5. Outstanding action jackets: None.

In accordance with Commission policy, subject matter listed above, not disposed of at the scheduled meeting, may be carried over to the agenda of the following meeting.

By order of the Commission.
Issued: September 12, 2012.

William R. Bishop,

Hearings and Meetings Coordinator.

[FR Doc. 2012–22958 Filed 9–13–12; 4:15 pm]

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DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[Docket No. 12–31]

Cleveland J. Enmon, Jr., M.D.; Decision and Order

On April 26, 2012, Administrative Law Judge Gail A. Randall (ALJ) issued the attached recommended decision. Neither party filed exceptions to the decision.

Having reviewed the entire record in this matter, I have decided to adopt the ALJ's recommended rulings, findings of fact,[1] conclusions of law, and recommended order. Accordingly, I will order that Respondent's registration be revoked and that his pending application to renew and modify his registration be denied.

[1] The ALJ made several factual findings based on the statements made to a Special Agent by two employees of the Brunswick Wellness Center (BWC) during the execution of a search warrant, as well as statements made during interviews the Special Agent conducted of several patients of Respondent's subsequent clinic. *See* ALJ Slip Op. at 7 (statements of BWC employees that clinic lacked basic medical equipment and attracted patients from out-of state who did not appear to be in pain), *id.* at 9–10 (statement of Ocean Care patient that he obtained controlled substances from Respondent in order to sell them on the street and that Respondent did not perform a physical examination and increased prescription upon request). While the ALJ found the Special Agent's testimony credible, as do I, the ALJ did not apply the factors for assessing the reliability of the underlying hearsay statements as set forth in the case law of either the Eleventh or DC Circuits. *See Basco* v. *Machin,* 514 F.3d 1177, 1182 (11th Cir. 2008); *J.A.M. Builders* v. *Herman,* 233 F.3d 1350, 1354 (11th Cir. 2000); *Hoska* v. *United States Dep't of the Army,* 677 F.2d 131, 138 (DC Cir. 1982). However, I conclude that this does not constitute prejudicial error because the ALJ's legal conclusions are amply supported by substantial evidence, including the uncontroverted testimony of the Government's Expert, and the ALJ did not cite these statements as support for her conclusion that Respondent repeatedly prescribed controlled substances without a legitimate medical purpose and outside the course of professional practice in violation of both federal and state law. *See* ALJ Slip. Op. at 38–44 (citing 21 CFR 1306.04(a) and Ga. Code Ann. 16–13–41(f)).

Order

Pursuant to the authority vested in me by 21 U.S.C. 823(f) and 824(a), as well as 28 CFR 0.100(b), I order that DEA Certificate of Registration No. BE9655284, issued to Cleveland J. Enmon, Jr., M.D., be, and it hereby is, revoked. I further order that the pending application of Cleveland J. Enmon, Jr., M.D., to renew and modify his registration, be, and it hereby is, denied. This Order is effective immediately.[2]

Dated: August 31, 2012.

Michele M. Leonhart,

Administrator.

Brian Bayly, Esq., for the Government

Cleveland J. Enmon, Jr., M.D., for the Respondent

RECOMMENDED RULINGS, FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DECISION OF THE ADMINISTRATIVE LAW JUDGE

Gail A. Randall, Administrative Law Judge.

I. PROCEDURAL BACKGROUND

The Administrator of the Drug Enforcement Administration (''DEA'' or ''Government''), issued an Order to Show Cause and Immediate Suspension of Registration (''Order'') dated January 10, 2012, immediately suspending the DEA Certificate of Registration, No. BE9655284, of Cleveland J. Enmon, Jr., M.D. (''Respondent''), pursuant to 21 U.S.C. 824(d), and proposing to revoke his DEA Certificate of Registration as a practitioner, pursuant to 21 U.S.C. 824(a)(4), and to deny any pending applications for renewal of such registration, pursuant to 21 U.S.C. 823(f), because the continued registration of the Respondent would be inconsistent with the public interest, as that term is used in 21 U.S.C. 823(f). [Administrative Law Judge Exhibit (''ALJ Exh.'') 1 at 1].

The Order stated that Respondent is registered with the DEA as a practitioner with authority to handle controlled substances in Schedules II–V, and that his registration expired by its terms on August 31, 2011. [*Id.*]. The Order further stated that although Respondent submitted a timely renewal application, which would have allowed him to lawfully handle controlled substances under 5 U.S.C. 558(c) (2006), his current practice location is not at his DEA registered address because he abandoned that location. Therefore, he is not permitted to issue controlled substances from his current practice location. [*Id.*].

The Order alleged that Respondent issued controlled substances prescriptions from locations in Brunswick, Georgia and Jesup, Georgia, without obtaining permission from the Government to change his DEA registered address to either of these locations. [*Id.* at 2].

Next, the Order alleged that Respondent had prescribed oxycodone and hydrocodone to at least nineteen patients with no or insufficient medical history, with no relevant physical examinations, without diagnosing any medical conditions warranting such medications and without monitoring the patients to determine if the patients were diverting the controlled substances. [*Id.*]. The Order also asserted that Respondent had prescribed alprazolam to eighteen of these patients with no diagnosis or other justification except for checking a boilerplate form marked ''anxiety'' in the patient file. [*Id.*]

Lastly, the Order alleged that Respondent prescribed two hundred and thirty dosage units of oxycodone to patient, M.B.S. based on a diagnosis with no documentation. [*Id.*]. The Order alleged that this patient was admitted to a local hospital emergency room and that the hospital subsequently determined that the patient was opiate dependent and needed detoxification treatment. [*Id.*]. Further, the Order alleged that on October 11, 2011, the Respondent prescribed the same patient sixty dosage units of alprazolam without documenting any findings of anxiety symptoms in the patient's file. [*Id.*].

The Administrator then gave the Respondent the opportunity to show cause as to why his registration should not be revoked on the basis of those allegations. [*Id.* at 3].

On February 3, 2012, Respondent filed a request for a hearing in the above-captioned matter. [ALJ Exh. 3].

On March 1, 2012, a Protective Order was issued to protect patient names and medical files used in this proceeding. [ALJ Exh. 6].

The hearing was conducted on March 6–7, 2012, in Beaufort, South Carolina. [ALJ Exh. 5]. At the hearing, counsel for the DEA called three witnesses to testify and introduced documentary evidence. [Transcript (''Tr.'') Volume I–II]. The Respondent called one witness to testify and testified on behalf of himself. [*Id.*].

After the hearing, the Government submitted Proposed Findings of Fact, Conclusions of Law and Argument (''Govt. Brief''). The Respondent did not submit a post-hearing brief.

II. ISSUE

The issue in this proceeding is whether or not the record as a whole establishes by a preponderance of the evidence that the Drug Enforcement Administration should revoke the DEA Certificate of Registration Number BE9655284 of Cleveland J. Enmon, Jr., M.D., as a practitioner, pursuant to 21 U.S.C. 824(a) (2006), and deny any pending applications for renewal or modification of such registration, pursuant to 21 U.S.C. 823(f), because his continued registration would be inconsistent with the public interest, as that term is defined in 21 U.S.C. 823(f). [Tr. 5; ALJ Exh. 4].

