K. another prescription for 120 Vicodin 10/325 but was discharging him, B.K. asked Respondent if he could come back if he was able to get ''[p]roof of an injury.'' *Id.* at 172. Respondent then stated that because B.K. did not ''have proof of injury * * * at this point you couldn't come back to me and say well all of a sudden I've got an injury I forgot about'' because ''that tells me you're lying to me.'' *Id.* at 172–73. Respondent then stated that ''I'm not gonna write you narcotics knowing that you've already told me that there's nothing wrong with you.'' *Id.* at 173. Respondent then told B.K. that he would have to go see a rheumatologist and get checked out. *Id.* Notwithstanding his acknowledgment that there was nothing wrong with B.K., Respondent then wrote B.K. another prescription for 120 Vicodin 10/325 before discharging him.

The Government's Expert reviewed Respondent's medical records for K.R. and B.K., the audiotapes of their initial visits, the video tape of B.K.'s second visit, and the available transcripts.[6] GX 18, at 1. The Government's Expert concluded that both K.R. and B.K. ''portrayed drug seeking individuals, with 0/10 pain, [and] with no documentation through past records, present records, radiologic studies, or physical examination of any condition warranting treatment with opioid medication.'' *Id.* at 3. Continuing, the Expert found that ''[t]he Medical Records are inadequate, inaccurate, representing falsifications and omissions, with no proper history and physical, no documentation of pathology that would warrant treatment with opioids, with fabricated details in an attempt to substantiate opioid prescriptions.'' *Id.* at 4. The Expert also explained that ''[t]here is no 120 day window, as mentioned by [Respondent], that allows opioid prescribing without past records and documentation.'' *Id.; see also* Tr. 431. The Expert further opined that Respondent's prescribing of controlled substances to both undercover patients lacked a ''legitimate medical purpose.'' Tr. 431.

I agree. Based on the record, I conclude that Respondent's prescribing of controlled substances to the undercover patients went ''beyond the bounds of any legitimate medical practice,'' *United States* v. *McIver,* 470 F.3d 550, 559 (4th Cir. 2006), and ''completely betrayed any semblance of legitimate medical treatment.'' *United States* v. *Feingold,* 454 F.3d 1001, 1010 (9th Cir. 2006).

At the hearing, Respondent offered testimony only in regards to his prescribing to K.R. Tr. 761. Respondent

[6] Due to an equipment malfunction, there was no recording of K.R.'s second visit.

asserted that he had examined K.R. and she had told him that she had pain in her back. *Id.* However, as the ALJ found, Respondent had already agreed to write a prescription (which he did for 70 tablets of oxycodone 30 mg, a schedule II controlled substance) before he did his ''exam.'' ALJ at 49. Moreover, K.R. had told him she was getting Percocet from her father (and not from a physician) and never stated that she had pain (other than after he poked her), let alone pain that would support prescribing a schedule II narcotic. Tr. 406. (testimony of Government's Expert discussing titration and adjustment of dosage).

K.R. made a second visit to Respondent at which she again obtained a prescription for 70 tablets of oxycodone 30 mg, even though she again made no representation that she had pain and Respondent did not perform a physical exam or take a history. Tr. 218–20. However, Respondent offered no testimony as to why he prescribed to her at this visit. Moreover, Respondent offered no testimony addressing his medical justification for prescribing Vicodin 10/325[7] to B.K. at either visit.

It is well settled that the Agency can draw an adverse inference from a respondent's failure ''to testify in response to probative evidence offered against'' him. *See Baxter* v. *Palmigiano,* 425 U.S. 308, 316 (1976); *see also United States* v. *Solano-Godines,* 120 F.3d 957, 962 (9th Cir. 1997) (''In civil proceedings * * * the Fifth Amendment does not forbid fact finders from drawing adverse inferences against a party who refuses to testify.''). Based on Respondent's failure to address why he prescribed to K.R. at her second visit, and B.K. at both of his visits, it is appropriate to draw the adverse inference that Respondent knowingly prescribed controlled substances to both B.K. and K.R. without a legitimate medical purpose.

While in his testimony Respondent asserted that when he opened his pain practice, he did not ''comprehend the deceit of many of my patients to get narcotics,'' and that ''[a]s time progressed, I learned more about pain management,'' and started ''doing better documentation, drug screening, * * * appropriate physical testing, better validation and proof of injury,'' Tr. at 756–57, the undercover visits make clear that Respondent knowingly diverted controlled substances. Notably, when the State sanctioned Respondent based on his prescribing of Viagra, the State found that his doing so ''without first conducting a physical examination'' constituted ''unprofessional conduct'' under Arizona law. GX 2, at 3–4. Yet Respondent prescribed to both undercover officers without performing a physical examination (other than to perform a cursory physical examination on K.R. to, in his words, ''find something out about ya,'' after he had already agreed to write the prescription). Accordingly, this is not a case of a ''naive or gullible'' practitioner who did not intentionally prescribe to drug abusers and who has since learned from his mistakes and reformed his practices.[8] *See Paul J. Caragine, Jr.,* 63 FR 51592, 51601 (1998).

Based on the above, I find that Respondent knowingly diverted controlled substances by issuing prescriptions outside of the usual course of profession practice and which lacked a legitimate medical purpose to the two undercover officers. 21 CFR 1306.04(a). This finding is sufficient to support the conclusion that Respondent committed acts which rendered the continuance of his then-existing registration ''inconsistent with the public interest'' and ''an imminent danger to public health and safety,'' and thus supported the suspension of his registration pursuant to 21 U.S.C. 824(d).[9] I therefore affirm the Order of Immediate Suspension.

Order

Pursuant to the authority vested in me by 21 U.S.C. 824, as well as 28 CFR 0.100(b), I order that the Order of Immediate Suspension issued to Darryl J. Mohr, M.D., be, and it hereby is, affirmed. This Order is effective immediately.

Dated: June 2, 2012.

Michele M. Leonhart,

Administrator.

Dedra S. Curteman, Esq., *for the Government*

Mary Baluss, Esq., *for the Respondent*

Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of the Administrative Law Judge

Introduction

Timothy D. Wing, Administrative Law Judge. This proceeding is an adjudication pursuant to the Administrative Procedure Act, 5 U.S.C. § 551 et seq., to determine whether the Drug Enforcement Administration (DEA) should revoke a physician's Certificate of Registration (COR) as a practitioner. Without this registration the practitioner, Respondent Darryl J. Mohr, M.D. (Respondent), of Phoenix, Arizona, will be unable to lawfully possess, prescribe, dispense or otherwise handle controlled substances in the course of his practice.

On May 25, 2010, the Deputy Administrator, DEA, issued an Order to Show Cause and Immediate Suspension of Registration (OSC/IS), immediately suspending Respondent's DEA COR and giving Respondent notice to show cause why the DEA should not revoke his COR pursuant to 21 U.S.C. § 824(a)(1), on grounds that his continued registration would be inconsistent with the public interest as that term is used in 21 U.S.C. §§ 824(a)(4), 823(f) and 823(g)(2)(E)(i).

In substance, the OSC/IS alleges that: Respondent is registered with DEA as a practitioner in Schedules II–V under DEA COR BM2040498 at Access 2 Care Family Medical Center, 4607 North 12th Street, Phoenix, Arizona 85014; that COR BM2040498 expires by its terms on January 31, 2011; that pursuant to the Drug Addiction Treatment Act (DATA), Respondent is authorized to treat no more than thirty narcotic dependent patients at any one time with Schedule III–V narcotic controlled substances; that Respondent materially falsified his applications for renewal of his DEA COR on January 26, 2005, and January 29, 2008, by answering ''no'' to the liability questions despite the fact that his state medical license was suspended on November 27, 2001, in violation of 21 U.S.C. § 843(a)(4); and that Respondent prescribes and dispenses inordinate amounts of controlled substances, primarily hydrocodone compounds, Schedule III controlled substances, among others, under circumstances where Respondent knows or should know the prescriptions are not for legitimate medical purposes or are issued outside the course of usual professional practice. (ALJ Ex. 1.)

The OSC/IS includes the following specific allegations: Family Practice and Pain Management recommends that patients fill their prescriptions at one pharmacy, Community Pharmacy (in various locations) and often provides a coupon for patients' use. On November 27, 2009, Respondent's patient,

[7] Vicodin is a schedule III narcotic, which contains hydrocodone.

[8] Respondent also takes exception to the weight which the ALJ gave to the hearsay statements made by two of his patients (J.G. and L.W.) to the Task Force Officers. However, the statements have no bearing on the issue of whether Respondent's prescriptions to the undercover officers complied with Federal law. I therefore do not consider the exception.

[9] Respondent did not challenge the imminent danger finding at any point in this proceeding.

''[MC],'' [1] died at [MC]'s home from ''Combined Drug Toxicity.'' Three days before [MC]'s death, on November 24, 2009, Respondent prescribed [MC] 150 oxycodone 30 mg tablets, 70 alprazolam 2 mg tablets and 35 amphetamine salts 30 mg tablets. [MC] filled the prescription on the same day at the Community Pharmacy located at 17233 N. Holmes Blvd., Suite 1615, Phoenix, Arizona 85053. Respondent also prescribed controlled substances in various amounts on October 20, 2009, September 16, 2009, August 17, 2009, July 22, 2009, June 25, 2009, and May 27, 2009. The drugs found near [MC]'s body and in [MC]'s system at the time of death were consistent with the controlled substances Respondent prescribed for [MC]. (ALJ Ex. 1.)

The OSC/IS further alleges that on January 6, 2010, Respondent's patient, ''[CS],'' died at [CS]'s home; that [CS] received prescriptions from Respondent as recently as December 31, 2009, when Respondent prescribed 90 oxycodone 15 mg tablets and 60 alprazolam 2 mg tablets; and that [CS] obtained prescriptions for controlled substances from Respondent on a monthly basis since December 2008. (ALJ Ex. 1.)

In addition, the OSC/IS alleges that on February 10, 2010, B.R., a twenty-four-year-old male, died of a possible overdose at his home; that at the time of Mr. B.R.'s death, the Phoenix Police Department found a blue medical bottle prescribed by Respondent to ''[TR]'' with a date of December 16, 2009, for alprazolam 2 mg; that law enforcement personnel conducted four undercover visits to Respondent's office in November and December 2009; and that on these occasions Respondent prescribed controlled substances including Schedule II and III controlled substances to undercover law enforcement personnel with cursory or no medical examinations, without medical records and without a legitimate medical purpose in violation of 21 C.F.R. § 1306.04 and Ariz. Rev. Stat. §§ 32–1401(27)(a), (q) & (ss) (2010). (ALJ Ex. 1.)

On June 23, 2010, in a letter dated June 21, 2010, Respondent, through counsel, timely filed a request for hearing on the allegations in the OSC/IS. Following prehearing procedures, a hearing was held in Phoenix, Arizona, between September 21–23, 2010, and in Arlington, Virginia, on October 19, 2010, with the Government and Respondent both represented by counsel. Both parties called witnesses to testify and introduced documentary evidence. After the hearing, both parties filed proposed findings of fact, conclusions of law, and argument. All of the evidence and post-hearing submissions have been considered, and to the extent the parties' proposed findings of fact have been adopted, they are substantively incorporated into those set forth below.

I. Issue

Whether the record evidence establishes by substantial evidence that Respondent's DEA COR should be revoked as inconsistent with the public interest as that term is used in 21 U.S.C. §§ 824(a)(4), 823(f) and 823(g)(2)(E)(i); and because Respondent materially falsified an application for DEA registration or renewal pursuant to 21 U.S.C. § 824(a)(1).

II. Evidence and Incorporated Findings of Fact

I find, by a preponderance of the evidence, the following facts:

A. Background

(a) Darryl J. Mohr, M.D. (Respondent)

Respondent received his medical degree in 1970. (Transcript (Tr.) at 34.) After thirty years of working in other practitioners' practices, Respondent opened his own practice on August 3, 2009. (Tr. 34–35, 39–40.) He has no certifications or training in pain management. (Tr. 36.)

Respondent's most recent previous practice was a family practice. (Tr. 35.) Respondent's current practice entails approximately eighty percent pain management and twenty percent family care. (Tr. 35–36, 39.)

Respondent is the only physician at his practice. (Tr. 40.) Each month he sees between 225 and 300 patients, or approximately three to four patients per hour, devoting fifteen minutes to each patient. (Tr. 36, 37.) Approximately eighty percent of Respondent's patients are cash-only. (Tr. 38.) The average age range of his patients is twenty-seven to thirty-three. (Tr. 61.)

(b) Respondent's Employees

Respondent began his new practice with ''[CP],'' [2] his sole employee at that time. (Tr. 38–39.) In November 2009 he began to train a receptionist named Ana. (Tr. 38.) Ana could not handle the patient load, and left after about two months. (Tr. 38, 39.) Respondent next hired Erin Kelly, who also left after about two months. (Tr. 39.)

In January 2010, Respondent hired ''[SO]'' to be his medical assistant. (Tr. 39.) [SO] is also a patient of Respondent. (Tr. 41.) Respondent pays a salary for [SO]'s work; he also prescribes [SO] controlled substances as a patient. (Tr. 41.)

(c) Respondent's Arizona State Medical License

Respondent possesses a state medical license, but that license has been suspended in the past. (Tr. 85–86; *see* Gov't Exs. 2 & 3.)

(d) The Arizona Controlled Substances Prescription Monitoring Program (PMP)

The Arizona PMP is a database maintained by the Arizona State Board of Pharmacy (Board of Pharmacy) since approximately April 2008. (Tr. 96–97, 124, 318.) Every pharmacy provides records of filled prescriptions for controlled substances, as well as information such as the prescribing doctor and DEA registration number. (Tr. 97.) The Board of Pharmacy collects data from pharmacies on a weekly basis, and there can be a lag of up to two weeks before data appears on a PMP report. (Tr. 153.) Checking the PMP allows a doctor to determine whether a patient is receiving prescriptions from multiple doctors. (Tr. 171.) The normal way to access the PMP is via the Internet. (Tr. 97.) Doctors simply provide their credentials and receive Internet and phone access. (Tr. 386.)

B. The Evidence

(a) The Government's Witnesses

Task Force Officer Jeremy Dean (TFO Dean) is a member of the Apache Junction Police Department and is currently assigned to the Phoenix field division of the DEA. He was the lead investigator on Respondent's case. (Tr. 70–72.) He began as a task force officer in March 2009. (Tr. 120.) Before joining the DEA Task Force, which is responsible for investigating the diversion of legitimate pharmaceuticals to the illegitimate market, TFO Dean served for three years as a patrol officer at the Apache Junction Police Department and a large telecommunications company. (Tr. 71–72.)

Diversion Investigator Gary Linder (DI Linder) has worked as a DEA Diversion Investigator for approximately five years. (Tr. 176.) He previously served as a police officer for six years and received a bachelor's degree in criminal justice. (Tr. 176.)

Task Force Officer Mike Baldwin (TFO Baldwin) is a DEA Task Force

[1] To protect patient privacy, initials are used in this Recommended Decision when referring to Respondent's current and former patients.

[2] As noted below, [CP] is also a patient of Respondent (Tr. 693), and her name is therefore redacted.

Officer and a detective with the city of Surprise. (Tr. 181–82.) He has been a Task Force Officer with the DEA for approximately one and one half years. (Tr. 182.) TFO Baldwin has worked for the Surprise Police Department for approximately nine years, investigating illicit drug use in many cases. (Tr. 184.) He received a bachelor's degree in secondary education. (Tr. 184.)

Task Force Officer ''[JB]'' [3] (TFO [JB]) is a Task Force Officer with DEA's Tactical Diversion Squad in Phoenix. (Tr. 204.) She is employed by the City of Phoenix Police Department and has been a Task Force Officer since March 2009. (Tr. 204.) Before joining the Tactical Diversion Squad, TFO [JB] was a narcotics detective for the City of Phoenix Police Department for over twelve years, serving as a patrol officer and a field training officer. (Tr. 204.)

Task Force Officer ''[BK]'' [4] (TFO [BK]) is a detective with the City of Peoria Police Department and a task force officer with the Phoenix field division of the DEA in the diversion area task force. (Tr. 252–53.) TFO [BK] has been a Task Force Officer since June 2009. He previously worked as a narcotics detective with the City of Peoria Police Department for four years. (Tr. 253.) He also worked for six years as a patrol officer. (Tr. 253–54.) TFO [BK] received a bachelor's degree in psychology. (Tr. 254.)

Intelligence Research Specialist Stone (IRS Stone) is a DEA Intelligence Research Specialist. (Tr. 302.) He is a pattern analyst, looking at data to discern trends. (Tr. 303.) IRS Stone has worked at DEA for nineteen years, following a career as an intelligence officer with the U.S. Army. (Tr. 302–03.) He received a bachelor's degree in accounting. (Tr. 303.)

The Government's expert witness, Stephen Borowsky, M.D. (Dr. Borowsky), is a board-certified anesthesiologist,[5] board-certified and re-certified in pain medicine. (Tr. 378, 384.) His specialty is pain medicine and he is the founding president of the Arizona Pain Society. He belongs to regional, national and international societies for pain management. (Tr. 384–85.)

In addition to working at John C. Lincoln North Mountain Hospital and Phoenix Surgicenter, Dr. Borowsky also works at the U.S. Department of Veterans Affairs Hospital (VA) one day a week and teaches at the University of Arizona Medical School. He is a member of a group of physicians that conducts independent medical examinations. (Tr. 378.) He has worked in his specialty for thirty years. (Tr. 379.)

Dr. Borowsky holds a degree in mechanical engineering from Drexel University and a medical degree from Temple University. He interned at Baystate Medical Center in Massachusetts, and served two years in the U.S. Public Health Service in the Indian Health Service in a remote reservation in South Dakota. (Tr. 379.) He completed his anesthesia residency at Beth Israel Hospital in Boston, and was simultaneously considered a Fellow at Harvard Medical School. He then served as a staff physician at Beth Israel and as an instructor at Harvard. (Tr. 379.) He began practicing pain medicine when he was appointed Assistant Clinical Professor of Anesthesia at Boston University. (Tr. 379.)

Dr. Borowsky came to Phoenix in 1980, where he practiced anesthesia and was recruited to work at a pain program. (Tr. 380.) He has served on the staff of eleven area hospitals. (Tr. 380.) He is a Clinical Professor of Anesthesia at the University of Arizona College of Medicine, and served on several task forces for the Arizona Legislature on chronic pain. He also served on the task force from the Board of Pharmacy for establishing the PMP. (Tr. 381, 385–86.) He participated in the development of the PMP. (Tr. 386.)

Dr. Borowsky currently cares for eighty to ninety patients and performs procedures at the VA and other locations. (Tr. 381.) He is co-chairman of the VA hospital's Multidisciplinary Pain Committee. (Tr. 382.) He sees between ten and twenty patients, all of which are pain patients, on the one day per week he works at the VA hospital. (Tr. 382–83.)

Dr. Borowsky is a lecturer in the area of pain management. He stays apprised of recent developments in the field by reading journals and Internet web sites, attending or holding conferences and communicating with other practitioners. (Tr. 387–88; *see generally* Gov't Ex. 17.)

(b) Respondent's Witnesses

In addition to his own testimony, Respondent presented testimony by his patient ''[CM].'' Respondent also presented testimony by his employees ''[SO]'' and [CP], who are current or former patients. Finally, Respondent presented testimony of ''[RF],'' the fiancé of Respondent's late patient ''[CS].''

(c) About the DEA Investigation of Respondent, Generally

The DEA's investigation of Respondent, which began in August of 2009, centered around: (1) Allegations that Respondent falsified his application for a DEA registration; (2) allegations that Respondent was practicing at an unregistered location; (3) allegations that Respondent was prescribing controlled substances outside of a normal, professional practice; and (4) a number of fatalities allegedly connected with Respondent's prescribing practices. (Tr. 72–74.)

TFO Dean testified that a federal search warrant was executed at Respondent's medical practice in May 2010. (Tr. 115–16.) Items seized included medical records for approximately eight patients, controlled substances and financial documents. (Tr. 116.)

DI G.L. testified that he served Respondent with the OSC/IS on May 26, 2010, at Respondent's business, at 16601 North 40th Street, Suite 115 in Phoenix. (Tr. 177.)

(d) Material Falsification of DEA Application

As discussed in a later section of this Recommended Decision,[6] there is uncertainty as to some of the details of Respondent's history of registration with the DEA. Certain details, however, are clear and undisputed. Respondent presently holds DEA COR number BM2040498. (Tr. 78; Gov't Ex. 1 at 2.) He applied to renew his COR on January 29, 2008. (Gov't Ex. 1 at 2; *see also* Tr. 795.) On his 2008 renewal application, Respondent answered ''no'' to liability questions inquiring, in pertinent part, whether Respondent had ever had a state medical license suspended or placed on probation (*see, e.g.,* Gov't Ex. 28), notwithstanding the fact that the Arizona Medical Board had previously suspended Respondent's medical license in 2001. (*See* Tr. 85–86, 760–61; Gov't Ex. 28; Gov't Ex. 3 at 4.) Respondent testified that he did not ''really have a good answer'' for why he said ''no'' on the renewal application, ''other than I didn't pay much attention to the wording.'' (Tr. 760.) Respondent

[3] As noted below, TFO [JB] and TFO ''[BK]'' conducted undercover visits to Respondent's office while posing as patients ''[KR]'' and ''[BK].'' Although they visited Respondent for the purpose of an investigation, TFO [JB] and TFO [BK] are nevertheless assumed, *arguendo,* to be patients of Respondent, and their privacy is protected in this Recommended Decision by the use of initials. *See supra* note 1.

[4] Supra note 3.

[5] Dr. Borowsky has previously submitted questions for the board certification in anesthesiology. (Tr. 384.)

[6] *See generally infra* Section III.B (discussing ambiguities surrounding the dates of Respondent's COR registration and renewal(s)).

maintains that he ''never tried to deceive anyone.'' (Tr. 760–61.)

Record evidence indicates that on October 23, 2000, the Arizona Medical Board issued a consent agreement and order. (Tr. 86–87; *see* Gov't Ex. 2.) The consent agreement reprimanded Respondent for unprofessional conduct and required forty hours of continuing medical education in pharmacology. (Tr. 87; *see* Gov't Ex. 2 at 4.) Moreover, on November 27, 2001, the Board placed Respondent's medical license on probation.[7] (Tr. 88; *see* Gov't Ex. 3.)

(e) Respondent's Registered Location and Practice Location

Respondent testified that his current practice location is 16601 North 40th Street, Suite 115, Phoenix Arizona 85032. (Tr. 34.) Respondent conceded that this location is not reflected on his DEA COR. (Tr. 35; *see also* Tr. 90.) Respondent's COR reflects a registered address of ''Access2care Family Medical Center, 4607 N. 12th Street, Phoenix, Arizona 85014.'' (Gov't Ex. 28.) Respondent explained that when he last filled out the application to renew his COR, he ''was working at Access to Care, and that was a family practice.'' [8] (Tr. 35.) Respondent failed to update his address when he moved to his new practice in August 2009. (Tr. 760.) Respondent testified he did not realize he had to notify DEA of the change in address in addition to notifying the Arizona Medical Board. (Tr. 760.)

(f) Respondent's Care as a Physician

(1) Proof of Patient Identity

Respondent testified that he requires every patient to provide identification, but leaves the type of identification up to his staff. (Tr. 47–48.) While somewhat credible, this testimony is rebutted by record evidence that Respondent's staff permitted TFO [BK], posing as patient [BK], to see Respondent after producing only an ''admin per se form,'' despite the fact that Respondent's staff stated that the admin per se form was not an acceptable form of identification. (Tr. 258, 295–96.) On his second visit to Respondent, on December 23, 2009, TFO [BK] was again permitted to see Respondent, who prescribed controlled substances to TFO [BK] for a second time without verifying the patient's identification. (Tr. 266–67.)

(2) Proof of Injury

The Government's expert medical witness, Dr. Borowsky, opined that obtaining a patient's medical history is critical to avoiding diversion and overdose, which are becoming widespread. (Tr. 396.) Indeed, Dr. Borowsky testified that the Arizona Medical Board requires that physicians maintain medical records for patients. (Tr. 418.) In his own pain management practice, every patient Dr. Borowsky sees is referred to him by another practitioner; he does not accept walk-ins. (Tr. 388–89.) Moreover, Dr. Borowsky reviews patients' medical records before consulting with patients, ''so I know whether this is an appropriate patient for me or whether it [sic] needs some other direction, so that we're not wasting anybody's time.'' (Tr. 389, 404.) He refuses to see patients ''unless there's the proper documentation and radiologic studies that have been done. I'm not a primary [care] physician, and I want to make sure everything has been done before they get to me.'' (Tr. 390.) He conceded, however, that when a patient needs testing, he orders testing. (Tr. 390.)

Respondent's employee [CP] testified that Respondent has had a policy of requiring proof of injury ''[f]rom day one.'' (Tr. 713.) Respondent's testimony, however, shows otherwise. Respondent testified that in the past, because it could take three or four months to acquire a patient's medical records (Tr. 42), Respondent would write prescriptions beginning once the patient signed release forms to permit Respondent to acquire her records. (Tr. 42–43.) Respondent explained that he did this as a ''compassionate doctor.'' (Tr. 42.) ''I always required proof of injury. But I waited sometimes for the proof of injury to come in'' and prescribed controlled substances in the interim. (Tr. 43–44; *see also* Tr. 45.)

Respondent further testified that he began requiring proof of injury from pain management patients in December 2009 or January 2010. (Tr. 42.) Now that Respondent has ''gotten more into the pain management process,'' Respondent requires that every patient present proof of injury. (Tr. 42–44.) Proof of injury can take the form of MRIs, CTs, X-ray reports, reports from a previous doctor or blood work, depending on the diagnosis. (Tr. 43, 46.) Respondent might accept a three-year-old MRI that shows significant disease. (Tr. 45.) In some cases, he has accepted a six-year-old MRI. (Tr. 46.)

Respondent's testimony that he has required proof of injury since December 2009 or January 2010 is called into question by record evidence that TFO [BK], posing as patient [BK], provided no medical records before or during his December 23, 2009 visit to Respondent, at which Respondent prescribed controlled substances. (Tr. 265–67.) Similarly, the record shows that Respondent prescribed controlled substances to TFO [JB] on December 18, 2009, without requiring any past medical records. (Tr. 219, 247.) Indeed, TFO [JB] testified that Respondent stated that ''if he were to continue to prescribe to me, I would need to get proof of injury because he was in danger of losing his license.'' (Tr. 220; *see* Tr. 244.) Moreover, ''Respondent does not contest the fact that he prescribed to the two undercover agents without demanding previous medical records,'' (Resp't Br. at 39), explaining that ''I'm a good doctor and that at times I found myself not being prepared to manage such difficult situations,'' (Tr. 756.) I find by substantial evidence that during the relevant time period, Respondent did not consistently require proof of injury.

(3) Physical Examination of Patients

Dr. Borowsky testified that the Arizona Medical Board requires that physicians conduct a physical examination and patient history. (Tr. at 416.) An examination is important to show discrepancies and determine whether a patient is credibly in pain. (Tr. 397.) Dr. Borowsky testified on the importance of being skeptical, and that prescribing properly requires picking the right patient and monitoring the patient. (Tr. 397.)

In his own pain management practice, Dr. Borowsky does not take vital records on every patient; it depends on the patient. (Tr. 391–92.) However, he does conduct physical examinations. (Tr. 393.) An examination of a patient with low back pain, for instance, would include directing the patient to walk both on her heels and on her toes. (Tr. 393.) Dr. Borowsky would direct the patient to sit and do straight leg-raising, ''and if that was positive, ultimately, I would lay them down and look for continuing [sic] with a straight leg-raise to see if it was the same result.'' (Tr. 393, *see also* Tr. 394.) Throughout the examination, Dr. Borowsky would watch for ''non-organic findings, in

[7] Respondent also conceded that the Arizona Medical Board recently placed his license on probation for two years, (Tr. 62), on August 11, 2010. (*See* Gov't Ex. 27 at 4). Respondent stated that the Board required him to be monitored, and that he has signed a contract to employ monitors. Respondent equivocated, however, as to whether the monitoring program is currently in place. (Tr. 62–63, 67–68.) Because this probation occurred after Respondent applied to renew his COR in 2008, it is not relevant for purposes of the material falsification analysis. *But compare infra* Section III.D (discussing Respondent's August 11, 2010 probation in light of the 21 U.S.C. § 823(f) public interest analysis).

[8] The different spellings of Respondent's former clinic, *compare* Tr. 35 (''Access to Care''), *with* Gov't Ex. 28 (''Access2care Family Medical Center''), appear to reflect a typographical error in the transcript.

other words, non-physical findings like Waddell's signs. One of those would be lightly pressing on somebody's head, and if they respond by exclaiming that they have radiating leg pain, that's not a physical finding that creates a credible picture.'' (Tr. 394.)

Respondent's patients ''[CM],'' ''[CP]'' and ''[RF]'' each testified that Respondent examined them on their first visits. (Tr. 515, 567, 700.) In addition, Respondent testified that when he conducts physical examinations of patients, he does not use the Waddell's signs test. Instead, his exams are ''heel to toe, hip flexion, range of motion, reflexes.'' (Tr. 48.) This testimony is undercut by record evidence that Respondent conducted no physical examination of TFO [BK] when the latter posed as patient [BK] on November 18, 2009, and December 23, 2009. (Tr. 258, 260, 267–68.) Respondent gave TFO [BK] prescriptions for controlled substances on both occasions. (Tr. 256, 265.) Moreover, Respondent failed to conduct a physical examination of TFO [JB] when the latter posed as patient [KR] on December 18, 2009. (Tr. 219.) Respondent gave TFO [JB] a prescription for controlled substances anyway. (Tr. 247.)

In mitigation, the record reflects that during TFO [JB]'s November 13, 2009 undercover visit, Respondent did touch TFO [JB]'s back in several places, asked if it hurt and moved her right foot. (Tr. 215, 238–40.) This incident, however, occurred only as Respondent was starting to leave the examination room, after he had already told TFO [JB] of his decision to prescribe controlled substances. (Tr. 214–15, 246.) Moreover, Dr. Borowsky testified that Respondent's purported examination in this regard was inadequate because Respondent's statement '''I'm poking you' . . . is not a physical exam.'' (*See* Tr. 421–22.) I find by substantial evidence that during the relevant time period, Respondent did not consistently conduct adequate physical examinations before prescribing controlled substances.

(4) Patient Drug Screens

Dr. Borowsky testified that in his own pain management practice, before prescribing a controlled substance, he orders patients to complete a urine drug test. (Tr. 392–93.)

Respondent testified that he performs drug screens on ''[e]very patient that walked through the door'' at every appointment. (Tr. 46.) Under certain circumstances, however, when a patient with an opioid prescription tests negative for opiates, Respondent might nevertheless prescribe controlled substances, such as, for example, if the patient loses the medication or forgets to take it. (Tr. 47.)

The credibility of Respondent's testimony that he performs drug screens on all patients is called into question by evidence that Respondent did not require undercover investigators posing as patients to complete drug screens on November 13, 2009 (Tr. 209), November 18, 2009 (Tr. 258), December 18, 2009 (Tr. 219) or December 23, 2009 (Tr. 267). This discrepancy, however, may be explained in part by Respondent's testimony that he began conducting drug screens in February 2010. (Tr. 805; *see generally* Tr. 221, 616–17.) In any event, ''Respondent . . . concedes that his willingness to prescribe based on office observation, examination and patient complaints was unwise.'' (Resp't Br. at 40.)

(5) Referrals for Treatment by Specialists

Dr. Borowsky testified that the Arizona Medical Board requires that physicians consult with specialists (Tr. 417) because ''[m]ost of these problems involve areas that can be beyond the practitioner, even a pain management doctor, and it's important to get the appropriate consultations . . . .'' (Tr. 429.) Respondent testified that he makes referrals for psychiatric evaluation to patients with insurance. (Tr. 48.) For patients without insurance, Respondent asks them about their psychiatric treatment history. (Tr. 49.) Most of his patients lacking insurance cannot afford psychiatric treatment, ''[b]ut I tell them they still need to go if the situation calls for it.'' (Tr. 49.)

Respondent's testimony that he makes referrals is called into question by his failure to make a referral to TFO [BK], posing as patient [BK], notwithstanding Respondent's stated concern that TFO [BK] might have fibromyalgia. (Gov't Ex. 23 at 1.)

(6) Respondent's Use of the Arizona PMP

Dr. Borowsky testified that it is the obligation of a doctor to check the PMP.[9] (Tr. 386–87; *accord* Tr. 170 (testimony of TFO Dean).) When prescribing controlled substances, however, Respondent did not initially consult the PMP. (Tr. 50.) Respondent explained that he did not initially know about the PMP, and ''there were certain things I didn't know about pain management.'' (Tr. 50.) But once he was informed of the PMP, in approximately December 2009 or January or February of 2010, he did start to use it. (Tr. 50–51.) This testimony is slightly undercut by Respondent's statement to TFO [JB] on November 13, 2009, that ''the only place you can get these medications is from me . . . it's all computerized, so you're gonna get red-flagged and they're gonna call you a drug addict and a doctor shopper and then all of a sudden no pharmacy . . . is gonna give you any medication'' (Gov't Ex. 21 at 147; *see also* Tr. 213), which evinces Respondent's knowledge of the PMP on that earlier date.

Respondent also testified to relying on a pharmacy to check the PMP for him. (Tr. 51.) The pharmacy would call Respondent if a review of the PMP indicated ''doctor shopping.'' (Tr. 51.) ''And if that were the case, every one of those patients got discharged.'' (Tr. 52.)

(7) Patient Treatment Plans

Dr. Borowsky testified that the Arizona Medical Board requires that physicians document a treatment plan. (Tr. 417.) He opined that it is critical to document both patient treatment plans and informed consent to substantiate the basis for treating the patient and the patient's diagnosis. (Tr. 399–400.) ''[I]f it's not in writing, others will assume that it was not done.'' (Tr. 400.)