III. FINDINGS OF FACT

A. Dr. Enmon's Registration History

The Agency first issued a certificate of registration as a practitioner to Dr. Enmon on March 9, 2006. [Govt. Exh. 3 at 4]. On September 4, 2008, Dr. Enmon requested to

[2] For the same reasons that I concluded that Respondent's conduct posed an imminent danger to public health and safety and warranted the Immediate Suspension of his registration, I conclude that the public interest necessitates that this Order be effective immediately. 21 CFR 1316.67.

change his DEA registered address from King/Drew Medical Center in Los Angeles, California to Cleveland Health Care in Atlanta, Georgia. [*Id.;* Tr. 179]. The DEA approved Respondent's request for an address change that same day. [Govt. Exh. 3 at 3].

Dr. Enmon ceased practicing at Cleveland Health Care in approximately 2009. [Tr. 177]. On August 31, 2011, Dr. Enmon requested to change his DEA registered address from Cleveland Health Care in Atlanta, Georgia, to Ocean Care Clinic in Jesup, Georgia. [Govt. Exh. 3 at 1; Tr. 175–176]. The DEA did not approve Dr. Enmon's address change request. [Tr. 176]. Therefore, Dr. Enmon's DEA registered address remains at Cleveland Health Care in Atlanta, Georgia. [Tr. 175; Govt. Exh. 3].

DEA Diversion Investigator Charles Sikes testified at the hearing. I find his testimony credible and consistent with the documentary evidence in the record. He testified that the DEA does not automatically grant address change requests. [Tr. 176]. Instead, the DEA treats an address change request as a new application for registration. [*Id.*]. He further testified that registrants must request a change of address if they leave their current registered location. [Tr. 205]. He also testified that Dr. Enmon was not entitled to the practitioner exemption under 21 C.F.R. 1301.12(b)(3) (2011) because he had ceased practicing at his original registered location in Atlanta, Georgia. [Tr. 204–205].

B. Dr. Enmon

Dr. Enmon received an undergraduate degree from Morehouse College and then attended medical school at the Morehouse School of Medicine. [Tr. 330]. After graduating from medical school, Respondent began a residency program in emergency medicine, at the Martin Luther King Jr./Drew Medical Center in Los Angeles, California. [*Id.*]. Following his residency training, Respondent practiced emergency medicine in Los Angeles, California before moving to Atlanta, Georgia. [Tr. 331].

C. Brunswick Wellness Center

Dr. Enmon began working at Brunswick Wellness Center in Brunswick, Georgia (''BWC'') on approximately May 2, 2011. [Tr. 308, 183]. Respondent testified about his employment at BWC. I find this portion of his testimony credible and consistent with the evidence in the record. A staffing company recruited Dr. Enmon to work at BWC. [Tr. 334, 182]. Upon his arrival at BWC, Dr. Enmon testified that the clinic did not appear to be a normal doctor's office. [Tr. 334]. There, Dr. Enmon met with BWC's office manager, a woman who, according to Dr. Enmon's testimony, appeared to be under the influence of controlled substances. [*Id.,* 343].

Dr. Enmon further testified that he was ''not comfortable'' with several elements of BWC's operation. [Tr. 339]. Specifically, Respondent claimed that BWC's management directed him to treat out-of-state patients and patients under twenty-five years old, even though he initially refused to treat these kinds of patients. [*Id.*]. According to Dr. Enmon, he realized that continued employment at BWC placed him ''at risk'' and in fact spurred him to open his own chronic pain management clinic. [Tr. 340, 343]. While Dr. Enmon testified at length about his concerns about BWC's operation, he also testified that ''a lot'' of Brunswick's patients were in fact ''legitimate'' pain patients. [Tr. 335].

D. Search Warrant Served on Brunswick Wellness Center on July 14, 2011

On July 12, 2011, a federal search and seizure warrant was issued against Brunswick Wellness Center. [Govt. Exh. 8; Tr. 16–17]. A team of local and federal law enforcement agents executed the warrant on July 14, 2011 at 10:00 a.m. [Tr. 181]. DI Sikes was a member of the law enforcement team that executed the warrant. [*Id.*].

DI Sikes interviewed Dr. Enmon during the execution of the search warrant. [Tr. 181]. At the time of the search warrant's execution, Dr. Enmon was the only physician employed by BWC. [Tr. 183]. Dr. Enmon admitted to DI Sikes that while he had no specialized training in pain management, he was practicing as a pain management doctor at BWC. [Tr. 182]. Respondent further stated that he practiced non-interventionist pain management, which he explained as concentrating in medication management for chronic pain patients. [Tr. 184]. Dr. Enmon also admitted to prescribing oxycodone and hydromorphone products to BWC patients for pain management. [*Id.*].

Dr. Enmon informed DI Sikes that he saw between thirty-five and forty patients a day at BWC, although he also disclosed that his patient load was starting to increase due to the closure by law enforcement of several neighboring pain clinics. [Tr. 185]. Dr. Enmon charged his patients three hundred and fifty dollars per visit. [*Id.*]. BWC did not accept insurance or other forms of payments besides cash. [*Id.*].

DEA Special Agent Michael Marbert also participated in the execution of the search warrant on BWC. [Tr. 213–214]. I find his testimony credible and consistent with the documentary evidence in the record. He interviewed two employees of BWC, a security guard, and a phlebotomist. [Tr. 215]. The phlebotomist told SA Marbert that BWC lacked basic medical equipment, like a defibrillator, tongue depressors, and thermometers. [Tr. 218]. The security guard reported that BWC attracted patients from Tennessee and Kentucky and that many of the patients did not appear to show any signs of being in pain. [Tr. 219]. Following the execution of the search warrant, BWC's business license was revoked and it ceased to operate after July 14, 2011. [Tr. 187].

E. Ocean Care Clinic

Following the closure of BWC, Dr. Enmon opened his own pain management clinic, Ocean Care, in Jesup, Georgia on August 15, 2011. [Tr. 187–188]. Ocean Care was located at 129 South Macon Street in Jesup, Georgia, about thirty-eight miles from BWC. [*Id.*]. Respondent was the sole owner of Ocean Care. [Tr. 188].

Linda Henderson, Ocean Care's office manager testified at the hearing. [Tr. 265]. Ms. Henderson was a patient of Dr. Enmon while he worked at BWC. [Tr. 266]. She testified that Dr. Enmon help to wean her off pain medication that previous doctors at BWC had prescribed for her. [*Id.*]. I do not find her testimony credible on this point in light of Ms. Henderson's testimony on cross-examination regarding the specific prescriptions that Dr. Enmon issued to her while at BWC and Ms. Henderson's ScriptSure records. [Tr. 313–316; Govt. Exh. 33].