Dr. Borowsky testified that in his own pain management practice, following the physical examination of a patient, he consults with the nurse case manager to develop a written plan of treatment. (Tr. 395.) Frequently, such a treatment plan would involve any of the following: physical therapy, psychology, referral to a psychiatrist and injection techniques such as epidural steroid injections or trigger-point injections. (Tr. 394–95.) Treatment could also involve medication management, such as opioids, narcotics, anti-inflammatories, anti-convulsives, antidepressants and various medications along that line. (Tr. 394–95.)

Respondent testified that he formulates treatment plans in his mind for his patients. (Tr. 52.) Respondent's testimony was unclear as to whether he reduces his treatment plans to writing. (*See* Tr. 52.) The testimony of DEA investigators posing as patients indicates that Respondent discussed no treatment plan before prescribing

[9] Respondent argues that Dr. Borowsky used the term ''obligation'' ''in the aspirational or hortatory sense.'' (Resp't Br. at 22 ¶ 106 (citing Tr. 479–80).) Respondent was given ample opportunity before, during and after the hearing in Phoenix, Arizona to present testimony by an expert witness of his choosing. Such testimony could have addressed, *inter alia,* whether an Arizona physician is obligated to consult the PMP. Respondent declined to call an expert witness. (Tr. 863.) Dr. Borowsky's unqualified and fully credible testimony therefore stands unrebutted.

controlled substances on November 13, 2009 (Tr. 212) November 18, 2009 (Tr. 262) December 18, 2009 (Tr. 220) or December 23, 2009 (Tr. 269). Moreover, the patient files of TFO [JB], posing as [KR], and TFO [BK], posing as [BK], reveal no treatment plans.[10] (Tr. 416; *see also* Gov't Exs. 15 & 16.)

(8) Informed Consent and Opioid Contract

Dr. Borowsky testified that the Arizona Medical Board requires that physicians obtain informed consent from patients. (Tr. 417.) In his own pain management practice, Dr. Borowsky discusses the risks and benefits of medications he prescribes to patients. (Tr. 395.) He also directs patients to sign an informed consent agreement using a standard form that is readily available in pain management societies. (Tr. 399.) He said it is critical to discuss with patients the risks and benefits of medications, especially opioids. (Tr. 399.) Dr. Borowsky opined that it is critical to document treatment plans and informed consent to substantiate the basis for treating the patient and the patient's diagnosis. (Tr. 399–400.) Although diagnoses can be vague after patients undergo various surgeries and treatments, there does ultimately need to be credibility and substantiation for a diagnosis. (Tr. 398.)

Respondent testified that he has required patients to sign an opioid contract since December 2009 or January 2010, but he was not sure exactly when. (Tr. 55.) Before he began using his current opioid contract, Respondent used an ''opioid flow sheet,'' which ''explained about taking the drugs, and being responsible for how you take the drugs and potential side effects, and so on and so forth.'' (Tr. 55.) Respondent has an informed consent agreement in place as a part of the opioid contract. (Tr. 65.) Respondent took the language in the opioid contract from his previous clinic. (Tr. 65–66.)

In contrast to Respondent's testimony, TFO [BK] testified that Respondent did not discuss the risks and benefits of the controlled substances he prescribed to TFO [BK] on December 23, 2009. (Tr. 269.) Nor did Respondent discuss the risks and benefits of the drugs he prescribed to TFO [JB] during her second visit in an undercover capacity on December 18, 2009. (Tr. 220.) Taken together, this testimony calls into question the extent to which Respondent consistently obtains informed consent from his patients.

(9) Pain Scale

Dr. Borowsky testified that in his own pain management practice, it is customary to have patients fill out a questionnaire that includes a pain diagram. He stated that ''the coloring-in of the location of pain many times can give you a good idea of the diagnosis.'' (Tr. 390.) His intake form also includes a pain scale ranging from zero to ten, as well as adjectives that patients can circle to describe their pain. (Tr. 390.) Dr. Borowsky conceded that under some circumstances, a patient circling zero on a pain scale might mean zero pain while on medication. (Tr. 430–31.) Respondent testified that he would prescribe controlled substances to a patient that indicated zero on the pain scale. (Tr. 59.) Indeed, TFO [JB], posing as patient [BK], indicated zero out of ten on a patient intake form on November 13, 2009 and again on December 18, 2009. (Tr. 208, 219, 223; *see* Gov't Ex. 15 & 16.) Respondent prescribed controlled substances to TFO [JB] on both occasions. (Tr. 207, 211–12, 247.) Similarly, TFO [BK], posing as a patient on November 18, 2009, indicated zero out of ten on a pain scale. (Tr. 257; *see* Gov't Ex. 16.) On his second undercover visit, on December 23, 2009, TFO [BK] left the pain scale blank. (Tr. 266; *see* Gov't Ex. 16.) Respondent prescribed controlled substances to TFO [BK] in both instances. (Tr. 256, 265.)

(g) Respondent's Knowledge of Controlled Substances

DI G.L. testified that when he served the OSC/IS on Respondent on May 26, 2010, Respondent asked DI G.L. ''what a controlled substance was, and if Xanax was a controlled substance.'' (Tr. 177–79.) DI G.L. replied that ''Xanax was in fact a controlled substance, and if he needed to refer to anything else, he could go to [the DEA] Web site, and there would be a full list of controlled substances on the diversion Web site.'' (Tr. 179.) DI G.L. testified that in his experience as a DEA investigator, DI G.L. had never encountered that question before. (Tr. 179.)

(h) Quantity of Controlled Substances Prescribed

Dr. Borowsky testified that when prescribing controlled substances, it is appropriate to ''start[] off with the lowest level of medication . . . If you start high, you can't go back very easily, but if you start low, you can assess [the patient's] response.'' (Tr. 406.) He elaborated that ''it's not just the pain relief that you're looking for. The goal . . . is not just pain relief, but improvement in function . . . .'' (Tr. at 406.)

Respondent testified that the average amount of oxycodone he prescribes is 30 mg, with the dosages running from ninety to one hundred and fifty, corresponding to three to five times per day. (Tr. 54.) Thirty milligrams is the highest dosage available of oxycodone. (Tr. 55.)

(1) ''Street Value'' of Controlled Substances

TFO [JB] noted that based on her experience as an investigator, the term ''on the street,'' in the context of controlled substances, means the controlled substances are received illegally, or from illegal means. (Tr. 213–14.) TFO Dean testified that ''many of the drugs [Respondent] was prescribing were ending up in the illegitimate market, in the street market.'' (Tr. 73.)

Respondent acknowledged prescribing to patients when he knew the patients bought drugs on the street in the past. (Tr. 58.) He said patients subsequently ''came to me because they didn't want to continue breaking the law.'' (Tr. 57.) When he sees such patients, he tells them not to buy on the street and only to get drugs from him. (Tr. 58.)

Respondent testified that he did not personally know any patients who sell pills on the street, and that he immediately discharges any patient he discovers to be selling drugs. (Tr. 55–56.) Respondent estimated that the amount of patients he discovers are selling constitutes less than one percent. (Tr. 56–57.) Yet Respondent also testified that between December 2009 and May 2010, he discharged 264 patients. (Tr. 757.) ''The reasons were from selling drugs, using medications that weren't prescribed by me, multiple doctor shopping, using the pharmacy monitoring program, use of illicit drugs and drug screens where they came positive for cocaine or methamphetamine . . ..'' (Tr. 757.)

Dr. Borowsky testified that he does not discuss the street value of medications with his patients. (Tr. 428.) Respondent stated that in general, he does not discuss street values of drugs with patients. (Tr. 59.) However, he conceded having done so in the past. (Tr. 59.) ''I would tell them what my

[10] Respondent proposes that it is ''not necessarily reasonable to expect an elaborate treatment plan for patients who have been advised to get diagnostics ([JB]) or to find a primary care doctor to provide evaluation, diagnostics and probably referral ([BK]).'' (Resp't Br. at 38 n.10.) Respondent was given ample opportunity before, during and after the hearing in Phoenix, Arizona to present testimony by an expert witness of his choosing. Such testimony could have addressed, *inter alia,* whether a treatment plan was called for in the case of TFO [JB] and TFO [BK]. Respondent declined to call an expert witness. (Tr. 863.) Dr. Borowsky's unqualified and fully credible testimony therefore stands unrebutted.

patients tell me. I know nothing about street drugs per se. I repeat what I've heard from my patients.'' (Tr. 59.) This testimony by Respondent stands in contrast to other record evidence that on November 13, 2009, Respondent told TFO [JB] that the drugs he prescribed to her possessed a high street value. He noted that the pills sold for about ten dollars per pill on the street and that OxyContin sold for forty dollars to eighty dollars on the street. (Tr. 213.) In mitigation, a transcript of that visit suggests that when Respondent discussed the street value of drugs with TFO [JB], he did so for the patient's own protection:

these medications . . . there's a high street value for them. That's number one. So it's not a good idea for you to tell your friends that you're taking these medications because [even] your mother will take them from you . . . These medications go for about ten dollars a pill on the street . . . what's called oxycontins . . . go like anywhere from like 40 to 80 dollars a pill . . . So there's a huge street value. People are always stealing them. So be careful. Uh because if you lose your medications, even if you have a police report, can't get em. Once a month is all you can get. (Gov't Ex. 21 at 147–48.)

(2) Statistical Analysis of Respondent's Prescribing Practices

IRS Stone testified that he analyzed the PMP data on Respondent's prescriptions. (Tr. 303.) He focused on the number of patients involved, the dates covered and the kinds and combinations of controlled substances Respondent prescribed. (Tr. 304.) Government Exhibit 14 consists of charts IRS Stone prepared on this basis. (Tr. 305; *see* Gov't Ex. 14.) IRS Stone did not verify that the data he was given was correct before analyzing it, because he had no basis to do so. (Tr. 318.)

The category ''oxycodone'' on the first chart of Government Exhibit 14 refers to drugs prescribed by Respondent in which oxycodone is the main ingredient, including Percocet, Endocet, OxyContin and 12 oxycodone 30s. (Tr. 306.) The category ''benzodiazepine'' in the same chart refers to drugs prescribed by Respondent in which benzodiazepine is an active ingredient, such as Klonopin, Xanax, alprazolam, clonazepam and lorazepam. (Tr. 306–07.)

The first chart indicates that between August 2009 and March 2010, Respondent wrote 9411 prescriptions. (Tr. 307.) The highest number of prescriptions was 5126, for oxycodone. (Tr. 307, 310.) The total tablet count was 681,590. (Tr. 310.) This amount represents 54.47 percent of Respondent's prescriptions and 71.08 percent of the tablets he prescribed. (Tr. 311.)

The second highest number of prescriptions Respondent wrote between August 2009 and March 2010 was 3230, for benzodiazepine. (Tr. 307, 310.) The total tablet count was 208,318. (Tr. 310.) This amount represents 34.32 percent of Respondent's prescriptions and 21.72 percent of the tablets he prescribed. (Tr. 311; *see* Gov't Ex. 14 at 2.) The tablet counts noted above do not distinguish between tablets of various dosages. (Tr. 319.)

The second chart of Government Exhibit 14 contains the number of prescriptions within each drug group, the number of tablets prescribed within that drug group and the average number of tablets per prescription. (Tr. 307–08.) For instance, when Respondent prescribed hydrocodone, he did so with an average of one-hundred and ten tablets per prescription. (Tr. 309.) This average prescription indicates a patient taking a prescription more than three times per day during a month of thirty days. (Tr. 309.) The prescription average for oxycodone was one-hundred and thirty-three. (Tr. 310.)

The third chart identifies how many of Respondent's patients received various drugs between August 2009 and March 2010. (Tr. 311–14.) According to information IRS Stone received from the PMP, the age group in Arizona that received the highest number of prescriptions for controlled substances was the fifty to fifty-nine age group. (*See* Tr. 491 (correcting mistake in witness's prior testimony, *see* Tr. 317).)

(3) [JG] and Diversion

TFO Baldwin testified to an interview he conducted with ''[JG].'' (Tr. 184.) [JG] was twenty nine or thirty years old at the time of the interview. (Tr. 189.) [JG] said she was addicted to oxycodone, and that she visits Respondent on a monthly basis and pays cash. (Tr. 185.) She has her prescriptions filled at Community Pharmacy, at 29th Avenue and Bell Road. (Tr. 186.) That location is ten miles away from Respondent's office; to get from Respondent's office to that location, one passes by many other pharmacies on the way. (Tr. 186.) TFO Baldwin testified that [JG] said she goes to that particular location of Community Pharmacy because it has the cheapest price in town, because it always has her stock on-hand and because Respondent directed her to go there. (Tr. 186.) TFO Baldwin has heard that Community Pharmacy has ''the cheapest cash prices. That's how they advertise.'' (Tr. 197.)

TFO Baldwin testified that [JG] said that she and her boyfriend sell their pills to pay their bills. (Tr. 187.) She and her boyfriend go to Respondent because a friend of hers had said: ''Hey, this doctor can give you the hook up.'' (Tr. 187, 197.) TFO Baldwin testified that he understood that to mean that without a lot of questions asked, a person can get the medications that they seek. (Tr. 187.) TFO Baldwin testified that he asked [JG] if Respondent knew that she was selling her pills, and her response was that ''he should know because half the patients in there are just like me.'' (Tr. 196.)

TFO Baldwin further testified that [JG] said that fifty percent of Respondent's patients are getting pills for no medical reason. (Tr. 187.)

(4) [LW] and Diversion

TFO [JB] testified that she talked with ''[LW],'' one of Respondent's patients, at a pharmacy on November 13, 2009. (Tr. 216.) TFO [JB] knew [LW] was a patient of Respondent because they saw one another in Respondent's waiting room. (Tr. 244.) [LW] said she was taking oxycodone 30, and that she was addicted. (Tr. 216.) She usually took five pills per day; she used to sell part of her prescription on the street but now needs to take all of them to avoid withdrawal. (Tr. 217.)

[LW] said she sent several patients to Respondent to get prescriptions to sell on the street. (Tr. 217.) [LW] told TFO [JB] that Respondent had never asked [LW] for proof of injury, nor did she provide any, but that he had recently begun to ask patients for proof of injury. (Tr. 217.)

(5) Pharmacists Questioning Respondent's Prescribing Practices

Respondent testified that a pharmacist has never questioned his prescribing of controlled substances. (Tr. 61.) On multiple occasions, however, pharmacists have contacted Respondent to ensure a prescription was valid. (Tr. 66.) In such situations, Respondent asked the pharmacist to fax him the suspicious prescription, and Respondent advised whether it was his own handwriting. (Tr. 66–67.)

Contrary to Respondent's testimony that a pharmacist has never questioned Respondent's prescribing of controlled substances (*see* Tr. 61), the testimony of TFO Dean and an August 10, 2009 letter by pharmacist S.G. (*see* Gov't Ex. 4) suggest otherwise. (*See also* Tr. 168.)

TFO Dean testified that the official investigation of Respondent began when pharmacist S.G. contacted TFO Dean because he was suspicious of Respondent's prescribing practices. (Tr.

73.) S.G. told TFO Dean that Respondent ''had a large number of customers at his pharmacy who all were receiving similar prescriptions, usually oxycodone and alprazolam, and that many of them seemed to be organized in some sort of group, as they were all using the same physical prescription discount card.'' (Tr. 74.)

Directly contradicting Respondent's testimony, TFO Dean testified that S.G. contacted Respondent and expressed his suspicion that some of Respondent's patients were diverting drugs. (Tr. 74.) According to TFO Dean, Respondent replied to S.G. that all the prescriptions in question were legitimate. (Tr. 75.) TFO Dean testified that S.G. said Respondent told S.G. a story about a previous practice where Respondent had worked, where Respondent had prescribed to a family of ten patients, but only two of them needed their medications. (Tr. 75.) On cross examination, TFO Dean said S.G. did not indicate where or when this story was said to have occurred, other than at a previous employer of Respondent. (Tr. 132–33.) TFO Dean testified that Respondent told this story to S.G. in response to S.G.'s suspicions. (Tr. 168.) In his testimony, Respondent denied that such a family existed, and denied prescribing to any such family. (Tr. 774–76.)

TFO Dean stated that following his conversation with S.G., TFO Dean asked S.G. in late July or early August 2009 to formalize in a letter what they had talked about. (Tr. 124–25.) The record reflects a letter from S.G. to the DEA dated August 10, 2009. (Gov't Ex. 4; *see* Tr. 76.)

TFO Dean testified on cross examination as to how S.G. connected an individual prescription by Respondent to concerns of diversion. For one thing, the amounts of some prescriptions were similar. Moreover, S.G. noted that patients were using the same physical prescription discount card because it was creased in a particular way. (Tr. 128.)

S.G. told TFO Dean that S.G. followed patients out into the parking lot and saw them exchange cash with someone in a vehicle. (Tr. 128.) S.G. said he and his staff ''would see them go outside—they'd come inside often, ask how much their prescriptions were going to be, go out to a vehicle, receive cash from the driver, walk back in. [They would p]ay with that cash, and go back and get in a vehicle and leave.'' (Tr. 126–29, 130, 168.)

TFO Dean did not recall whether S.G. said he had told Respondent about following the patients into the parking lot. (Tr. 130.) On redirect examination, TFO Dean testified that TFO Dean did not inform Respondent of his suspicions relating to the parking lot story, but that S.G. did. (Tr. 168.)

(i) Undercover Visits to Respondent, Generally

Pursuant to a federal warrant executed on Respondent's medical practice in May 2010, law enforcement officers seized medical files under the names of [BK] and [KR]. (Tr. 116.) These files are patient records associated with four undercover visits by two undercover law enforcement officers. (Tr. 118–19; *see* Gov't Ex. 15 & 16.)

Law enforcement officers made audio or video recordings of three of these undercover visits.[11] (Tr. 118–19.) TFO Dean monitored all of the undercover visits via audio receiver. (Tr. 119.)

(j) Undercover Visits to Respondent by TFO [JB], AKA ''[KR]''

TFO [JB] testified that on November 13, 2009, and December 18, 2009, she visited Respondent in an undercover capacity, posing as patient ''[KR],'' and Respondent gave her prescriptions for 70 oxycodone 30 mg. (Tr. 205–06, 211, 221.)

(1) TFO [JB] Undercover Visit of November 13, 2009

During her first undercover visit to Respondent's office, posing as ''[KR],'' TFO [JB] possessed a functioning recording device. (Tr. 206–07, 230; *see* Gov't Exs. 21 & 24.) TFO [JB] filled out a patient intake form and paid seventy dollars in cash. (Tr. 208.) The patient intake form included a pain scale of zero to ten for ''pain score on medications,'' on which TFO [JB] marked ''zero,'' indicating no pain. (Tr. 208, 223.) TFO [JB] did not provide medical records. (Tr. 208.)

The consultation with Respondent lasted ten minutes, and Respondent also took a phone call during that time. (Tr. 207; *see* Gov't Ex. 21 at 145.) When Respondent entered the examination room, Respondent asked who sent TFO [JB] to him. (Tr. 210; Gov't Ex. 21 at 142.) He then stated that he was going to flirt with TFO [JB], because he flirts with his good-looking patients. (Tr. 210; Gov't Ex. 21 at 143.) After approximately the third time he said this to her, she responded ''Oh, that's fine.'' (Tr. 236; Gov't Ex. 21 at 143.) Respondent asked if TFO [JB] was single, and whether she had ever been out with a doctor. (Tr. 214; Gov't Ex. 21 at 148.) He told her that she was attractive, and that she was single, and that he was single. (Tr. 215; Gov't Ex. 21 at 148–50.) TFO [JB] testified that Respondent made her feel uncomfortable (Tr. 234, 246), and that she was not sure whether he was joking or not. (Tr. 234.) This had never occurred in her investigation of other doctors. (Tr. 246.)

The examination room contained an examination table, but no instruments. (Tr. 209.) No one checked her vital signs, such as her pulse, heart rate, height, weight or blood pressure. (Tr. 208–09.) She did not submit a urinalysis for drug screening. (Tr. 209.) TFO [JB] said Respondent did not give her a physical, neurological or musculoskeletal examination. (Tr. 212.) He asked if she had had an MRI; she said she had not and Respondent recommended she go to Simon Med, which would give her a discount. (Tr. 212; Gov't Ex. 21 at 144, 146.)

TFO [JB] did not say she had any pain. (Tr. 210, 245; *see e.g.,* Gov't Ex. 21 at 143.) She said she had been taking her father's Percocet ''to feel good, or better.'' (Tr. 211; *see* Gov't Ex. 21 at 144.) She said she had not seen a doctor in a few years. (Tr. 210; Gov't Ex. 21 at 143.) Respondent then asked how TFO [JB] hurt her back, even though TFO [JB] never said her back hurt. (Tr. 210, 245; Gov't Ex. 21 at 143.) TFO [JB] explained that Respondent coached her, and when he said ''lower back?'' she agreed. (Tr. 210–11; Gov't Ex. 21 at 145; *see also* Tr. at 233.)

Respondent did not discuss a treatment plan with TFO [JB], nor did he discuss the risks and benefits of the controlled substances he ultimately gave her. (Tr. 212; *see generally* Gov't Ex. 21.) Although Respondent initially said he would prescribe oxycodone 15 mg, he ultimately prescribed oxycodone 30 mg 70 tablets, representing a little more than one month's supply. (Tr. 207, 211–12; *see also* Gov't Ex. 21 at 146.)

As Respondent started to leave the examination room, and after he had already told TFO [JB] that he would write her a prescription, he turned back and asked TFO [JB] to roll over on the examination table onto her stomach. (Tr. 214–15, 246; Gov't Ex. 21 at 150.) TFO [JB] told Respondent she did not need an examination. (Tr. 215.) Respondent replied: ''An exam? . . . No. I'm gonna poke you. I gotta find something out about ya . . . let me know whether that causes you pain.'' (Gov't Ex. 21 at 151. *See generally* Tr. 215.) He then had her roll over, touched her back in several places, asked if it hurt and moved her right foot. (Tr. 215, 238–40.) TFO [JB] testified that she told him there was no pain. (Tr. 215.) On cross examination,

[11] TFO [JB]'s recording device malfunctioned during the December 18, 2009 undercover visit. (Tr. 218.)

however, she conceded that she had said ''Oh, yes, that does'' when he poked a part of her back. (Tr. 238; Gov't Ex. 21 at 151.) TFO [JB] explained that Respondent's touch startled her. (Tr. 239, 248.) She felt very uncomfortable when Respondent asked her to roll onto her stomach and found the whole visit unnerving. (Tr. 247.)

TFO [JB] testified that Respondent stated that the prescription he gave her had high street value. (Tr. 213; Gov't Ex. 21 at 147.) Particularly, the pills he was giving her went for ten dollars each on the street; OxyContins went for forty to eighty dollars on the street. (Tr. 213; Gov't Ex. 21 at 147.) Respondent also said she ''could only get the medication from him because it was electronically tracked, and I could be labeled a doctor shopper, or a drug user, or drug addict, and then I wouldn't be able to get the mediation [sic] anymore.'' (Tr. 213; *see* Gov't Ex. 21 at 147 (''medication'').) The transcript of the visit provides some context for these remarks, and also evinces a degree of concern by Respondent for TFO [JB]'s wellbeing. these medications . . . there's a high street value for them . . . So it's not a good idea for you to tell your friends that you're taking these medications because [even] your mother will take them from you . . . People are always stealing them. So be careful. Uh because if you lose your medications, even if you have a police report, can't get em. Once a month is all you can get. (Gov't Ex. 21 at 147–48.)

TFO [JB] testified that Respondent's staff recommended Community Pharmacy, located about five miles away from Respondent's office, which had a five-dollar coupon. (Tr. 216.) She had never encountered pharmacy coupons offered in any other doctor's office. (Tr. 247.)

(2) TFO [JB] Undercover Visit of December 18, 2009

TFO [JB] returned to Respondent's office on December 18, 2009. (Tr. 218.) Although her recording device malfunctioned that day, the transmitter functioned properly. (Tr. 218.)

TFO [JB] did not tell Respondent or indicate on any paperwork during the second visit that she had pain. (Tr. 218–19.) She again marked zero on the pain scale. (Tr. 219.) Respondent completed no physical, neurological or musculoskeletal examination of TFO [JB]. (Tr. 219.) TFO [JB] did not submit any medical records, nor did she submit a urinalysis for drug testing. (Tr. 219.) Respondent asked if TFO [JB] had an MRI; she said no. Respondent answered that ''if he were to continue to prescribe to me, I would need to get proof of injury because he was in danger of losing his license.'' (Tr. 220; *see* Tr. 244.)

But Respondent prescribed controlled substances to TFO [JB] on her second visit anyway. (Tr. 247.) Respondent said he had noted that TFO [JB] was taking fifteen-mg oxycodone. (Tr. 221.) TFO [JB] corrected him and said Respondent had actually given her thirty-mg oxycodone on the previous visit. (Tr. 221.) Respondent replied ''Well, I wrote 15 milligrams in the chart, but I sometimes make mistakes.'' (Tr. 221.) Respondent gave TFO [JB] a second prescription identical to the first: Another prescription for 70 tablets of oxycodone 30 mg. (Tr. 218.) Respondent did not discuss a treatment plan, nor did he discuss the risks and benefits of the drugs he prescribed to TFO [JB] during her second visit. (Tr. 220.)

Respondent said he was in debt due to the day-to-day cost of operating his office. (Tr. 220.) He said he intended to raise the office visit fee to eighty dollars per visit, to cover the cost of the urinalysis testing he was going to begin, and to help with his own debt. (Tr. 221.) Respondent also stated that some of his patients used to get their drugs on the street. (Tr. 221.)

(k) Undercover Visits to Respondent by TFO [BK], AKA ''[BK]''

TFO [BK] testified that on November 18, 2009, and December 23, 2009, he visited Respondent's office in an undercover capacity, posing as patient ''[BK],'' and Respondent gave him prescriptions for 120 Vicodin 10/325 mg on each visit. (Tr. 255–56, 265; *see* Gov't Exs. 16, 22, 23, 25 & 26.)

(1) TFO [BK] Undercover Visit of November 18, 2009

During his first undercover visit to Respondent, TFO [BK] used a functioning recording device. (Tr. 256–57.) The interaction with Respondent lasted approximately five to ten minutes. (Tr. 257.) TFO [BK] filled out an intake form and indicated zero out of ten on a pain scale, with zero meaning ''no pain.'' (Tr. 257.)

As part of the intake process, TFO [BK] provided an admin per se form that indicated his driver's license had been taken away due to a DUI.[12] (Tr. 258.) Respondent's office staff told TFO [BK] that the admin per se form was not an acceptable form of identification, but Respondent saw him anyway.[13] (Tr. 258, 295–96.) He paid cash and did not provide medical records during the intake process. (Tr. 258.)

TFO [BK] described the examination room as approximately eight by eight feet with an examination table, chair and desk, but no medical equipment. (Tr. 259.) When Respondent entered the room, he told TFO [BK] ''[o]bviously you're here looking for pain medication,'' (Gov't Ex. 22 at 159), and asked what TFO [BK] did that he needed it. (Tr. 259–60.) TFO [BK] said Respondent went on to suggest several reasons, including back and arm pain. (Tr. 260.) TFO [BK] did not respond with a specific reason, but just said ''you name it,'' and also ''general pain.'' (Tr. 260.) Respondent then said there would need to be a specific reason, and suggested a motor vehicle accident. (Tr. 260–61.) TFO [BK] agreed to a motor vehicle accident. (Tr. 261.) Respondent then stated that TFO [BK] would need to produce proof of injury. (Tr. 261.)

TFO [BK] testified that Respondent recommended that TFO [BK] go to Simon Med, where he could get a discount on an MRI. (Tr. 262.) This testimony is called into question by other evidence of record. As Respondent notes (Resp't Br. at 10), the audio recording and the transcript of the November 18, 2009 visit are devoid of any discussion of Simon Med or an MRI. (*See* Gov't Ex. 22 & Gov't Ex. 25 at track one.) One possible explanation is that a number of sections of the recording are inaudible, with corresponding blank spaces appearing in the transcript. Even so, TFO [BK] testified at hearing that he listened to the recording and that it accurately reflects what occurred during the visit. (Tr. 270.) Accordingly, I do not assign any weight to TFO [BK]'s assertion that Respondent recommended Simon Med to him. The remaining testimony of TFO [BK], however, is otherwise internally consistent and credible, and does appear to be corroborated by other record evidence.[14]

TFO [BK] further testified that Respondent asked TFO [BK] what kind of medication he wanted. TFO [BK] responded that he wanted ''oxy 30s,'' or oxycodone 30-milligram pain medication. Respondent asked where TFO [BK] got oxy 30s; TFO [BK] responded that he was getting them wherever he could. (Tr. 261.)

During the meeting, Respondent sat approximately four to six feet away from

[12] DEA prepared the admin per se form for this undercover purpose. (Tr. 258.)

[13] Respondent's staff asked: ''[D]o you have any kind of photo id with your picture on it?'' (Gov't Ex. 23 at 157). I therefore reject Respondent's assertion that ''in November new patient [BK] was not asked for his ID.'' (Resp't Br. at 13 ¶ 50.)

[14] *But see infra* note 15 (discussing the TFO [BK]'s testimony as to Simon Med during his second visit).

TFO [BK] and never came any closer. (Tr. 260.) No one took TFO [BK]'s pulse, heart rate, height, weight or blood pressure. (Tr. 258.) Nor did TFO [BK] submit a urinalysis for drug testing. (Tr. 258.) Respondent conducted no physical, neurological, musculoskeletal or other examination of TFO [BK]. (Tr. 260, 262.)

Respondent gave TFO [BK] a prescription for 120 Vicodin 10/325 mg, a hydrocodone/acetaminophen compound and Schedule II narcotic. (Tr. 256.) The quantity was enough for thirty-five days. (Tr. 256.) Respondent did not discuss the medication's risks and benefits. (Tr. 262.)

TFO [BK] testified that Respondent told him that Respondent has some patients who get drugs off the street, and ''I don't care whether you are or not, I have patients that do that . . . .'' (Gov't Ex. 22 at 162.) Respondent told TFO [BK] that it is more expensive to buy drugs off the street. Therefore, some of Respondent's patients come to him to be evaluated and obtain prescriptions at a lower price. (Tr. 263.)

TFO [BK] testified that the people present in Respondent's waiting room were in their twenties and thirties and appeared sleepy. (Tr. 259, 284.) TFO [BK] estimated observing between fifteen and twenty patients. (Tr. 284.) He did not notice any outward signs of chronic pain. (Tr. 259.)

Respondent recommended that TFO [BK] fill his prescription at Community Pharmacy, located approximately thirteen miles away. There was a coupon for Community Pharmacy in the lobby. (Tr. 264.)

(2) TFO [BK] Undercover Visit of December 23, 2009

On December 23, 2009, TFO [BK] provided no identification whatsoever, nor did he provide medical records, but Respondent nevertheless allowed him a second office visit. (Tr. 266–67.) TFO [BK] possessed a functioning audio and video recording device and transmitter. (Tr. 264–65.) The visit lasted between five and ten minutes. (Tr. 266.)

TFO [BK] brought no proof of injury to the second visit. (Tr. 266.) He filled out intake forms, leaving the pain scale blank. (Tr. 266.) On cross examination, TFO [BK] agreed that circling ''zero'' indicated ''with medication, no pain.'' (Tr. 281.) He also told Respondent that he was obtaining medication ''here and there.'' (Tr. 282; *see* Gov't Ex. 23.) He told Respondent he was experiencing ''general pain.'' (Tr. 285.) The transcript of the visit corroborates that Respondent suggested to TFO [BK] options in terms where his pain might stem from. (Gov't Ex. 23 at 171; Tr. 297.) The evidence supports TFO [BK]'s assertion that ''I followed [Respondent] down the road I was led.'' (Tr. 287.)

Respondent told TFO [BK] that he would need to obtain proof of injury. (Tr. 268, 285.) As with the first visit, TFO [BK] testified that Respondent recommended getting a discount MRI at Simon Med. Also as with the first visit, this testimony is inconsistent with other record evidence.[15] (Tr. 268.)

TFO [BK] testified that during the second visit, Respondent prescribed the same prescription as at the first visit: 120 count Vicodin 10/325 mg. (Tr. 265.) Vicodin is a controlled substance. (Tr. 298.) On cross examination, TFO [BK] conceded that while he had requested ''Oxy 30s . . . I got [a lesser strength].'' (Tr. 283.) TFO [BK] filled the second prescription at Community Pharmacy. (Tr. 269.)

Respondent did not discuss a treatment plan, nor did he discuss the risks and benefits of the medication he prescribed to TFO [BK]. (Tr. 269.) No one took TFO [BK]'s vital signs, nor did TFO [BK] submit a urinalysis for drug testing. (Tr. 267.) Neither Respondent nor his staff conducted a physical, neurological or musculoskeletal examination of TFO [BK], and Respondent again sat four to six feet away from him throughout the course of the meeting. (Tr. 267–68.)

(l) Dr. Borowsky's Evaluation Regarding Undercover Visits to Respondent

The Government's expert witness, Dr. Borowsky, reviewed Respondent's records relating to the undercover visits discussed above by TFO [JB] and TFO [BK], to determine whether Respondent complied with the standard of care in prescribing opioids. (Tr. at 408, 410.) In evaluating Respondent's conduct, Dr. Borowsky relied on the Arizona Medical Board Guidelines for the Use of Controlled Substances for the Treatment of Chronic Pain. He also relied on the Model Policy for the Use of Controlled Substances for the Treatment of Pain, published by the Federation of State Medical Boards. (Tr. 411–13.)