Ms. Henderson also testified about the operation of Ocean Care. [Tr. 271]. I find this portion of her testimony credible and consistent with the evidence in the record. She testified that Ocean Care did not treat out of state patients. [Tr. 272–273]. Ocean Care also required that patients be at least twenty-five years old and possess a Georgia state ID. [Tr. 273, 276]. Ms. Henderson further testified that Ocean Care denied treatment to approximately thirty to sixty patients every day. [Tr. 274]. Ocean Care had patients come in for pill counts. [Tr. 278–279, 288]. Ocean Care also did not advertise and relied solely on word of mouth to attract new patients. [Tr. 292]. During Ocean Care's operation from August to December 2011, Dr. Enmon treated over nine hundred patients. [Tr. 324]. Some of these Ocean Care patients also received treatment from Dr. Enmon while he was employed at BWC. [Tr. 325].

DI Sikes further testified about a complaint he received from a local hospital regarding one of Dr. Enmon's Ocean Care patients. [Tr. 371]. This patient, M.B.S., presented complaints of abdominal pain but the admitting physician at the hospital determined that she was in fact suffering from opiate-induced constipation. [Tr. 371–372; Govt. Exh. 7 at 3]. Concerned about Respondent's treatment of M.B.S., a patient whom the admitting physician diagnosed as opiate dependent, the admitting physician had M.B.S.'s treatment records faxed to the DEA and asked DI Sikes to investigate Dr. Enmon. [Tr. 373, 376–77, 380–381; Govt. Exh. 7].

F. Search Warrant Served on Ocean Care Clinic on October 6, 2011

On October 5, 2011, a federal search and seizure warrant was issued against Ocean Care. [Govt. Exh. 9]. A team of local and federal law enforcement agents executed the warrant on October 6, 2011. [Tr. 188]. DI Sikes was a member of the law enforcement team that executed the warrant. [*Id.*]. Six employees and Respondent were present at Ocean Care during the execution of the warrant. [Tr. 189].

DI Sikes interviewed Dr. Enmon during the execution of the search warrant at Ocean Care. [*Id.*]. Dr. Enmon told DI Sikes that he was the sole owner of Ocean Care and had opened the clinic on August 15, 2011. [Tr. 189–190]. Respondent informed DI Sikes that Ocean Care required potential patients to produce a Georgia ID, be at least twenty-five years old, and have a MRI or CT scan record prior to receiving treatment at the clinic. [Tr. 191].

Dr. Enmon also told DI Sikes that he saw between twenty and forty patients a day and that Ocean Care drew patients from a number of surrounding pain clinics including the

shuttered Brunswick Wellness Center. [Tr. 191–192]. Patients paid two hundred and seventy-five dollars per visit and Ocean Care only accepted payment in cash or money orders. [Tr. 194]. Respondent further stated that Ocean Care possessed medical equipment ranging from a scale and stethoscope to a blood pressure cuff but lacked gloves, Band-Aids, a defibrillator, first aid kit, tongue depressors, cotton balls, gauze and a thermometer. [Tr. 193–194].

With regard to his prescribing practices, Respondent admitted to issuing prescriptions to Ocean Care patients for fifteen and thirty milligram dosage units of Roxicodone, a schedule II controlled substance, and for two milligram dosage units of Xanax, a schedule IV controlled substance. [Tr. 192]. Respondent typically issued prescriptions for between one hundred and twenty to one hundred and fifty dosage units of thirty milligram Roxicodone and between thirty and ninety dosage units for fifteen milligram Roxicodone. [Tr. 192–193]. Respondent also typically issued prescriptions for thirty dosage units of two milligram Xanax. [Tr. 193].

Following the execution of the search warrant, SA Marbert conducted interviews with several Ocean Care patients. [Tr. 236–237]. One patient told SA Marbert that he obtained controlled substances prescriptions from Dr. Enmon in order to sell them on the street. [Tr. 240]. The patient further reported that Dr. Enmon did not perform a physical examination prior to writing the prescriptions and was able to have the dosage units of his prescriptions increased upon request. [*Id.*].

G. DEA's December 8, 2011 Letter to Dr. Enmon

On December 8, 2011, Dr. Enmon called DI Sikes and inquired about the status of his renewal for his DEA certificate of registration. [Tr. 196–197]. DI Sikes informed Dr. Enmon that he could no longer handle controlled substances because he was working from an unregistered location. [Tr. 197]. DI Sikes also asked to meet with Dr. Enmon to provide him with a letter from the DEA's Chief Counsel's Office regarding the status of his registration. [Tr. 199].

On December 9, 2011, Dr. Enmon was personally served with this letter at the DEA office in Savannah, Georgia. [Tr. 199; Govt. Exh. 4]. This letter instructed Dr. Enmon that he was without the necessary authority to handle controlled substances at his practice location, the Ocean Care Clinic because the DEA had not approved the address change request he had submitted on August 31, 2011.[1] [Govt. Exh. 4]. After receiving this letter, Dr. Enmon closed the Ocean Care Clinic and ceased issuing prescriptions for controlled substances from this location. [Tr. 202, 301].

H. Patient Files

On October 6, 2011, DI Sikes, using a federal search warrant, obtained over nine hundred patient treatment files from the Ocean Care Clinic.[2] [Tr. 19–22; Govt. Exh. 9]. A random sampling of these patient files were provided to the Government's expert medical witness, Dr. Eugene Kennedy. [Tr. 21, 23–24]. Dr. Kennedy reviewed forty patient files from the Ocean Care Clinic. [Tr. 155–156]. A total of nineteen of these patient files were admitted into the record in this proceeding. [Govt. Exh. 12–30].

Dr. Kennedy testified at the hearing concerning these nineteen patient files and his medical report. [Tr. 27; Govt. Exh. 6]. I qualified Dr. Kennedy as an expert medical witness in ''the use of controlled substances for pain management and the use of benzodiazepines.'' [Tr. 59]. Correspondingly, I find his testimony credible and consistent with the documentary evidence in the record.

Dr. Kennedy, a board certified family practitioner, is licensed to practice medicine in Georgia. [Tr. 31–33; Govt. Exh. 31]. While Dr. Kennedy is not board certified in pain management, he is a credentialed member of the American Academy of Pain Medicine. [Tr. 59; Govt. Exh. 31]. He has taken the required courses and test to qualify for this credential. [Tr. 32–33]. He has a private practice where he treats chronic pain patients, and for about seventy-five percent of his patients, he issues controlled substance prescriptions in order to manage their pain treatment. [Tr. 34–35, 39]. Dr. Kennedy sees fourteen to fifteen patients a day. [Tr. 39]. According to Dr. Kennedy, a patient load of forty patients a day qualifies as a heavy patient load. [Tr. 39].

Prior to treating a chronic pain patient, Dr. Kennedy requires the patient or referring physician to provide the patient's past medical records. [Tr. 40]. Dr. Kennedy only sees such patients on a referral basis. [*Id.*]. He requires ''a very solidly established medical history—usually surgical history—that would support'' the medical necessity for treating a patient with long-term narcotics. [*Id.*]. Dr. Kennedy testified that a physical examination is a necessary requirement in order to properly treat a chronic pain patient. [Tr. 41]. Dr. Kennedy will first explore nonpharmacologic options with the patient before considering prescribing medication. [Tr. 42]. Dr. Kennedy next will look to non-narcotic medications, and after exploring these options, will begin treating the patient incrementally with narcotic medications. [Tr. 43]. Dr. Kennedy credibly testified that he ''would have to have substantial support from previous treating physicians before I would put someone on chronic narcotics.'' [*Id.*]. Dr. Kennedy further credibly testified that every patient in his practice has a urine drug screen before they get their first prescription, and that urine drug screens are done randomly thereafter to ensure the patient is taking the controlled substances as prescribed. [Tr. 44].