Dr. Borowsky found that Respondent's evaluation and treatment was nearly identical for both patients, and ''[t]he medical records showed no substantiation for a diagnosis, a plan, or a treatment with opioid medication . . ..'' (Tr. 416.) He further found that both patients presented as drug-seeking individuals due to their lack of insurance, complaints of zero pain on a pain scale, and lack of background history or documentation to support any claims of pain. (Tr. 418–19.) He testified that Respondent failed to acquire patient histories and that Respondent's documentation was both ''inappropriate'' and ''inadequate.'' (Tr. 421, 430.) Moreover, he testified that Respondent did not conduct any physical examination of TFO [BK] at either visit. (*See* Tr. 421–22.) With respect to TFO [JB], he found that Respondent did not conduct a physical examination on one visit, and that for the other visit Respondent's statement that ''I'm poking you'' did not constitute an adequate physical examination. (Tr. at 421–22.) Respondent moreover failed to conduct neurological or musculoskeletal examinations. (Tr. 422–23.) Respondent did not document an adequate treatment plan or plan for periodic review for either patient. (Tr. 424–28.) Respondent did not perform urinalysis or other drug screens on either patient. (Tr. 428.) Nor did he access the Arizona PMP. (Tr. 428.) Respondent did not consult with specialists. (Tr. 428.)

In sum, Dr. Borowsky credibly found that Respondent's prescription of controlled substances to TFO [BK] and TFO [JB] were not issued for a legitimate medical purpose. (*See* Tr. at 431.)

(m) Deaths of Three Individuals

(1) [CS]

Respondent's patient [CS] was born on June 26, 1968, and died on January 6, 2010. (Tr. 105; Gov't Ex. 8.) A PMP report shows that Respondent prescribed controlled substances to [CS] starting in approximately August 2008, with the most recent prescription on December 31, 2009 for 90 oxycodone 15 mg and 60 alprazolam 2 mg. (Tr. 106–07; Gov't Ex. 9.) The oxycodone prescription was filled on New Year's Eve; the alprazolam prescription was filled on January 2, 2010. (Tr. 107.) The PMP report indicates that Respondent saw [CS] monthly. (Tr. 108.)

According to an autopsy report, a bottle of oxycodone was found near [CS]'s body. (Gov't Ex. 10 at 2.) Respondent had recently prescribed oxycodone to [CS]. (Tr. 109.) The autopsy report listed the cause of death as ''Intoxication due to the combined effects of multiple prescription medications including oxycodone.'' (Gov't Ex. 10 at 1; Tr. 109.)

TFO Dean testified that he did not know the colors of various pills listed in

[15] As Respondent notes (Resp't Br. at 11 ¶ 37), TFO [BK]'s testimony about Simon Med is inconsistent with the transcript and recording of the second visit, which contain no reference to Simon Med. (Gov't Exs. 23 & 26.) I do not assign any weight to TFO [BK]'s testimony about Simon Med. I find, however, TFO [BK]'s other testimony to be generally credible and internally consistent. *See supra* text at note 14 (discussing similar issue).

the police report as present when [CS] died: calcium, folic acid, CVS vitamins, vitamin D and zinc. (Tr. 150–51.) Even carisoprodol, which is usually white, can be a different color depending on the brand. (Tr. 151; *see generally* Tr. 152; Gov't Ex 8 & 9.)

TFO Dean testified that Respondent was one of several doctors prescribing medication for [CS] shortly before her death, based on the PMP report. (Tr. 156; *see* Gov't Ex. 9.) Indeed, TFO Dean testified that Respondent was not the only doctor prescribing oxycodone and hydrocodone to [CS]. (Tr. 157–58; *see* Gov't Ex. 9 at 69.) TFO Dean testified that a patient who receives prescriptions for the same controlled substance from multiple doctors is an indication of diversion. (Tr. 170–71.)

[RF], Respondent's patient and fiancé of [CS], testified about the circumstances of [CS]'s death. Having known [CS] since 2006 and being generally aware of [CS]'s many medical problems, [RF] testified that he found it impossible that Respondent had anything to do with [CS]'s death. (Tr. 550–53, 555–56.) In the weeks before her death, [CS] suffered an injury to her ileostomy wound for which she did not seek treatment. (Tr. 558, 575.) On the day [CS] died, [RF] testified that [RF] did not see her take any medication nor does he recall seeing a bottle of oxycodone near [CS] when she died. (Tr. 561–62.) [RF] also testified that Respondent is a good doctor and that he did not observe anything unusual in Respondent's practice. (Tr. 566, 569.) I find [RF]'s testimony credible. His testimony was internally consistent and the witness was able to recall factual events with a reasonable level of certainty.

(2) B.R.

B.R. was born on February 14, 1985, and died on February 10, 2010. (Tr. 111, Gov't Ex. 11.) Investigators at the time of death found medications that Respondent prescribed. (Tr. 111.) In particular, investigators found a blue medication bottle with prescription number C255226 prescribed to Respondent's patient ''[TR],'' filled December 16, 2009, for alprazolam 2 mg tablets. (Tr. 112.) They also found two and one half white tablets imprinted with ''G3722,'' which is consistent with an alprazolam two milligram tablet. (Tr. 112.)

A PMP report reveals that Respondent wrote an alprazolam prescription to [TR] on November 19, 2009, which was filled on December 16, 2009. (Tr. 114; Gov't Ex. 12.) An autopsy of Mr. B.R.'s body revealed the presence of alprazolam. (Tr. 115; Gov't Ex. 15.)

On cross examination, TFO Dean conceded that neither he nor any agent interviewed Respondent's patient, [TR], at the time of Mr. B.R.'s death. (Tr. 164.) However, ''[h]e spoke with someone recently.'' (Tr. 164.) TFO Dean said he believed [TR] is no longer a patient of Respondent and stated that [TR] acquired prescriptions for controlled substances after Respondent's DEA COR was suspended. (Tr. 165–66.)

(3) [MC]

On November 27, 2009, [MC] was found dead in his house with foam coming out of his mouth. (Tr. 101, 137; Gov't Ex. 5.) Prescription bottles with Respondent's name on them were found near his body. (Tr. 101.) A PMP report confirmed that Respondent prescribed controlled substances to [MC]. (Tr. 98, 101; Gov't Ex. 5.)

In particular, [MC] ''received prescriptions for amphetamine salts in a 30-milligram tablet, oxycodone in a 30-milligram tablet. Also alprazolam in a two-milligram tablet.'' (Tr. 99.) On November 24, 2009, just days before he died, [MC] received ''70 alprazolam two-milligram tablets, 150 oxycodone 30-milligram tablets, and 35 amphetamine salt 30-milligram tablets.'' (Tr. 99–100.) These prescriptions constituted only minor variations from what Respondent prescribed to [MC] in the past. (Tr. 100.)

Substances present in [MC]'s blood at death included oxycodone metabolites, amphetamine, alprazolam and nordiazepam. (Tr. 103; Gov't Ex. 7.) TFO Dean testified that these substances were consistent with Respondent's prescriptions. (Tr. 103.) On cross examination, TFO Dean conceded that Respondent did not prescribe the diazepam. (Tr. 148; *see* Gov't Ex. 6.) Indeed, the PMP report did not show that [MC] had received diazepam, a controlled substance, from any doctor. (Tr. 148–49.)

[MC]'s house contained evidence that he abused cocaine or other drugs. (*See* Tr. 137–38.) There was a square piece of mirror on the armoire, with white powder residue and a red straw, and a credit card with white powder residue on it. (Tr. 141.) TFO Dean testified that this was consistent with both cocaine and also with smashing and snorting oxycodone and alprazolam. (Tr. 141–42.) Alprazolam is commonly snorted. (Tr. 142.) TFO Dean testified that he did not know what the white powdery substance in the bedroom was. (Tr. 142.)

In addition, the bedroom armoire contained several plastic baggies containing a white powdery residue that TFO Dean testified was consistent with drug sales and storage. (Tr. 142–43.) The small digital scales and syringes found near [MC] were also consistent with drug distribution. (Tr. 144.) TFO Dean testified that the substances in the white plastic baggies could have been a variety of substances, including substances Respondent did not prescribe. (Tr. 143.) Moreover, the white powdery substance was never tested. (Tr. 143.) TFO Dean conceded that the plastic baggies could have been the source of the white powder on the armoire. (Tr. 144.)

TFO Dean did not know when the bottles and partially used blister pack found near [MC] at death had been used. (Tr. 138.) TFO Dean also conceded that the police report of [MC]'s death was unclear as to whether any medication remained in the bottles labeled oxycodone 30 mg, alprazolam or amphetamine salts. (Tr. 139–40.)

TFO Dean also testified to being unfamiliar with a number of drugs that the police report listed as present near [MC]'s body: biobolt, undecyclenate and eltrenam. (Tr. 144–45.) The police report indicated that one of the drugs was indicated ''for veterinary use,'' which led TFO Dean to speculate it was not prescribed to an individual for his own use. (Tr. 145.) TFO Dean also conceded that [MC]'s housemates told the police that [MC] had some injuries. (Tr. 146.) Referring to the PMP report for [MC] (*see* Gov't Ex. 6), TFO Dean indicated that a prescription for Suboxone was prescribed by Michael Warren Carlton and not by Respondent. (Tr. 146.)

III. The Parties' Contentions

A. Government

The Government argues that Dr. Borowsky's testimony, which was unrebutted, establishes by a preponderance of the evidence that Respondent failed to act within the bounds of professional practice and issued controlled substances without a legitimate medical purpose, in contravention of the law, such as 21 C.F.R. § 1306.04 (2010). (Gov't Br. 23.)

The Government also highlights Dr. Borowsky's testimony. Analyzing whether Respondent conformed to Arizona practice standards, Dr. Borowsky testified that Respondent's medical records demonstrated no substantiation for a diagnosis plan or treatment with opioid medication. (Tr. 416.) Dr. Borowsky opined that Respondent's evaluation and treatment of undercover agents TFO [JB] and TFO [BK] posing as patients who exhibited drug-seeking behavior (Tr. 416; Gov't Ex. 18 at 130), ''was identical and exhibited no adherence to the Guidelines for Treatment of Chronic

Pain from the Arizona Medical Board.'' (Gov't Ex. 18 at 130.) With Respect to TFO [BK], for instance, Dr. Borowsky testified that Respondent should not have prescribed 120 Vicodin 10 mg. (Tr. 421.)

Moreover, the Government argues that Respondent performed no patient monitoring, indicated by the lack of drug screens or access to the Arizona PMP. (Gov't Ex. 18 at 130.) Respondent did not take a patient history, perform a physical examination, execute a treatment plan, provide informed consent and a treatment agreement, consult with specialists or maintain adequate and accurate medical records. (Gov't Ex. 18 at 130–31.)

The Government also argues that Respondent has failed to accept responsibility for his actions. (Gov't Br. at 26.) The Government notes that Respondent has failed to admit specific wrongdoing, and has merely made a blanket assertion of ''shortcomings.'' The Government finally argues that because the Government has made a prima facie case, the burden of proof shifts to Respondent, and Respondent has failed to demonstrate he will not engage in future misconduct.

B. Respondent

Respondent argues in defense that he is naïve. (Tr. 24.) While he concedes he was casual about documentation (*see* Tr. 24, 28–29), he argues he is not indifferent to drug abuse and diversion and has no state convictions. (Tr. 24.) Respondent argues that opening a new practice in August of 2009 was a ''learning experience'' (Tr. 25), which was a ''work in progress period.'' (Tr. 28.) Respondent argues that, over time, he has sought to improve his practice standards. For instance, Respondent terminated over 250 patients for failing drug screens or failing to produce health records. (Tr. 27; *see generally* Tr. 752.) Additionally, Respondent has accepted the Arizona Medical Board's requirement that he establish a monitoring program for his documentation. (Tr. 29.) Moreover, Respondent has started dictating his reports. (Tr. 28.) In any event, Respondent denies that the care of his patients was substandard. (Tr. 28.) He moreover argues that except as confirmed by the recordings and transcripts of TFO [BK]'s undercover visits, the testimony of TFO [BK] is not credible. (Resp't Br. at 11 ¶ 41.) In addition, Respondent contends that ''no reasonable conclusion can be drawn from the fact of [the] numbers or frequencies'' of controlled substances that Respondent prescribed. (Resp't Br. at 32.) Finally, Respondent argues that there is no causal connection between Respondent's prescribing practices and the deaths of [CS], B.R. and [MC]. (Tr. 27.)

III. Discussion and Conclusions

A. The Applicable Statutory and Regulatory Provisions

The Controlled Substances Act (CSA) provides that any person who dispenses (including prescribing) a controlled substance must obtain a registration issued by the DEA in accordance with applicable rules and regulations.[16] ''A separate registration shall be required at each principal place of business or professional practice where the applicant . . . dispenses controlled substances.'' [17] DEA regulations provide that any registrant may apply to modify his registration to change his address but such modification shall be handled in the same manner as an application for registration.[18]

''A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner'' with a corresponding responsibility on the pharmacist who fills the prescription.[19] It is unlawful for any person to possess a controlled substance unless that substance was obtained pursuant to a valid prescription from a practitioner acting in the course of his professional practice.[20] In addition, I conclude that the reference in 21 U.S.C. § 823(f)(5) to ''other conduct which may threaten the public health and safety'' would as a matter of statutory interpretation logically encompass the factors listed in § 824(a).[21]

In an action to revoke or deny a registrant's application for a DEA COR, the DEA has the burden of proving that the requirements for granting registration are not satisfied.[22] The burden of proof shifts to Respondent once the Government has made its prima facie case.[23]

B. Material Falsification of Application

The CSA, at 21 U.S.C. § 824(a)(1), provides, insofar as pertinent to this proceeding, that the Deputy Administrator may revoke a registration if an applicant or registrant ''has materially falsified any application filed pursuant to or required by this subchapter or subchapter II of this chapter.''

The evidence reflects that Respondent falsified his applications for renewal of his DEA registration on at least one occasion, by answering ''no'' to the liability questions, notwithstanding the fact that Respondent had previously had his medical license suspended in 2001. TFO Dean testified in substance that his investigation revealed Respondent falsified his application because the Arizona Medical Board previously investigated and suspended Respondent's medical license. (Tr. 85–86.) Respondent testified that he did not ''really have a good answer'' for why he said ''no'' on the re-registration form, ''other than I didn't pay much attention to the wording.'' Respondent maintained that he ''never tried to deceive anyone.'' (Tr. 760–61.)

The evidence also includes a September 21, 2010 sworn certification by Richard A. Boyd, Chief, DEA Registration and Support Section, stating in substance that he is the DEA official charged with custody and control of all documents relative to registration of practitioners, among others. Mr. Boyd certified that DEA registration ''BM2040498 was assigned to [Respondent] on *October 4, 1998,* that the last two renewals of this registration were issued to [Respondent] on *January 29, 2005,* at the address of Access2care Family Medical Center, 4607 N. 12th Street, Phoenix, Arizona 85014.'' (Gov't Ex. 28.) (emphasis supplied). Mr. Boyd further certified that Respondent answered ''background questions'' to include: ''3. Has the applicant ever had a state professional license or controlled substance registration revoked, suspended, denied, restricted, or place [sic] on probation, or is any such action pending? 'No'.'' (*Id.*)

The evidence also includes a June 30, 2010 sworn certification from Mr. Boyd, certifying that DEA registration ''BM2040498 was assigned to [Respondent] on or before *October 04, 1989* . . . [and the] last renewal of this registration was on *January 29, 2008.* . . . '' (Gov't Ex. 1.) (emphasis supplied). The evidence further includes a DEA Master Information Report for DEA Number BM2040498, reflecting a registration date of October

[16] 21 U.S.C. § 822(a)(2).

[17] 21 U.S.C. § 822(e).

[18] 21 C.F.R. § 1301.51 (2010).

[19] 21 C.F.R. § 1306.04(a).

[20] 21 U.S.C. § 844(a).

[21] *See Kuen H. Chen, M.D.,* 58 Fed. Reg. 65,401, 65,402 (DEA 1993).

[22] *See* 21 C.F.R. § 1301.44(d) (2010).

[23] *Medicine Shoppe—Jonesborough,* 73 Fed. Reg. 364, 380 (DEA 2008); *see also Thomas E. Johnston,* 45 Fed. Reg. 72,311, 72,311 (DEA 1980).

10, 1989, and last renewal date of January 29, 2008. (Gov't Ex. 1 at 2.)

Neither the testimony at hearing nor the post-hearing briefs addressed the date discrepancies between the two certifications, nor is it entirely apparent from the record evidence exactly what the correct dates should be. For example, the September 21, 2010 sworn certification indicates an assignment of registration on *October 4, 1998,* and then states the last two renewals were issued on *January 29, 2005.* Clearly the last two renewals were unlikely to both have been issued on the same date, which is also consistent with Respondent's testimony that he believes he last renewed his registration in 2008. (Tr. 795.) The information contained within the DEA Master Information Report is also consistent with Respondent's recollection. There is also an unexplained discrepancy regarding the registration assignment date, with one date listed as October 4, 1998 (Gov't Ex. 28) and the second listed as ''on or before October 04, 1989,'' (Gov't Ex. 1 at 2.) Again, the DEA Master Information Report (Gov't Ex. 1 at 2) suggests that the ten-year discrepancy between the initial registration dates listed in the two certifications may simply be a typographical error, but speculating on possible reasons for the errors offers little assurance about the reliability of either certification.

The issue of dates is certainly material, because the premise of the false statement allegation rests on when Respondent was first subject to a suspension that could serve as the predicate for a false statement. The record establishes that Respondent's first relevant suspension occurred in 2001. (*See* Gov't Ex. 3 at 4.) I find the inconsistencies and apparent errors in the two DEA certifications discussed above of sufficient consequence to preclude their use as substantial evidence for purposes of relevant dates.[24]

Accordingly, I do not assign any weight to Mr. Boyd's June 30, 2010 (Gov't Ex. 1 at 1) or September 21, 2010 (Gov't Ex. 28) certifications with regard to information as to Respondent's registration or re-registration dates.

The remaining record evidence, including the DEA Master Information Report (Gov't Ex. 1 at 2) and Respondent's testimony, does support a finding by substantial evidence that on one occasion in January 2008 Respondent materially falsified his application for re-registration, by failing to acknowledge a prior adverse action against his state medical license. A DEA COR may be revoked based on an unintentional falsification of an application, ''but lack of intent to deceive is a relevant consideration in determining whether a registrant or applicant should possess a DEA registration.'' *Rosalind A. Cropper, M.D.,* 66 Fed. Reg. 41,040, 41,048 (DEA 2001). The unrebutted record evidence reflects that on November 6, 2000, the Arizona Medical Board issued Respondent a Letter of Reprimand, a $5,000.00 fine and forty hours of continuing medical education (CME), among other restrictions. (Gov't Ex. 2 at 4.) On December 6, 2001, the same entity entered an order suspending Respondent's medical license for a period of twelve months, but stayed the suspension during a probationary period. (Gov't Ex. 3 at 4.) The gravamen of Respondent's misconduct was an instance of Respondent prescribing without first conducting a physical examination or establishing a physician-patient relationship with an undercover agent.

Respondent's history of state action regarding his medical license, as set forth below in further detail,[25] was sufficiently significant that he could not under any reasonable circumstances have answered the relevant background question in the negative. Respondent's brief explanation of the issue, including a claim of lack of intent to deceive, is not credible. Respondent's failure to disclose the relevant information was material because it had ''a natural tendency to influence, or was capable of influencing'' the decision to renew Respondent's registration. *Gilbert Eugene Johnson, M.D.,* 74 Fed. Reg. 65,663, 65,665 (DEA 2010). In fact, DEA renewed Respondent's registration in January 2008, a decision that relied in part on Respondent's false statement.

Accordingly, I find the Government has met its burden of proving a violation of Section 824(a)(1), *see* 21 CFR § 1301.44(d) (2010), placing the burden on Respondent to show that despite his material false statement, revoking his registration would be contrary to the public interest. *Medicine Shoppe—Jonesborough,* 73 Fed. Reg. 364, 380 (DEA 2008); *see also Thomas E. Johnston,* 45 Fed. Reg. 72,311, 72,311 (DEA 1980). I further find that for reasons set forth below, revoking Respondent's COR is in the public interest and substantial evidence supports revocation of Respondent's COR on the material falsification ground alone.

C. The Public Interest Standard

The CSA, at 21 U.S.C. § 824(a)(4), provides, insofar as pertinent to this proceeding, that the Deputy Administrator may revoke a COR if she finds that the continued registration would be inconsistent with the public interest as that term is used in 21 U.S.C. § 823(f).

Pursuant to 21 U.S.C. § 823(f), the Deputy Administrator may deny an application for a DEA COR if she determines that such registration would be inconsistent with the public interest. In determining the public interest, the Deputy Administrator is required to consider the following factors:

(1) The recommendation of the appropriate state licensing board or professional disciplinary authority.

(2) The applicant's experience in dispensing, or conducting research, with respect to controlled substances.

(3) The applicant's conviction record under federal or state laws relating to the manufacture, distribution or dispensing of controlled substances.

(4) Compliance with applicable state, federal or local laws relating to controlled substances.

(5) Such other conduct which may threaten the public health and safety.

As a threshold matter, the factors specified in Section 823(f) are to be considered in the disjunctive: the Deputy Administrator may properly rely on any one or a combination of those factors, and give each factor the weight she deems appropriate, in determining whether a registration should be revoked or an application for registration denied. *See David H. Gillis, M.D.,* 58 Fed. Reg. 37,507, 37,508 (DEA 1993); *see also D & S Sales,* 71 Fed. Reg. 37,607, 37,610 (DEA 2006); *Joy's Ideas,* 70 Fed. Reg. 33,195, 33,197 (DEA 2005); *Henry J. Schwarz, Jr., M.D.,* 54 Fed. Reg. 16,422, 16,424 (DEA 1989). Additionally, in an action to revoke a registrant's COR, the DEA has the burden of proving that the requirements for revocation are satisfied.[26] The burden of proof shifts to the registrant once the Government has made its prima facie case.

[24] I also note there is significant Agency precedent taking official notice of records of the Agency, to include filing of renewal applications. *See, e.g. East Main Street Pharmacy,* 75 Fed. Reg. 66,149, 66,152 (DEA 2010). The errors evidenced in the instant record, however, undermine any use of official notice to clarify this issue, because the record does not reveal whether the errors are due to preparation of the sworn certifications or whether the record checks of agency data on different dates produce different results.

[25] *Infra* Section III.D.

[26] 21 CFR § 1301.44(e) (2010).

D. The Factors to Be Considered

Factors 1 and 3: The Recommendation of the Appropriate State Licensing Board or Professional Disciplinary Authority and Conviction Record Under Federal or State Laws Relating to the Manufacture, Distribution or Dispensing of Controlled Substances

In this case, regarding Factor One, it is undisputed that Respondent currently holds a valid medical license in the State of Arizona, but Respondent's medical license has been the subject of state disciplinary action in the past. On November 6, 2000, the Arizona Medical Board, pursuant to a consent order, issued Respondent a Letter of Reprimand, a $5,000.00 fine and forty hours of CME, among other restrictions. (Gov't Ex. 2 at 4.) The stipulated findings of fact included an instance of Respondent prescribing without first conducting a physical examination or establishing a physician-patient relationship with an undercover agent of the Food and Drug Administration. (Gov't Ex. 2.) On December 6, 2001, the Board entered an order suspending Respondent for a period of twelve months, which was stayed during a probationary period. Respondent was further required to complete the requirements of the November 6, 2000 Board order. (Gov't Ex. 3.)

On August 11, 2010, pursuant to a consent order, the Board issued Respondent a Letter of Reprimand and two years' probation with terms and conditions to include Board pre-approved monitoring (periodic chart reviews) by a contractor. (Gov't Ex. 27 at 4–5.) The Board action was initiated ''after receiving a complaint regarding Respondent's care and treatment of five patients. During the Board's investigation, five patient charts were reviewed and deviations were found in all five.'' (Gov't Ex. 27 at 1.) The Board concluded Respondent's conduct constituted ''unprofessional conduct pursuant to A.R.S. § 32–1401(27)(e) ('[f]ailing or refusing to maintain adequate records on a patient.') and A.R.S. § 32–1401(27)(q) ('[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.').'' (*Id.* at 4.)

The most recent action by the Arizona Medical Board reflects a determination that Respondent, notwithstanding findings of unprofessional conduct, can be entrusted with a medical license subject to probationary terms and conditions. While not dispositive,[27] this action by the Arizona Medical Board does weigh against a finding that Respondent's continued registration would be inconsistent with the public interest. *See Robert A. Leslie, M.D.,* 68 Fed. Reg. 15,227, 15,230 (DEA 2003) (under Factor One, prior suspension of respondent's state medical license held not dispositive where state license currently under no restrictions).

Regarding Factor Three, there is no evidence that Respondent has ever been convicted under any federal or state law relating to the manufacture, distribution or dispensing of controlled substances. I therefore find that this factor, although not dispositive, weighs against a finding that Respondent's continued registration would be inconsistent with the public interest.

Factors 2 and 4: Respondent's Experience in Handling Controlled Substances; and Compliance With Applicable State, Federal or Local Laws Relating to Controlled Substances

(a) Respondent's Registered Location

Federal law requires every person who dispenses (including prescribing) any controlled substance to obtain a registration from the Attorney General.[28] Additionally, a separate registration must be obtained for each principal place of practice where a registrant dispenses controlled substances and a registrant must report any change of address by applying to modify his or her registration to change his or her address, which shall be treated as an application for registration.[29] The Code of Federal Regulations delineates the procedures a registrant must follow to request a change in registered address.[30]

In this case, the undisputed evidence indicates that Respondent's DEA registered address is ''Access2care Family Medical Center, 4607 N. 12th Street, Phoenix, Arizona 85014.'' (Gov't Ex. 28.) In or about August 2009, Respondent moved from that location to his current practice at 16601 N. 40th Street, Suite 115, Phoenix, Arizona. (Tr. 36, 90.) Respondent testified that he was unaware that he had to notify DEA when he moved to his new office. (Tr. 760.) In mitigation, Respondent explained that ''I called the Arizona Medical Board and gave them my change of address. I didn't know that I had to do anything more than that.'' (Tr. 760.)

Respondent's failure to properly request a change in registered location does not appear to have been done with intent to deceive, given the unrebutted testimony that Respondent notified the Arizona Medical Board of the change. It does, however, demonstrate Respondent's lack of compliance with applicable DEA regulations, weighing in favor of a finding that Respondent's continued registration would be inconsistent with the public interest.

(b) Deceased Patients [MC] and [CS]; B.R.

The evidence at hearing included information related to the deaths of two of Respondent's patients: [MC], who died on November 27, 2009; [CS], who died on January 6, 2010; and a non-patient, B.R., who died on February 10, 2010, in possession of a prescription issued to Respondent's patient [TR]. (Tr. 93.)

The documentary evidence with regard to patient [MC] consists of a police report, a PMP report for [MC], and an autopsy report. (Gov't Exs. 5–7.) The autopsy report lists the cause of death as accidental ''combined drug toxicity.'' (Gov't Ex. 7.) The findings of a toxicological report noted positive findings for the presence of: oxycodone, noroxycodone, oxymorphone, amphetamine, alprazolam and nordiazepam. (Gov't Ex. 7 at 6.) A Phoenix Police Department report noted that [MC] was found dead in his bedroom at home on November 27, 2009, and that located in an adjacent nightstand were three empty prescription bottles for oxycodone, alprazolam and cephalexin, with prescription labels in Respondent's name, dated between June 2009 and October 2009. (Gov't Ex. 5.) A partially used fifteen-count ''blister pack'' for omifin with two blisters remaining was also found. (*See* Tr. 128.) Also found at the foot of [MC]'s bed were prescriptions bearing Respondent's name dated November 24, 2009, for oxycodone, alprazolam and amphetamine salt. (Tr. 139–40.) Additionally, an empty prescription bottle of carisoprodol in Respondent's name was noted.[31] (Gov't Ex. 5 at 7.) The police report also noted that on top of an armoire in the bedroom rested a mirror with white powder residue, along with a red straw and credit card. (Tr. 137–8, 141.) Inside the armoire were numerous small plastic bags, several of which contained white

[27] *Mortimer B. Levin, D.O.,* 55 Fed. Reg. 8209, 8210 (DEA 1990) (finding DEA maintains separate oversight responsibility and statutory obligation to make independent determination whether to grant registration).

[28] 21 U.S.C. § 822(a)(2).

[29] 21 U.S.C. §§ 822(e), 827(g); 21 C.F.R. § 1301.51 (2010).

[30] *See* 21 C.F.R. § 1301.51 (2010).

[31] The spelling in the police report of Respondent's name as ''Dr. Moher,'' (*see* Gov't Ex. 5 at 7), appears to be a typographical error.

powder residue and digital scales, among other items. (Tr. 142–43.)

TFO Dean testified that he did not participate in the investigation pertaining to [MC]'s death, other than having a few conversations with detectives at the Phoenix Police Department. (Tr. 95.) TFO Dean further testified that he was unaware of what the white powdery substance was, but the items found in the bedroom were consistent with buying, selling and storing drugs. (Tr. 143.) TFO Dean also opined that the mirror, white powder residue, straw and credit card were consistent with drug use, common to cocaine use and ''also common to the process of smashing up oxycodone or alprazolam, and using those to snort drugs.'' (Tr. 141–42.) TFO Dean also testified that the PMP report confirmed that Respondent prescribed controlled substances to [MC] just prior to [MC]'s death, but the report did not reflect any prior prescriptions for diazepam. (Tr. 148–49.)

The documentary evidence with regard to patient [CS] consists of a police report, a prescription history report and an autopsy report. (Gov't Exs. 8–10.) The January 8, 2010 autopsy report found cause of death to be ''[i]ntoxication due to the combined effects of multiple prescription medications including oxycodone.'' (Gov't Ex. 10 at 1.) The report also noted a history of Crohn's disease and depression, and a ''bottle of oxycodone, found in close proximity to her, appeared to have been taken at an accelerated rate.'' (*Id.* at 2.) A PMP history report covering the time period January 1, 2008 to March 8, 2010, reflects that [CS] was prescribed multiple controlled substances by multiple practitioners, including Respondent. (Gov't Ex. 9.) A Tempe, Arizona Police Department report dated January 6, 2010, reflects that [CS] was found unresponsive at home by her fiancé, [RF]. (Gov't Ex. 8 at 2.) It further notes that [CS] suffered from numerous medical conditions including Crohn's disease, and had been complaining of a fever and hip pain. (Gov't Ex. 8 at 2.) Contrary to the autopsy report, the police report does not reflect any notations regarding a bottle of oxycodone found in close proximity to [CS] or evidence that it was taken at an accelerated rate. (Tr. 161. *Compare* Gov't Ex. 10 at 2, *with* Gov't Ex. 8.)

Respondent presented the testimony of [CS]'s fiancé, [RF], regarding the circumstances of [CS]'s death. [RF] testified in substance that he had known [CS] since 2006, and is himself a patient of Respondent. (Tr. 550–51.) [RF] testified to a number of medical problems that [CS] had experienced and found it impossible that Respondent's care had anything to do with her death. (Tr. 552–53, 555–56.) [RF] testified that [CS] had been ''unusually sick'' a couple of weeks prior to her death and that she had had an altercation with a police officer, to include an injury to her ileostomy wound. (Tr. 558.) [RF] testified that [CS] did not seek any medical attention as a result of the altercation. (Tr. 556, 575.) [RF] further testified that on the day of [CS]'s death he did not see her take any medications and does not recall seeing a bottle of oxycodone anywhere in proximity to [CS] at the time of her death. (Tr. 561–62.) [RF] also testified that in his experience Respondent is a good doctor, and he has not observed anything unusual at Respondent's practice. (Tr. 566, 569.)

The documentary evidence regarding the death of B.R. on February 10, 2010, includes a police report, an autopsy report and a PMP report for prescriptions issued to [TR]. (Gov't Exs. 11–13.) The evidence at hearing reflected that Mr. B.R. was not a patient of Respondent, but an empty medication bottle bearing prescription number C255226 and prescribed by Respondent to patient [TR] on December 16, 2009, for 70 alprazolam [32] 2 mg tablets was found near Mr. B.R.'s body. (Tr. 112.) Other items found in the vicinity included empty beer bottles, short straws, a rolled up one dollar bill with white residue inside and a plastic baggie containing two and one half pills, identified in the police report as alprazolam 2 mg tablets. (Gov't Ex. 11; Tr. 93, 112–13.) A PMP report for patient [TR] reflects a prescription for 70 alprazolam 2 mg tablets written by Respondent on November 19, 2009, with a fill date of December 16, 2009. (Gov't Ex. 12.) A February 11, 2010 autopsy report for B.R. listed the cause of death as accidental acute opiate, benzodiazepine and alcohol intoxication. (Gov't Ex. 13.)

Respondent argues that the Government has not proven by a preponderance of the evidence that the deaths of two patients and a third person stem from Respondent's prescribing practices.[33] In fact, no evidence was presented at hearing involving any of the foregoing patients' medical files, nor did either party offer testimony or other evidence of specific facts surrounding Respondent's prescribing practices with regard to patients [TR], [CS] or [MC]. The expert testimony offered at hearing related to only the patient records of two law enforcement undercover agents posing as patients. I find that the Government has not established by a preponderance of the evidence that Respondent's prescribing practices caused the foregoing deaths. For example, the evidence relating to the death of patient [CS] and the linkage to one oxycodone prescription cited in an autopsy report was directly contradicted by the sworn testimony of [RF], corroborated by the relevant police report. (*Compare* Gov't Ex. 10 at 2, *with* Tr. 561–62, *and* Gov't Ex. 8.) In the case of patient [MC], there is evidence that the cause of death was accidental and due to a combination of drugs, (Gov't Ex. 7 at 1), and other evidence found in the vicinity of [MC]'s body is consistent with the buying, selling and storage of drugs, (Tr. 143). Yet there was no evidence or testimony offered at hearing related to Respondent's prescribing or treatment of patient [MC]. The evidence regarding patient [TR] and the death of Mr. B.R. is even more tenuous in terms of linking the cause of death to Respondent's prescribing practices.

With regard to all three decedents, there is no evidence of record, such as, for example, relevant medical files, sufficient to determine and evaluate Respondent's prescribing practices with regard to the three deaths. Making a finding that Respondent's prescribing practices caused the deaths of these decedents, therefore, would require engaging in pure speculation. ''Speculation is, of course, no substitute for evidence, and a decision based on speculation is not supported by substantial evidence.'' *White ex rel. Smith v. Apfel,* 167 F.3d 369, 375 (7th Cir. 1999) (citing *Erhardt v. Sec'y, DHS,* 969 F.2d 534, 538 (7th Cir. 1992)). I find there is insufficient evidence to conclude that Respondent's prescribing practices caused the deaths of these decedents. This finding weighs against a finding that Respondent's continued registration would be inconsistent with the public interest.