Xanax is a brand name for alprazolam, a schedule IV controlled substance. [Tr. 45; Govt. Exh. 11]. It is chemically classified as a benzodiazepine and is commonly prescribed as an anti-anxiety drug. [Tr. 45–46; Govt. Exh. 11]. Dr. Kennedy credibly testified that before prescribing Xanax to a patient, he would need ''substantial documentation as to what their symptomatology is, how long it has lasted, how it is affecting their life, and why it's necessary for me to treat them with scheduled medications.'' [Tr. 68–69]. Specifically, he noted that the patient's file should contain a ''specific anxiety diagnosis'' with a detailed description of their current symptoms, past medical treatment, and their social history. [Tr. 123].

Klonopin is a brand name for clonazepam, which is another Schedule IV controlled substance. [Tr. 46; Govt. Exh. 10]. It is also a benzodiazepine, and is commonly prescribed for use as a muscle relaxant. [Tr. 46–47]. Dr. Kennedy credibly explained, ''I would want to establish that the patient has either failed or has not done well on any of the plethora of non-scheduled non-controlled muscle relaxants and anti-spasmodics that are available'' before issuing a prescription for Klonopin. [Tr. 47].

1. D.B.

D.B., a patient at Respondent's Ocean Care Clinic, was diagnosed with neck and low back pain. [Tr. 62; Govt. Exh. 12]. His patient file contains an MRI report, but Dr. Kennedy found that ''the report alone does not support prescribing narcotic medication.'' [Tr. 62; Govt. Exh. 6 at 2]. Dr. Kennedy stated that the Respondent would need a supporting physical examination because the MRI findings were not severe enough to support prescribing narcotics. [Tr. 62–63; Govt. Exh. 6 at 2]. Further, Dr. Kennedy found that there was nothing in D.B.'s patient file that justified the amount and strength of narcotics that were prescribed to D.B. [Tr. 63–64; Govt. Exh. 12]. Although D.B. indicated that he had long-term pain, there were no previous medical treatment records in D.B.'s chart, despite the listing of a previous prescribing physician. [Tr. 64–65; Govt. Exh. 12 at 19, 21]. Although D.B. reported that his ''left fingertips stay numb,'' Dr. Kennedy could not find anything that would support such a symptom in D.B.'s medical chart. [Tr. 65; Govt. Exh. 12 at 21].

Given what little medical examination that was provided, Dr. Kennedy found that, ''with full range of motion'' and ''normal neurologic exam,'' the Respondent had failed to find a basis to ''support prescribing a large number of scheduled medications'' for D.B. [Tr. 66; Govt. Exh. 12 at 2]. Yet the Respondent prescribed one hundred and twenty dosage units of 30 milligram Roxicodone, sixty dosage units of 15 milligram Roxicodone, sixty dosage units of 2 milligram Xanax and sixty dosage units of 350 milligram Soma to D.B. [Govt. Exh. 12 at 3–7]. Instead of issuing these prescriptions, Dr. Kennedy opined that the Respondent should have tried ''all medical reliefs that are available before embarking on a course of large dosages of narcotics, to include non-scheduled medications and lifestyle changes, diet, exercise, heat applications, physical therapy, [and] possibly injections.'' [Tr. 67]. Attempting to pursue these other options would be the standard of care. [Tr. 67].

Dr. Kennedy further found that the patient's file lacked the degree of information needed to support the prescribing of Xanax.

[1] The Respondent never filed an application to change his DEA registration from Atlanta to the Brunswick Wellness Center. [Tr. 180–181].

[2] The patient files and testimony about those files are protected by a Protective Order in this proceeding. [ALJ Exh. 6].

[Tr. 68–69; Govt. Exh. 12 at 27; Govt. Exh. 6 at 1–3]. Dr. Kennedy credibly testified that he would expect to see ''questions and responses that are significant enough to support assigning a patient a psychiatric diagnosis and prescribing controlled medications'' prior to issuing a prescription for Xanax [Tr. 171]. Further, the file contained no mention of any actual plan of treatment. [Govt. Exh. 6 at 2]. Overall, Dr. Kennedy found that the ''treatment of this patient falls below the standard of care.''[3] [Govt. Exh. 6 at 2–3].

2. T.C.

T.C.'s patient file contained a thoracic MRI report, which was essentially normal. [Tr. 69; Govt. Exh. 13 at 8]. Dr. Kennedy described the accompanying lumbar impressions as ''very minor,'' and in Dr. Kennedy's opinion, these lumbar impressions did not ''rise to the level of starting the patient on large dose narcotics.'' [Tr. 69–70]. In addition, T.C.'s patient chart indicated that there was no past medical history, no past surgical history, and no family medical history. [Tr. 72–73; Govt. Exh. 13 at 1]. Dr. Kennedy found that this lack of self-reported medical history ''does not support prescribing scheduled medications.'' [Tr. 73]. Further, there is no mention of anxiety in the file, and thus, the prescribing of Xanax is not justified by this medical record. [Tr. 73]. In sum, Dr. Kennedy found that there was ''no documentation to support pain that rises to the level of requiring the agents prescribed.'' [Govt. Exh. 6 at 4].

As for prescribing, Dr. Kennedy found that the Respondent ''inappropriately initially prescribed schedule II opiates and other scheduled medications in the absence of an appropriate supporting history and physical examination. The rationale for prescribing narcotics was never mentioned.'' [Govt. Exh. 6 at 5]. In addition, Dr. Kennedy found that the record fails to document ''any treatment modalities attempted in the past or anticipated for the future.'' [*Id.*]. The chart also fails to reflect any plan of treatment. [*Id.*]. Further, a ''coherent rationale for the treatment of this patient is absent entirely.'' [*Id.*]. Dr. Kennedy likewise found that a pertinent physical examination was never performed. In conclusion, Dr. Kennedy credibly opined that the ''treatment of this patient falls below the standard of care in almost every regard.'' [*Id.*]. He further noted that on the single, initial encounter, ''this patient was provided with prescriptions that resulted in a combined total of 290 pills. In my opinion, this patient's management is unacceptable, and falls below any reasonable standards of care.'' [*Id.*].