Although the evidence regarding the foregoing decedents does not support a finding that Respondent's prescribing practices caused their deaths, the evidence with regard to patient [MC] does reflect varying degrees of drug misuse or acts of diversion by Respondent's patient, at least as of November 2009. I find this evidence is consistent with other record evidence, including Respondent's testimony, that Respondent's prescribing practices during the same time period were significantly deficient in terms of

[32] Alprazolam is a benzodiazepine and Schedule IV depressant. *See* 21 C.F.R. § 1308.14(c) (2010); *infra* note 46.

[33] Resp't Br. at 33–37.

properly supervising his patients to prevent them from abusing or diverting controlled substances.

(c) Respondent's Prescribing Practices

The OSC/IS alleged that Respondent prescribes and dispenses inordinate amounts of controlled substances, primarily hydrocodone compounds, Schedule III controlled substances, among others, under circumstances where Respondent knows or should know the prescriptions are not for legitimate medical purposes or are issued outside the course of usual professional practice. (ALJ Ex. 1.)

To be effective, and lawful, a prescription for a controlled substance ''must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice . . . An order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription . . . and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.'' [34]

Revocation of an existing registration under the public interest standard of 21 U.S.C. § 823(f) is not limited to practitioners who intentionally violate the prescription requirement, but also includes a ''practitioner's failure to properly supervise her patients to prevent them from personally abusing controlled substances or selling them to others . . .'' *Jeri Hassman, M.D.,* 75 Fed. Reg. 8194, 8227 (DEA 2010). A practitioner must also ''have established a bona fide doctor-patient relationship with the individual for whom the prescription is written.'' *Mohammed F. Abdel-Hameed, M.D.,* 66 Fed. Reg. 61,366, 61,369 (DEA 2009). As to the issue of a bona fide doctor-patient relationship, the CSA looks to state law in determining whether a physician has established a valid doctor-patient relationship. *United Prescription Servs., Inc.,* 72 Fed. Reg. 50,397, 50,407 (DEA 2007).

The evidence at hearing regarding Respondent's prescribing practices included testimony from Dr. Stephen Borowsky, offered by the Government as an expert in pain management. Dr. Borowsky's testimony and related written report (Gov't Ex. 18) centered on his review of two patient files (Gov't Ex. 15 & 16) involving four undercover law enforcement visits to Respondent in November and December 2009. (*See also* Gov't Exs. 17 & 18.) Dr. Borowsky's experience includes board certification in pain medicine, among other specialties, and includes approximately thirty years of experience. (Tr. 378–79.) Dr. Borowsky has practiced in Arizona since 1980 and he has served on several task forces for the Arizona Legislature related to chronic pain. Additionally, Dr. Borowsky participated in the development of Arizona's Prescription Monitoring Program and at the time of hearing was involved in the care of approximately twenty pain patients per week on the one day per week that he saw pain patients. (Tr. 382–86.) Although Respondent timely objected to the witness's qualifications ''as a pain management expert in the primary care level,'' (Tr. 395–96), I have evaluated his testimony as an expert witness in pain management. Dr. Borowsky is clearly qualified to testify as an expert with regard to the standard of care and treatment of patients with pain management issues, based on his education, training and experience over thirty years. Dr. Borowsky's testimony at hearing was internally consistent and fully credible.

Dr. Borowsky testified in substance on direct examination that prior to being contacted by DEA he had no familiarity with Respondent. (Tr. 408). Dr. Borowsky further testified that he was asked to review two patient files in the name of [KR] and [BK] to determine how the records fit with established guidelines for prescribing opiates. (Tr. 410; *see* Gov't Exs. 15 & 16.) The evidence also included a written report prepared by Dr. Borowsky discussing his findings and opinion on review of the two patient files. (Gov't Ex. 18.)

Dr. Borowsky next testified to his conclusions regarding the [KR] and [BK] medical files, corresponding to undercover visits by TFO [JB] and TFO [BK]. With regard to both files, Dr. Borowsky's concluded that the ''records showed no substantiation for a diagnosis, a plan, or a treatment with opioid medication . . . .'' (Tr. 416.) Additionally, Dr. Borowsky opined that Respondent obtained no patient history in either case and conducted no appropriate physical examination. (Tr. 418–22.) Dr. Borowsky further opined that Respondent issued prescriptions for controlled substances to both patients without a legitimate medical purpose. (Tr. 431.)

On cross examination, Dr. Borowsky testified that over the past ten years perceptions of pain management have changed. (Tr. 435.) The term pseudo-addiction means a patient is undertreated with medication and may appear drug seeking, but really requires more medication. (Tr. 435–36.) Dr. Borowsky further testified that treatment of a pseudo-addict requires a rational understanding of the situation rather than just prescribing more medication. (Tr. 437.) Dr. Borowsky also testified that he routinely uses drug screens when prescribing controlled substances (Tr. 440) and only takes cases by referral. (Tr. 445.) Within the standard of care for prescribing opioids, he advised, there is room for individual decisions. (Tr. 458–59.)

The testimony from two undercover law enforcement agents, TFO [JB] and TFO [BK], who posed as patients [KR] and [BK], was fully consistent with Dr. Borowsky's findings. For example, TFO [JB] testified in substance that she met with Respondent at his office for an initial medical appointment on November 13, 2009, and again on December 18, 2009. During the November 13, 2009 initial visit, TFO [JB], posing as patient [KR], met with Respondent for approximately ten minutes, which included Respondent taking a telephone call. (Tr. 207.) TFO [JB] testified that she had marked zero for pain on a patient intake form and at no time during the visit was her pulse, heart rate, height, weight or blood pressure checked, nor was she given a urinalysis drug screen. (Tr. 209–09, 223.) TFO [JB] further testified that Respondent did not discuss a treatment plan, and the only incident arguably consisting of a physical examination occurred at the end of the visit, *after Respondent had already indicated his decision to prescribe controlled substances.*[35] (Tr. 214–15, 246.) The physical examination, such as it was, consisted of asking TFO [JB] to lie on her stomach after which Respondent proceeded to touch her back in several places, ask if it hurt and move her right foot and ankle.[36] (Tr. 215.) As a result of the visit, Respondent prescribed 70

[34] 21 C.F.R. § 1306.04(a) (2010).

[35] Because Respondent had already decided to prescribe controlled substances before he palpitated TFO [JB]'s back, I reject Respondent's argument that Respondent should be credited on the grounds that he did not give TFO [JB] a prescription ''until after the examination . . . .'' (Resp't Br. at 8 ¶ 27.)

[36] There is also evidence relating to a sexual harassment claim against Respondent, (*see, e.g.,* Tr. 62, 67, 217), and Respondent's ''flirting'' and related conduct with patients such as TFO [JB] (*see, e.g.,* Tr. 210, 214–15, 234–36, 246), [JG] (*see* Tr. 188–89, 198) and [LW] (*see* Tr. 217). *See generally* Tr. 264. Respondent and other witnesses testified in substance that Respondent ''flirts'' with many patients, as a ''joke,'' which is how he puts patients ''at ease.'' Inasmuch as this issue was not sufficiently noticed in the OSC/IS, and given its tenuous relevance to the central issues alleged in this case, I do not make any specific factual findings or conclusions with regard to the conflicting testimony. *See, e.g., CBS Wholesale Distribs.,* 74 Fed. Reg. 36,746, 36, 749 (DEA 2009) (discussing notice requirements before relying on given fact in revoking DEA COR).

oxycodone 30 mg tablets. In partial mitigation, Respondent gave TFO [JB] a warning, in an apparent effort to encourage TFO [JB] to protect herself from theft:

these medications . . . there's a high street value for them . . . it's not a good idea for you to tell your friends that you're taking these medications because [even] your mother will take them from you . . . oxycontins . . . go like anywhere from like 40 to 80 dollars a pill . . . So there's a huge street value. People are always stealing them. So be careful. Uh because if you lose your medications, even if you have a police report, can't get em. Once a month is all you can get.

(Gov't Ex. 21 at 147–48.) In addition, Respondent's statement that ''once a month is all you get'' (*Id.*) is evidence that Respondent did take some steps to manage his patients and guide them away from abuse or diversion.

Similar to the testimony of TFO [JB], TFO [BK] testified in substance that he met with Respondent on November 18, 2009, and again on December 23, 2009, posing as patient [BK]. On his initial office visit, which lasted approximately five to ten minutes, TFO [BK] marked zero for pain on an intake form. (Tr. 257.) Additionally, TFO [BK] provided no prior medical records. (Tr. 258.) TFO [BK] further testified that during the visit he received no examination of any kind, and Respondent gave him a prescription for 120 Vicodin 10–325 tablets. (Tr. 256, 258, 267.)

The testimony of TFO [JB] and TFO [BK], as summarized above, was internally consistent, corroborated by objective evidence including recordings and related transcripts, and I find it fully credible.[37] This testimony and evidence is moreover consistent with the opinion testimony of Dr. Borowsky.

Respondent's behavior during the undercover visits bears heavily upon whether his continued registration would be inconsistent with the public interest. Respondent's conduct during the second undercover visit by TFO [BK] tends to show that Respondent recognized it would be improper to issue a prescription to TFO [BK] without proof of injury or past medical records.[38] (*See* Tr. 287, 290; *see also* Gov't Ex. 22 at 162 (transcribing Respondent's statement that TFO [BK] should seek another doctor).) Respondent even offered to refund TFO [BK]'s money, stating that ''I'm not going to write you narcotics knowing that you've already told me that there's nothing wrong with you.'' (Gov't Ex. 23 at 173; Tr. 287–88, 294.) Nevertheless, Respondent issued TFO [BK] a second prescription for controlled substances anyway. The fact that Respondent terminated TFO [BK] as a patient that same day (Tr. 295) evinces Respondent's recognition that he acted improperly in prescribing controlled substances to TFO [BK].

Moreover, the transcript of TFO [BK]'s second visit to Respondent suggests that Respondent's professed concerns regarding proof of injury were motivated less by a desire to prevent the diversion of controlled substances than by his concern that he might lose his license. (Gov't Ex. 23; *see also* Tr. 299.)

At hearing, counsel for Respondent focused on Respondent's apparent concern for TFO [BK]'s wellbeing, indicating the need for a referral to a primary care physician to test for serious medical conditions (*see* Tr. 289–91), and Respondent's statement that Respondent was just ''giving you a chance to get over this pain . . ..'' (Gov't Ex. 22 at 165; *see also* Tr. 289.) Respondent's sincerity, however, is undercut by the fact that he never made any such referrals to TFO [BK]. (Tr. 299–300.)

The evidence at hearing also included a document referred to as the Arizona Medical Board Guidelines for the Use of Controlled Substances for the Treatment of Chronic Pain (Guidelines),[39] as well as a second document entitled Model Policy for the Use of Controlled Substances for the Treatment of Pain (Model Policy). (Gov't Exs. 19 & 20.) Dr. Borowsky testified that he relied on both documents in preparing his written report. The Guidelines reflect a substantive policy statement that is advisory only, developed by the Arizona Medical Board pursuant to Arizona statutory authority. (Gov't Ex. 19 at 1.) The standards reflected in the Guidelines include a pain assessment, treatment plan, ongoing assessment, consultation and documentation, as well as counting and destroying medication, among other guidance. (*Id.*) Additionally, the Guidelines exhort physicians to comply with all applicable laws in the prescribing and dispensing of controlled substances.

Under Arizona law, for instance, grounds for disciplinary action include ''[u]nprofessional conduct'' further defined as ''[f]ailing or refusing to maintain adequate records on a patient'' or ''[p]rescribing, dispensing or furnishing a prescription medication . . . to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship.'' [40] Ariz. Rev. Stat. §§ 32–1401(27)(e) & (ss). There is substantial evidence of record that Respondent's prescribing practices during the relevant time periods were contrary to applicable Arizona law.

Respondent's testimony at hearing did not significantly contradict the foregoing evidence. In fact, Respondent concedes in his post-hearing brief that ''his practice documentation and patient screening/compliance monitoring needed improvement'' from September 2009 through early January 2010.[41] Respondent maintains, in essence, that because he acknowledges his past misconduct and has been making improvements to his practice between January 2010 and the date of his immediate suspension, Respondent's DEA registration would not be inconsistent with the public interest.

Respondent testified in substance that he has been practicing medicine for approximately thirty years, working as a family practitioner for someone else. (Tr. 40.) In August 2009, Respondent opened his own solo-family practice, seeing approximately 200–300 patients per month. (Tr. 36, 37.) Respondent further testified that he does not have any training or certifications in pain management. (Tr. 36.) Respondent admitted that there were certain things he did not know about pain

[37] As noted above, I do not assign any weight to TFO [BK]'s assertions that Respondent suggested he go to Simon Med. *See supra* text at notes 14 & 15.

[38] Respondent also failed to require medical records before prescribing controlled substances to TFO [JB]. (Tr. 219, 247.)

[39] At hearing, counsel for Respondent suggested during cross examination that in 2004 the Arizona Medical Board adopted ''not [a] materially, hugely different—but a different set of Guidelines from the one that [the Government] presented . . . .'' (Tr. 474.) But this statement by counsel is not testimony, and in any event, counsel did not produce any alternative version of the Guidelines.

[40] The OSC/IS alleges violations of Ariz. Rev. Stat. §§ 32–1401(27)(a), (q) and (ss). Moreover, the parties addressed the issue of unprofessional conduct at hearing. (*See, e.g.,* Tr. 87, 93; Gov't Ex. 2.) In any event, I take official notice of Ariz. Rev. Stat. § 32–1401(27). Under the Administrative Procedure Act (APA), an agency ''may take official notice of facts at any stage in a proceeding—even in the final decision.'' U.S. Dept. of Justice, *Attorney General's Manual on the Administrative Procedure Act* 80 (1947) (Wm. W. Gaunt & Sons, Inc., Reprint 1979). In accordance with the APA and DEA's regulations, Respondent is ''entitled on timely request, to an opportunity to show to the contrary.'' 5 U.S.C. § 556(e); 21 C.F.R. § 1316.59(e); *see, e.g., R & M Sales Co.,* 75 Fed. Reg. 78,734, 78,736 n.7 (DEA 2010). Respondent can dispute the facts of which I take official notice by filing a properly supported motion for reconsideration within twenty days of service of this Recommended Decision, which shall begin on the date it is mailed. *See, e.g., Joseph Gaudio, M.D.,* 74 Fed. Reg. 10,083, 10,088 (DEA 2009) (granting Respondent opportunity to dispute officially noticed facts within fifteen days of service).

[41] Resp't Br. 30–31.

management, but once informed of these things, he began making improvements in or around December 2009 to January 2010. (Tr. 51). Respondent further testified that after starting his new practice he began to realize the difficulty of managing pain patients ''finding it difficult to comprehend the deceit of many'' patients. (Tr. 756.) As a result of these efforts, Respondent testified that during a period of from December of '09 until May of 2010, I tried to rid my practice of patients that were potential drug seekers as best I could. And in the process, I discharged 264 patients. The reasons were from selling drugs, using medications that weren't prescribed by me, multiple doctor shopping, using the pharmacy monitoring program, use of illicit drugs and drug screens where they came positive for cocaine or methamphetamine, and tried my best to make sure that my patients were compliant with the treatment plan that they were under.
(Tr. 757.)

The evidence also included the testimony of TFO Baldwin, who credibly testified to an interview with [JG], who admitted that she is addicted to drugs, primarily oxycodone, and sees Respondent on a monthly basis. [JG] also admitted that she and her boyfriend ''do sell their pills to pay their bills, get gas, etcetera.'' (Tr. 187.) On cross examination, TFO Baldwin further testified that he did not specifically ask [JG] if she told Respondent she was selling her medications. When asked if Respondent knew, however, [JG] responded that Respondent ''should know'' because ''half the patients in there are just like me.'' (Tr. 196.) I find the statements attributed to [JG] to be generally credible, because they are consistent in part with other credible evidence, including Respondent's testimony. That said, TFO Baldwin did not elicit a specific time frame during direct or cross examination as to when the statement from [JG] was taken, or the time frame that [JG] interacted with Respondent. TFO Baldwin's testimony regarding [JG] therefore provides some weight, but not full weight, in favor of a finding under Factors Two and Four that Respondent's continued registration would be inconsistent with the public interest.

The Government further presented testimony from IRS Stone relating to an analysis of Respondent's prescribing from August 1, 2009 to March 31, 2009. The evidence of record also includes three charts prepared by IRS Stone summarizing information received from the Board of Pharmacy pertaining to prescriptions for controlled substances issued by Respondent. (Gov't Ex. 14; Tr. 303–04.) The first chart reflects a total number of prescriptions written by Respondent during the stated time period to be 9411, including 5126 prescriptions for oxycodone and 3230 for benzodiazepine. The second chart provided a more detailed breakdown by percentage and tablet count, finding 681,590 tablets of oxycodone prescribed and 208,318 tablets of benzodiazepine prescribed during the relevant eight-month time period. The third chart analyzes the prescription numbers by patients, rather than drugs. (*See generally* Gov't Ex. 14 at 1–3.)

No other testimony or evidence was offered at hearing to provide context for the numbers of prescriptions and tablets issued by Respondent, or any reference point for past prescribing by Respondent; nor did either party offer evidence of comparative prescribing practices of similarly situated pain management practitioners. The evidence does support by substantial evidence the allegation in the OSC/IS that Respondent dispensed ''primarily hydrocodone compounds,'' among others. Beyond that, however, the record evidence does not provide sufficient comparative analysis to support by substantial evidence the allegation in the OSC/IS that Respondent prescribed and dispensed ''inordinate amounts of controlled substances.'' In the absence of a methodology including a base-line or other reliable comparative number, IRS Stone's numbers standing alone do not prove by a preponderance of the evidence that Respondent prescribed and dispensed inordinate amounts of controlled substances. *See Mr. Checkout North Texas,* 75 Fed. Reg. 4418, 4422 (DEA 2010) (finding that an unreliable methodology is not substantial evidence that respondent distributed excessive quantities of listed chemicals); *see also CBS Wholesale Distributors,* 74 Fed. Reg. 36,746, 36,749 (DEA 2009) (rejecting allegation that respondent sold excessive quantities of ephedrine products where Government expert did not provide ''the underlying documentation necessary to support this critical component of his testimony'').

Respondent's conduct during the relevant time period with regard to factors Two and Four weigh heavily in favor of revocation. Respondent's admission that he was not aware of the difficulties relating to pain management, and that once informed, began to take corrective steps, understates the evidence. Dr. Borowsky, the only expert witness to testify in this case, concluded after reviewing two of Respondent's patient files relating to four undercover visits, that Respondent prescribed controlled substances without a legitimate medical purpose. (Tr. 431.) The absence of documentation, including a diagnosis, plan or physical examination, formed in part the basis for Dr. Borowsky's opinion. (Tr. 416, 418–19, 421, 430.) Additionally, the fact that Respondent discharged over 250 patients between December 2009 and May 2010 for reasons such as ''doctor shopping,'' ''selling drugs'' and ''use of illicit drugs,'' among other reasons (*see e.g.,* Tr. 752, 757), is fully consistent with a finding that Respondent's experience in handling controlled substances and compliance with applicable law was substantially deficient on numerous occasions.[42] ''A practitioner's failure to properly supervise her patients to prevent them from personally abusing controlled substances or selling them to others constitutes conduct 'inconsistent with the public interest' and can support the denial of an application or the revocation of an existing registration.'' *Jeri Hassman, M.D.,* 75 Fed. Reg. 8194, 8227 (DEA 2010).

Under agency precedent, in the absence of a credible explanation by the practitioner, as few as two incidents of diversion are sufficient to revoke a registration. *Alan H. Olefsky, M.D.,* 57 Fed. Reg. 928, 929 (DEA 1992). In this case, Respondent maintains he began making changes to his practice in late 2009 and early 2010. Respondent testified that he learned about the PMP from the owners of a pharmacy in late 2009 and began implementing the monitoring in January 2010. (Tr. 768.) He testified that he implemented drug screening in February 2010. (Tr. 805.) Respondent's testimony on cross examination was only partially credible and at times inconsistent. For example, with regard to patient ''[SH]'' Respondent testified that he found the patient ''compliant'' notwithstanding a negative urine test for a prescribed controlled substance. (Resp't Ex. 5 at 34; Tr. 806, 818–19.) Respondent explained that by ''compliant'' one must ''look at it in a different light . . . you do have relapses. It's part of the management of a patient.'' (Tr. 819–19.) Respondent provided no credible explanation for the lack of a subsequent drug screen.

There is additional evidence of record reflecting inconsistencies with regard to Respondent's claim that he made substantial improvements to his practice but further elaboration is unnecessary. The weight of the evidence as a whole demonstrates that under Factors Two

[42] Evidence of diversion by Respondent's patients [MC] (*see* Tr. 137–38, 141–44) and [TR] (*see* Tr. 12, 14; Gov't Ex. 12) bolsters this conclusion.

and Four, Respondent's continued registration would be inconsistent with the public interest.

Factor 5: Such Other Conduct Which May Threaten the Public Health and Safety

As to factor five, ''Respondent's lack of candor and inconsistent explanations'' may serve as a basis for denial of a registration. *John Stanford Noell, M.D.,* 59 Fed. Reg. 47,359, 47,361 (DEA 1994). Additionally, where a registrant has committed acts inconsistent with the public interest, the registrant must accept responsibility for his or her actions and demonstrate that he or she will not engage in future misconduct. *Patrick W. Stodola,* 74 Fed. Reg. 20,727, 20,734 (DEA 2009).[43] Also, ''[c]onsideration of the deterrent effect of a potential sanction is supported by the CSA's purpose of protecting the public interest.'' *Joseph Gaudio, M.D.,* 74 Fed. Reg. 10,083, 10,094 (DEA 2009).

As an initial matter, I find that with the exceptions and inconsistencies noted above,[44] Respondent has displayed at least some degree of candor before this tribunal. For instance, he has acknowledged his failure to update the address of his current practice location with the DEA. (Tr. 760, 795.) Moreover, Respondent at times conceded that his practice documentation and patient compliance monitoring needed improvement.

This degree of candor, however, does not equate to a complete acceptance of responsibility for the full range of his misconduct embraced within the Government's prima facie case. Respondent testified at hearing that he is ''sorry for the shortcomings'' and requests that he be allowed to ''continue with the medical management of uncomplicated pain patients.'' (Tr. 758; *see also* Resp't Br. at 43.) But Respondent's testimony as a whole demonstrates that he does not fully accept responsibility for his actions nor has he demonstrated that he will not engage in future misconduct. Notably, at the time of hearing, due to stated financial difficulty, Respondent was ''in the process'' of putting in place the monitoring program required by the Arizona Medical Board. (Tr. 63; *see* Gov't Ex. 27 at 4.) A more compelling demonstration of acceptance of responsibility might have included a showing that a monitoring program is firmly in place. Instead, the absence of such a program required by order of the Arizona Medical Board, raises concerns that Respondent may engage in future misconduct.

In any event, Respondent's interactions with undercover investigators posing as patients highlight the risks to the public were Respondent's COR to be reinstated. The theme that emerges from these undercover visits is Respondent's awareness of diversion potential coupled with an indifference to diversion. For example, TFO [BK] testified, and a transcript corroborates, that Respondent told TFO [BK] that Respondent has some patients who get drugs off the street, and ''I don't care whether you are [one of them] or not, I have patients that do that . . . .'' (Gov't Ex. 22 at 162.) Even construed in a light most favorable to Respondent, this testimony evinces an indifference to diversion that is fundamentally at odds with the requirements and purpose of the CSA.

The record further reflects that Respondent told TFO [BK] that it is more expensive to buy drugs off the street than at a pharmacy, and that therefore, some of Respondent's patients come to him to be evaluated and obtain prescriptions at a lower price. (Tr. 263.) This statement by Respondent demonstrates an acceptance, if not an outright facilitation, of diversion. Under agency precedent, revocation of an existing registration under the public interest standard of 21 U.S.C. § 823(f) may be founded upon a ''practitioner's failure to properly supervise her patients to prevent them from personally abusing controlled substances or selling them to others . . .'' *Jeri Hassman, M.D.,* 75 Fed. Reg. 8194, 8227 (DEA 2010). Respondent's statements, especially his statement that he did not care if patients bought drugs off the street (Gov't Ex. 22 at 162), constitutes a failure by Respondent ''to properly supervise . . . patients to prevent them from personally abusing controlled substances or selling them to others . . . .'' *Hassman,* 75 Fed. Reg. at 8227. More troubling still is that indications of Respondent's indifference to or outright facilitation of diversion are corroborated by other evidence of record, including statements attributable to [LW] (*see* Tr. 217) (indicating that Respondent never asked patient [LW] for proof of injury before prescribing controlled substances, and that [LW] sent several patients to Respondent to get prescriptions to sell on the street), and [JG] (*see* Tr. 187, 196) (indicating that patient [JG] routinely sells pills on the street, and that ''half the patients in [Respondent's practice] are just like me'').

Moreover, Respondent's interactions with TFO [JB] and TFO [BK] indicate an awareness of and indifference to Respondent's failures to comply with Arizona standards of professional medical practice. For example, TFO [JB] testified that on the second occasion that Respondent prescribed controlled substances to TFO [JB] without requiring proof of injury or patient medical records, Respondent stated that ''if he were to continue to prescribe to me, I would need to get proof of injury because he was in danger of losing his license.'' (Tr. 220; *see* Tr. 244.) Even if I were to fully credit Respondent's testimony that his act of prescribing controlled substances without proof of injury or medical documentation was founded upon Respondent's compassion for his patients, Respondent's conduct would nevertheless constitute a departure from the Arizona standards of practice identified by Dr. Borowsky and supported by documentary evidence.

The record also reflects that during the same undercover visit by TFO [JB], Respondent said he noted that TFO [JB] was taking oxycodone 15 mg. (Tr. 221.) TFO [JB] corrected him and said Respondent had actually given her oxycodone 30 mg on the previous visit. (Tr. 221.) Respondent replied ''Well, I wrote 15 milligrams in the chart, but I sometimes make mistakes.'' (Tr. 221.) In light of the testimony that thirty milligrams is the highest available dosage of oxycodone (Tr. 55), Respondent's candid and cavalier attitude toward prescribing and recordkeeping constitutes a violation of Arizona medical standards in addition to presenting a risk of diversion. *See, e.g.,* Ariz. Rev. Stat. §§ 32–1401(27)(e) & (q).[45] Making matters worse, the unrebutted testimony of DI Linder indicates that as late as May 26, 2010, Respondent was unaware that Xanax, a benzodiazepine and Schedule IV

[43] *See also Hoxie v. DEA,* 419 F.3d 477, 484 (6th Cir. 2005) (decision to revoke registration ''consistent with the DEA's view of the importance of physician candor and cooperation.'')

[44] For example, I found Respondent's testimony regarding the material falsification of his application for renewal of his DEA COR not to be credible. *Supra* Section III.B.

[45] Although the OSC/IS alleged violations of Ariz. Rev. Stat. § 32–1401(27)(a), (q) & (ss), it did not explicitly allege a violation of § 32–1401(27)(e) (''Failing or refusing to maintain adequate records on a patient.''). Nevertheless, the Government's prehearing statement alleged that Respondent violated his standard of care by ''failing to take adequate medical histories or no medical histories [and], by failing to collecting [sic] previous medical records . . . .'' (Gov't PHS at 4.) I find this language adequate to apprise Respondent that this allegation would be litigated and considered. *See CBS Wholesale Distribs.,* 74 Fed. Reg. 36,746, 36,749–50 (DEA 2009). Alternatively, even without considering § 32–1401(27)(e), I would still find that Factor Five favors recommending revocation of Respondent's COR under 21 U.S.C. § 823(f).

depressant,[46] was a controlled substance. (Tr. 178–79 (''He asked me what a controlled substance was, and whether Xanax was a controlled substance.'').) Respondent testified that he commonly prescribes Xanax. (Tr. 778–79.)

There is additional record evidence reflecting Respondent's attitude toward diversion and his course of compliance with Arizona medical standards but further elaboration is unnecessary. As to all of these incidents, Respondent's testimony at hearing that his motivation ''was first and foremost the well-being of my patients,'' (Tr. 757), is availing, to a point. But Respondent's prepared testimony at hearing does not counter the more substantial weight properly given to his candid, un-coached remarks and behaviors toward undercover investigators posing as patients. These remarks and behaviors are telling, and I find substantial evidence that Respondent will engage in future misconduct if allowed to maintain his registration. In sum, Factor Five weighs in favor of a finding that Respondent's continued registration would be inconsistent with the public interest.

IV. Conclusion and Recommendation

I find that a balancing of the foregoing public interest factors supports a finding that the Government has established a prima facie case in support of revocation of Respondent's registration, or denial of an application for registration.[47] I conclude by a preponderance of the evidence that the Government has proved independent grounds for revoking Respondent's COR pursuant to 21 U.S.C. § 824(a)(1), and alternatively, that the balance of the other factors in this case weighs heavily in favor of a finding that Respondent's registration would be inconsistent with the public interest under 21 U.S.C. § 823(f).

Once DEA has made its prima facie case for revocation, the burden then shifts to the respondent to show that, given the totality of the facts and circumstances in the record, revoking the registrant's registration would not be appropriate. *Morall v. DEA,* 412 F.3d 165, 174 (D.C. Cir. 2005); *Humphreys v. DEA,* 96 F.3d 658, 661 (3d Cir. 1996); *Shatz v. United States Dep't of Justice,* 873 F.2d 1089, 1091 (8th Cir. 1989); *Thomas E. Johnston,* 45 Fed. Reg. 72,311, 72,311 (DEA 1980).

Additionally, where a registrant has committed acts inconsistent with the public interest, the registrant must accept responsibility for his or her actions and demonstrate that he or she will not engage in future misconduct. *Patrick W. Stodola,* 74 Fed. Reg. 20,727, 20,735 (DEA 2009). Also, ''[c]onsideration of the deterrent effect of a potential sanction is supported by the CSA's purpose of protecting the public interest.'' *Joseph Gaudio, M.D.,* 74 Fed. Reg. 10,083, 10,094 (DEA 2009). An agency's choice of sanction will be upheld unless unwarranted in law or without justification in fact. A sanction must be rationally related to the evidence of record and proportionate to the error committed. *See Morall v. DEA,* 412 F.3d 165, 181 (D.C. Cir. 2005) (sanction will be upheld unless unwarranted in law or without justification in fact). Finally, an ''agency rationally may conclude that past performance is the best predictor of future performance.'' *Alra Laboratories, Inc. v. DEA,* 54 F.3d 450, 452 (7th Cir. 1995).

The evidence as a whole demonstrates that Respondent has not credibly accepted responsibility for his actions, or presented evidence that could reasonably support a finding that he will not engage in future misconduct. Accordingly, Respondent has failed to rebut the Government's prima facie case. I therefore recommend that Respondent's DEA COR be revoked and any pending applications for renewal denied.

Dated: January 20, 2011

Timothy D. Wing

Administrative Law Judge

[FR Doc. 2012–14268 Filed 6–11–12; 8:45 am]

BILLING CODE 4410–09–P

[46] Alprazolam is a controlled substance. 21 C.F.R. § 1308.14(c) (2010). I take official notice that Xanax is a trade name for alprazolam. Respondent can dispute the facts of which I take official notice by filing a properly supported motion for reconsideration within twenty days of service of this Recommended Decision, which shall begin on the date it is mailed. *See supra* note 40. *See generally Joseph Gaudio, M.D.,* 74 Fed. Reg. 10,083, 10,088 (DEA 2009).

[47] Respondent all but concedes as much, arguing that ''Respondent is well aware that the Presiding Administrative Law Judge is likely to determine that the government has made a prima facie case against him. That having been acknowledged, the record supports by a preponderance of the evidence a finding that his continued registration is not inconsistent with the public interest.'' (Resp't Br. 31.)

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Importer of Controlled Substances Notice of Application

Pursuant to 21 U.S.C. 958(i), the Attorney General shall, prior to issuing a registration under this Section to a bulk manufacturer of a controlled substance in schedule I or II, and prior to issuing a regulation under 21 U.S.C. 952(a)(2) authorizing the importation of such a substance, provide manufacturers holding registrations for the bulk manufacture of the substance an opportunity for a hearing.

Therefore, in accordance with 21 CFR 1301.34(a), this is notice that on October 6, 2011, Arizona Department of Corrections, ASPC–Florence, 1305 E. Butte Avenue Florence, Arizona 85132, made application to the Drug Enforcement Administration (DEA) to be registered as an importer of Pentobarbital (2270), a basic class of controlled substance listed in schedule II.

The facility intends to import the above listed controlled substance for legitimate use. Supplies of this particular controlled substance are inadequate and are not available in the form needed within the current domestic supply of the United States.

Any bulk manufacturer who is presently, or is applying to be, registered with DEA to manufacture such basic class of controlled substance may file comments or objections to the issuance of the proposed registration, and may, at the same time, file a written request for a hearing on such application pursuant to 21 CFR 1301.43, and in such form as prescribed by 21 CFR 1316.47.

Any such comments or objections should be addressed, in quintuplicate, to the Drug Enforcement Administration, Office of Diversion Control, Federal Register Representative (ODL), 8701 Morrissette Drive Springfield, Virginia 22152; and must be filed no later than [insert date 30 days from date of publication].

This procedure is to be conducted simultaneously with, and independent of, the procedures described in 21 CFR 1301.34(b), (c), (d), (e), and (f). As noted in a previous notice published in the **Federal Register** on September 23, 1975, 40 FR 43745–46, all applicants for registration to import a basic class of any controlled substance in schedule I or II are, and will continue to be, required to demonstrate to the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration, that the requirements for such registration pursuant to 21 U.S.C. 958(a), 21 U.S.C. 823(a), and 21 CFR 1301.34(b), (c), (d), (e), and (f) are satisfied.