3. J.D.

J.D.'s patient file contained a MRI report for the patient's cervical and thoracic spine. [Tr. 74; Govt. Exh. 14 at 19–20]. Although the patient reported having scoliosis as a teenager, the MRI report does not support this claim. [Tr. 75; Govt. Exh. 14 at 19–20]. Dr. Kennedy opined that the findings in the MRI report were ''minimal'' and ''do not support large doses of narcotic medication.'' [Tr. 75; Govt. Exh. 6 at 8]. And although the patient noted two prior treating physicians, the patient file does not contain any previous medical records or any indication that these previous medical records were requested by Ocean Care. Dr. Kennedy opined that such records should have been requested. [Tr. 75–76]. J.D. also reported that she had previously been prescribed Lorcet.[4] [Govt. Exh. 14 at 8]. However, the Respondent prescribed Roxicodone, a schedule II controlled substance to J.D. [Govt. Exh. 14 at 17]. Dr. Kennedy opined that there were no notations in the patient file that would support increasing the strength of the opiate prescribed to J.D. [Tr. 76]. Rather, Dr. Kennedy noted that more ''conservative, non-scheduled treatments would have been appropriate for this patient.'' [*Id.*]. Also, the patient file failed to indicate any reason for prescribing Xanax other than a check-mark beside the word ''anxiety'' on the physical examination form. [Govt. Exh. 6 at 8]. Lastly, no treatment plan is reflected in this file. [Govt. Exh. 14].

Dr. Kennedy credibly opined that a ''coherent rationale for the treatment of this patient is absent entirely.'' [Govt. Exh. 6 at 8]. Further, he noted that the ''unsupported coadministration of oxycodone, Xanax and Soma could represent a significant risk to the patient. It should be noted that on the single, initial encounter, this patient was provided with prescriptions that resulted in a combined total of 330 pills. In my opinion, this patient's management is unacceptable, and falls below a reasonable standard of care.'' [Govt. Exh. 6 at 9].

4. L.D.

L.D.'s patient file contains a blank physical examination sheet, indicating that no physical exam was performed. [Tr. 80; Govt. Exh. 15 at 3–4]. The patient self-reported that he had never been prescribed pain medication in the past. [Tr. 81; Govt. Exh. 15 at 19]. Dr. Kennedy opined that the prescriptions written to L.D. were not supported by the physical examination. [Tr. 81; Govt. Exh. 6 at 10–11]. The patient file likewise failed to provide a medical justification for the Xanax prescription that Respondent issued to L.D. [Tr. 82]. Dr. Kennedy also noted that there was ''no mention of any treatment modalities attempted in the past or anticipated for the future. There is no documentation in the chart that indicates any actual plan of treatment or supports any rationale for prescribing controlled medication.'' [Govt. Exh. 6 at 10–11].

Overall, Dr. Kennedy concluded that the treatment of this patient fell ''below an acceptable standard of care.'' [*Id.*] Specifically, Dr. Kennedy found that ''nowhere in the medical record is there any evidence that even a cursory physical examination was ever performed'' and that ''this patient was provided with prescriptions that resulted in a combined total of 300 pills, and this was repeated on the subsequent encounter. In my opinion, this patient's management is entirely unacceptable, and falls below every reasonable standard of care.'' [Govt. Exh. 6 at 11–12].

5. A.J.

A.J.'s patient file listed a previous treating family physician, but the Ocean Care file does not contain any previous medical records from this physician. [Tr. 82; Govt. Exh. 16]. A.J. self-reported receiving prior prescriptions for oxycodone and Xanax. [Tr. 84; Govt. Exh. 16 at 8, 20]. Yet the patient file failed to provide any other medical history that would verify this information. [Tr. 84]. This patient file also contained a blank follow-up physical examination form with only the patient's blood pressure and heart rate recorded. [Tr. 84; Govt. Exh. 16 at 1]. Dr. Kennedy credibly testified that he would expect to see the complete vital signs for each patient visit to Dr. Enmon's clinic. [Tr. 84–85].

Although A.J. reported experiencing a pain level of nine and ten, the maximum indications available on the form, there is no medical information in the patient record that would support this report of such high levels of pain. [Tr. 85–86; Govt. Exh. 6 at 13]. A.J. also reported that her pain location was ''everywhere.'' [Govt. Exh. 16 at 28]. Dr. Kennedy found that a patient with that reported level of pain and that location of pain ''would have credibility problems,'' because such reports would be unbelievable. [Tr. 86]. Likewise, A.J.'s patient file does not contain any information concerning a complaint or diagnosis of anxiety, but Respondent nevertheless issued her a prescription for Xanax. [Tr. 86; Govt. Exh. 16]. Dr. Kennedy concluded that this prescription for Xanax was not issued for a legitimate medical purpose in the course of professional practice. [Tr. 86–87; Govt. Exh. 6 at 14].

Dr. Kennedy also found that there was no mention of any treatment modalities ''attempted in the past or anticipated for the future. There is no documentation in the chart that indicates any actual plan of treatment or supports any rationale for prescribing controlled medication.'' [Govt. Exh. 6 at 14]. He also opined that the ''treatment of this patient falls below an acceptable standard of care.'' [*Id.* at 14–15]. On A.J.'s first visit to Ocean Care, Respondent provided her with prescriptions for scheduled medications that ''resulted in a combined total of 240 pills, and this was repeated on the subsequent encounter.'' [*Id.*]. Overall, Dr. Kennedy found that ''this patient's management [was] unacceptable, and [it fell] below a reasonable standard of care.'' [Govt. Exh. 6 at 15].

6. B.B.

BB's patient file contained a physical examination form that is blank except for a check marked notation that B.B. ''appears in pain.'' [Govt. Exh. 17 at 11]. There are no other physical examination entries. [*Id.*]. The patient file contained an MRI report, but Dr. Kennedy credibly opined that the lack of a detailed physical examination coupled with the inconclusive MRI report, fails to medically support the prescribing of Roxicodone in the amounts and strengths that the Respondent prescribed to B.B. [Tr.

[3] Dr. Kennedy credibly testified that his assessment of the patient files in this matter was based on the Georgia standard of care. [Tr. 165].

[4] Lorcet is the brand name for combination hydrocodone and Tylenol, a schedule III controlled substance. [Tr. 76].

88; Govt. Exh. 17 at 2–5; Govt. Exh. 6 at 16–17]. Additionally, the patient's MRI report identified a referring physician, and Dr. Kennedy opined that Dr. Enmon should have acquired the patient's previous medical records. [Tr. 89–90; Govt. Exh. 6 at 16]. No previous medical records were present in the patient's Ocean Care file. [Tr. 90; Govt. Exh. 17]. Dr. Kennedy further noted that B.B.'s patient file did not contain any entries that would support the prescribing of Xanax to this patient. [Tr. 90–91; Govt. Exh. 17 at 26; Govt. Exh. 6 at 17].

Dr. Kennedy also noted that there was ''no mention of any treatment modalities attempted in the past or anticipated for the future.'' [Govt. Exh. 6 at 17]. B.B.'s patient file also did not contain a treatment plan. [*Id.*]. However, the patient was provided with prescriptions for a combined total of three hundred and ninety pills. [*Id.*]. In Dr. Kennedy's expert medical opinion, ''this patient's management [was] unacceptable, and [fell] below a reasonable standard of care, and may represent a significant danger to the patient's safety.'' [*Id.*].

7. J.B.

J.B.'s patient file contained a follow-up examination form, which was blank except for a notation of J.B.'s pulse and blood pressure. [Govt. Exh. 18 at 1]. Dr. Kennedy found this significant, for he credibly testified: ''There is no way of knowing what the patient's follow-up complaint status was. There's no way to tell what the physician intended. There is certainly no support for ongoing narcotics medication.'' [Tr. 92; Govt. Exh. 6 at 20].

Dr. Kennedy also found that J.B.'s patient file did not contain adequate entries to justify a diagnosis of chronic anxiety. [Tr. 94]. Therefore, he found that Xanax was not appropriate to prescribe based upon the entries in this patient file. [Tr. 94; Govt. Exh. 6 at 20]. Further, the patient file does not contain information that justified the prescribing of scheduled narcotics. [Tr. 95]. To this point, Dr. Kennedy explained that the patient file failed to note any treatment modalities attempted in the past or anticipated for the future. [Govt. Exh. 6 at 20]. He also pointed out that Respondent's treatment plan for J.B. was not recorded in the patient file. [*Id.*]. Overall, Dr. Kennedy found that ''this patient's management [was] unacceptable, and [fell] below a reasonable standard of care, and may represent a significant danger to the patient's safety.'' [Govt. Exh. 6 at 20–21].

8. A.A.

Dr. Kennedy found that Respondent's treatment of this patient ''achieve[d] an acceptable standard of care, although barely.'' [Tr. 96; Govt. Exh. 6 at 23]. Specifically, Dr. Kennedy noted that the Respondent's initial management of A.A. with opiates was acceptable, and ''giving both the patient and the [Respondent] the benefit of a doubt, minimally achieves a reasonable standard of care.'' [Govt. Exh. 6 at 24]. A.A.'s patient file demonstrated that she had a history of multi-level spine surgeries, and the MRI report supported her account. [Tr. 96]. Entries in the physical examination of surgical scarring and tenderness, and uncomfortable range of motion were also consistent with a history of these types of surgeries. [Tr. 96; Govt. Exh. 19 at 1–2].

But Dr. Kennedy testified that A.A.'s patient file did not support the prescribing of Xanax to this patient. [Tr. 97; Govt. Exh. 6 at 23]. He further noted that the patient file failed to reflect any other treatment modalities in the past or anticipated for the future. [Govt. Exh. 6 at 23]. Lastly, he found that the patient file did not contain a treatment plan for A.A. [*Id.*].

9. N.A.

This patient reported experiencing chronic pain resulting from an acute injury. [Tr. 98; Govt. Exh. 20 at 14, 16]. Yet N.A.'s MRI report does not support a history of traumatic injury. [Tr. 98–99; Govt. Exh. 20 at 9, 11]. N.A.'s patient file contained a history and physical examination form, but the physical examination portion of the form is largely blank except for notations of the patient's height, weight, blood pressure and pulse measurements. [Tr. 100; Govt. Exh. 20 at 1]. N.A. reported seeing a prior treating physician, but N.A.'s prior medical records were not present in the Ocean Care patient file for N.A. [Tr. 99; Govt. Exh. 20].

Given the largely blank physical examination form and the unremarkable MRI report, Dr. Kennedy concluded that there was no documented support in the patient file to justify prescribing Roxicodone to N.A. [Tr. 98, 100; Govt. Exh. 6 at 25]. Specifically, he found that the Respondent issued prescriptions for a total of two hundred and ninety scheduled pills even though the ''rationale for prescribing narcotics was never mentioned'' in the patient file. [Govt. Exh. 6 at 26]. Additionally, there was no mention of any past or future treatment modalities, and N.A.'s patient file also did not contain a treatment plan. [*Id.*].

N.A. self-reported symptoms of anxiety and panic attacks. [Govt. Exh. 20 at 25]. Yet her patient file provided no other diagnostic information or medical history relating to these claimed symptoms. [Govt. Exh. 20]. Dr. Kennedy found that, under these circumstances, the Xanax prescription issued to N.A. was not for a legitimate medical reason in the usual course of practice. [Tr. 101–102]. Dr. Kennedy concluded that N.A.'s ''management [was] unacceptable, [fell] below a reasonable standard of care, and may represent a significant danger to the patient's safety.'' [Govt. Exh. 6 at 26–27].

10. S.A.

S.A.'s patient file contained a completed release of information form for the patient's prior treating physician. [Govt. Exh. 21 at 1]. But S.A.'s patient file does not contain any prior medical records from this physician. [Tr. 103; Govt. Exh. 21]. Dr. Kennedy testified that he would expect to see prior medical records before prescribing oxycodone at the levels this patient was prescribed. [Tr. 103]. Furthermore S.A.'s history and physical examination form, except for vital signs and a notation that the sensory exam was normal, is blank. [Tr. 103–104; Govt. Exh. 21 at 31]. Given the lack of S.A.'s prior medical records and the incomplete physical examination form, Dr. Kennedy concluded that the controlled substances prescriptions issued by Dr. Enmon to this patient were not for a legitimate medical purpose. [Tr. 104; Govt. Exh. 6 at 29].

S.A.'s patient file also contains a prescription record that shows her previous treating physician wrote S.A. a prescription for Methylin, a schedule II controlled substance and amphetamine. [Govt. Exh. 21 at 15]. Dr. Enmon issued S.A. a prescription for Xanax but Dr. Kennedy explained that he would have explored whether S.A.'s anxiety was caused by the Methylin. [Tr. 105]. Yet the patient file did not demonstrate such an inquiry or any other information to justify the Xanax prescription. [Tr. 105]. Furthermore, Dr. Kennedy noted that the patient file failed to note any past or future treatment modalities, or an actual plan of treatment for S.A. [Govt. Exh. 6 at 29]. However, over two visits to Ocean Care, this patient was prescribed five hundred and twenty scheduled pills. Dr. Kennedy's overall opinion was that ''this patient's management [was] unacceptable, [fell] below a reasonable standard of care, and may represent a significant danger to the patient's safety.'' [Govt. Exh. 6 at 30].

11. M.G.

M.G. self-reported that he was taking ''Roxy'' and ''Loreys,'' which are slang names for Roxicodone and Lorcet. [Govt. Exh. 22 at 20; Tr. 106]. Dr. Kennedy testified that a patient's use of street names for pain medications would concern him. [Tr. 106]. Dr. Kennedy also noted that although M.G. identified a prior treating physician, M.G.'s patient file did not contain any prior medical records. [Govt. Exh. 22 at 19, 21].

Dr. Enmon's physical examination of M.G. produced ''essentially normal'' findings, although Respondent noted some mild tenderness in the patient's cervical spine. [Govt. Exh. 22 at 2; Tr. 107]. Although the patient file contained a cervical MRI report, Dr. Kennedy credibly testified that this data alone would not justify the issuance of the strengths and amounts of oxycodone prescribed by the Respondent. [Tr. 108–109; Govt. Exh. 22 at 11]. Nor would the results of M.G.'s physical examination justify the level of narcotics the Respondent prescribed for this patient. [Tr. 107–108; Govt. Exh. 22 at 2; Govt. Exh. 6 at 31–32]. Additionally, although the patient self-reported experiencing anxiety and panic attack symptoms, again Dr. Kennedy found no medical justification for issuing M.G. a Xanax prescription. [Tr. 108; Govt. Exh. 22 at 29; Govt. Exh. 6 at 32]. In summary, Dr. Kennedy surmised that ''this patient's management [was] unacceptable, [fell] below a reasonable standard of care, and may represent a significant danger to the patient's safety.'' [Govt. Exh. 6 at 33].

12. J.G.

Respondent's physical examination of J.G. produced ''essentially normal'' findings although Dr. Enmon noted that the patient appeared to be in pain along with some moderate paraspinal tenderness. [Tr. 109; Govt. Exh. 23 at 2]. Dr. Kennedy testified that J.G.'s physical exam and MRI report do not medically justify the prescription Respondent issued to J.G. for oxycodone. [Tr. 109–110; Govt. Exh. 6 at 34–35].

Additionally, J.G.'s patient file documented no past medical history or surgical history for this patient. [Tr. 109; Govt. Exh. 23 at 1]. Although the patient listed receiving treatment from another pain clinic, J.G.'s patient file does not contain any records from that clinic. [Govt. Exh. 23 at 15–16; Tr. 110]. Dr. Kennedy testified that Respondent should have acquired these prior records before prescribing the quantity of oxycodone issued to this patient. [Tr. 110–111]. Furthermore, Dr. Kennedy found that J.G.'s patient file failed to contain any mention of past or future treatment modalities or a treatment plan. [Govt. Exh. 6 at 35].

J.G. denied experiencing any anxiety or panic attack symptoms, but Respondent nevertheless issued J.G. a prescription for Xanax. [Tr. 111; Govt. Exh. 23 at 24]. Dr. Kennedy credibly testified that this prescription was ''not medically legitimate.'' [Tr. 111]. J.G.'s patient file provided no justification for the Xanax prescription. [Tr. 111; Govt. Exh. 23; Govt. Exh. 6 at 35]. In conclusion, Dr. Kennedy found that ''this patient's management [was] unacceptable, [fell] below a reasonable standard of care, and may represent a significant danger to the patient's safety.'' [Govt. Exh. 6 at 35–36].

13. T.G.

T.G. reported lower back pain stemming from a car accident in which she was ejected from the vehicle. [Govt. Exh. 24 at 4–5]. Despite this serious car accident and T.G.'s listing of a prior treating physician, T.G.'s patient file did not contain any prior medical records. [Govt. Exh. 24 at 6; Tr. 112]. Dr. Kennedy also found that the MRI report and physical examination findings for T.G. did not support the medications prescribed by Respondent. [Tr. 112; Govt. Exh. 6 at 37]. Specifically, he opined that T.G. should have been treated with ''non-scheduled modalities, even non-pharmacologic modalities initially prior to advancing to providing 300 narcotics pills.'' [Tr. 112]. In addition, Dr. Kennedy found that T.G.'s patient file failed to note any past or anticipated treatment modalities, or provide any actual treatment plan for the patient. [Govt. Exh. 6 at 38]. Lastly, Dr. Kennedy credibly testified that there was no information in the patient file that would justify the Xanax prescription issued to T.G. by the Respondent. [Tr. 114; Govt. Exh. 6 at 38]. T.G. did not report experiencing any anxiety symptoms. [Govt. Exh. 24 at 14; Tr. 114]. In Dr. Kennedy's expert medical opinion, ''this patient's management [was] unacceptable, [fell] below a reasonable standard of care, and may represent a significant danger to the patient's safety.'' [Govt. Exh. 6 at 38–39].

14. A.J.

A.J. lacerated his left thumb while uninstalling a countertop. [Govt. Exh. 25 at 5]. Prior to seeking treatment at Ocean Care, A.J. had been treated at a hospital emergency room and an urgent care clinic where he had been prescribed Lorcet, a schedule III controlled substance. [Tr. 115; Govt. Exh. 25 at 5–7]. Respondent issued A.J. a prescription for ninety dosage units of thirty milligram Roxicodone and sixty dosage units of two milligram Xanax. [Govt. Exh. 25 at 20–21, 24]. Dr. Kennedy found that the Roxicodone was ''inappropriately prescribed'' to A.J. because Dr. Enmon did not document or justify increasing the amounts and strength of scheduled medications necessary to treat A.J.'s pain symptoms. [Tr. 116; Govt. Exh. 6 at 41]. To that point, Dr. Kennedy noted that while A.J. self-reported pain in the arm, back and neck, in addition to the thumb pain, there was no documentation in the patient file that supported these claims. [Tr. 117; Govt. Exh. 25 at 6]. Nor did Dr. Enmon document any examination of A.J.'s reported pain symptoms outside of examining his left thumb. [Govt. Exh. 6 at 41]. A.J. also reported that ''almost anything'' causes or increases his pain level. [Govt. Exh. 25 at 11]. Dr. Kennedy highlighted that such a nonspecific complaint would cause him to question the patient's credibility. [Tr. 119].

Dr. Kennedy also found the prescription for Xanax was medically illegitimate. [Tr. 118; Govt. Exh. 6 at 41]. While A.J. reported experiencing anxiety symptoms, his patient file did not contain any further information that would support these assertions. [Tr. 118; Govt. Exh. 25 at 23]. Although A.J. reported that he was prescribed Xanax for pain, Xanax is not a drug that is indicated for the treatment of pain. [Tr. 119; Govt. Exh. 11].

Lastly, despite the indications that A.J. had recently received treatment from both a hospital emergency room and an urgent care clinic, his Ocean Care patient file did not contain any prior medical records. [Govt. Exh. 25; Tr. 115]. Nor did his patient file contain any mention of past or anticipated treatment modalities, and there is no documentation in the file ''that indicates a rationale for prescribing ongoing controlled medication.'' [Govt. Exh. 6 at 41]. Thus, Dr. Kennedy concluded that Respondent's treatment of this patient fell below an acceptable standard of care. [Govt. Exh. 6 at 42].

15. L.M.

L.M.'s patient file contained a history and physical examination form, but the physical examination portion of the form is almost entirely blank except for notations of the patient's height, weight, blood pressure and pulse measurements. [Tr. 120; Govt. Exh. 26 at 2]. L.M. self-reported taking several controlled substances, including oxycodone, Soma, Adderall, and Xanax, but Dr. Kennedy found that his patient file failed to provide sufficient information concerning L.M.'s need for these medications. [Tr. 121; Govt. Exh. 26 at 12]. In fact, L.M. reported that he was not currently under the care of a physician. [Govt. Exh. 26 at 18]. Dr. Kennedy further noted that L.M.'s prior medical records were not present in his Ocean Care patient file. [Tr. 121; Govt. Exh. 26].

L.M. reported experiencing anxiety symptoms. [Govt. Exh. 26 at 24]. L.M. also reported taking Adderall, an amphetamine and Schedule II controlled substance. [Tr. 122; Govt. Exh. 26 at 12]. Dr. Kennedy testified that while L.M.'s Adderall use could have produced his anxiety symptoms, Respondent ignored this possibility and instead issued a Xanax prescription to L.M. [Tr. 122–123; Govt. Exh. 26 at 24]. Dr. Kennedy testified that prior to issuing a prescription for Xanax, he would expect that the patient's file contain an anxiety diagnosis based on specific and detailed documentation of the patient's symptoms, psychosocial situation, and prior medical treatment. [Tr. 123].

Furthermore, Dr. Kennedy explained that while prescriptions for a total of three hundred and twenty scheduled pills and sixty dosage units of Soma were provided to L.M., the ''rationale for prescribing narcotics was never mentioned. There is nothing in the chart that even minimally supports the initial prescription of Xanax.'' [Govt. Exh. 6 at 44]. Likewise, L.M.'s patient file failed to reflect any past or anticipated treatment modalities, or provide a treatment plan for the patient. [*Id.*]. Dr. Kennedy concluded that Respondent's treatment of L.M. fell ''below an acceptable standard of care.'' [*Id.*].

16. S.M.

S.M.'s patient file contained a history and physical examination form, but the physical examination portion of the form is blank except for notations of the patient's height, weight, blood pressure and pulse measurements. [Govt. Exh. 27 at 24; Govt. Exh. 6 at 46]. Dr. Kennedy also testified that S.M.'s MRI report showed that the patient had only a ''mild disc bulge and mild bilateral foraminal stenosis,'' findings which do not ''connote any neurological impingement.'' [Tr. 125; Govt. Exh. 27 at 19]. Thus, Dr. Kennedy concluded that S.M.'s physical examination and MRI report do not justify the Roxicodone or Xanax prescriptions that Respondent issued to this patient. [Tr. 124–25; Govt. Exh. 27 at 19; Govt. Exh. 6 at 47]. As Dr. Kennedy noted, there was no documented physical examination in S.M.'s patient file to support any of his treatment. [Tr. 126–27].

Nor did S.M.'s patient file contain any prior medical records, despite the MRI report, which identified S.M.'s referring physician. [Tr. 125; Govt. Exh. 27 at 19]. The patient file also failed to record any treatment modalities or an actual plan of treatment for S.M. [Govt. Exh. 6 at 47]. Consequently, Dr. Kennedy concluded that ''[t]he documentation present in the chart is inadequate to support prescriptions for scheduled agents.'' [*Id.*]. Furthermore, S.M. reported alcohol consumption and a previous DUI arrest. [Govt. Exh. 27 at 8]. Dr. Kennedy credibly testified that when a patient reports a history with addictive substances, he ''would be mindful…when prescribing controlled medications'' to that patient. [Tr. 127]. Lastly, Dr. Kennedy found insufficient justification in the patient file to support the prescribing of Xanax to S.M. [Tr. 128; Govt. Exh. 6 at 47]. In conclusion, Dr. Kennedy found that Respondent's treatment of S.M. fell ''below an acceptable standard of care.'' [Govt. Exh. 6 at 47–48].

17. K.M.

K.M.'s patient file contained a history and physical examination form, but the physical examination portion of the form is blank except for notations of the patient's height, weight, blood pressure and pulse measurements and a checkmark indicating the patient demonstrated normal posture. [Tr. 130; Govt. Exh. 28 at 25; Govt. Exh. 6 at 49].

Dr. Kennedy also testified that findings from K.M.'s MRI report were ''fairly minimal.'' [Tr. 130; Govt. Exh. 28 at 20]. Thus, in Dr. Kennedy's expert medical opinion, the patient's physical examination and MRI report do not medically justify the prescriptions for oxycodone, Lorcet and Xanax issued by Respondent to K.M. [Tr. 130; Govt. Exh. 6 at 50]. Additionally, Dr. Kennedy testified that K.M.'s report of high pain level is not credible in light of her MRI report and physical examination. [Tr. 131–32; Govt. Exh. 28 at 5]. Nor did K.M.'s patient file provide any medical justification for Respondent issuing a Xanax prescription. [Tr. 132–33; Govt. Exh. 6 at 50].

The patient file also lacked any previous medical records other than the MRI report despite the identification of a previous treating clinic. [Tr. 132; Govt. Exh. 28 at 8]. Dr. Kennedy noted that, if K.M. was being treated for chronic pain condition ''that rises to the level of requiring narcotics'' he would expect ''there to be past medical records present in the chart.'' [Tr. 132]. In addition, the patient file failed to list any treatment modalities, either past or anticipated future modalities. [Govt. Exh. 6 at 50; Govt. Exh. 28]. Nor did the patient file illustrate a treatment plan for K.M. [*Id.*]. Lastly, Dr. Kennedy credibly opined that the ''documentation present in the chart is inadequate to support prescriptions for scheduled agents'' and that ''[a] coherent rationale for the treatment of this patient is completely absent.'' [Govt. Exh. 6 at 50]. Thus, Dr. Kennedy concluded that Respondent's treatment of this patient fell below an acceptable standard of care. [Govt. Exh. 50–51].

18. E.L.

E.L. presented complaints of back and shoulder pain stemming from a workplace related injury. [Govt. Exh. 29 at 5–9, 29]. After reviewing the physical examination and the MRI report, Dr. Kennedy credibly opined that those reports do not justify the quantity or strength of opiates prescribed by the Respondent to this patient. [Tr. 134–135; Govt. Exh. 29 at 19–20, 29–31]. Specifically Dr. Kennedy noted that E.L.'s MRI report was ''normal at all levels'' and did not document any ''nerve impingement.'' [Tr. 135; Govt. Exh. 29 at 19–20]. Thus, Dr. Kennedy found that ''the physical examination alone [did not] support the diagnosis of a pain condition that rises to the level of immediately pursuing schedule II narcotic management.'' [Govt. Exh. 6 at 53]. Yet the Respondent, over the course of two visits with this patient, prescribed three hundred and sixty scheduled pills and one hundred and fifty dosage units of Soma. [*Id.*] Dr. Enmon did not document his ''rationale for prescribing narcotics'' to E.L. [*Id.*]. Likewise, Dr. Kennedy found that E.L.'s patient file lacked any justification for the initial prescription of Soma. [*Id.*]. Similarly, on E.L.'s follow-up visit, both the oxycodone and the Lorcet were increased in quantity ''without explanation'' by Respondent [*Id.*].

E.L. reported receiving hydrocodone and Roxicodone from prior treating physician. [Govt. Exh. 29 at 5]. Yet his patient file does not contain any prior medical records. [Govt. Exh. 29; Tr. 133]. Nor does E.L.'s patient file reflect any past or anticipated future treatment modalities, or a treatment plan. [Govt. Exh. 6 at 53–54]. In Dr. Kennedy's expert medical opinion, he found that Respondent's treatment of E.L. fell ''below an acceptable standard of care.'' [*Id.*].

19. E.V.

EV presented complaints of neck and lower back pain. [Govt. Exh. 30 at 3–9]. Respondent issued E.V. a prescription for one hundred and twenty dosage units of thirty milligram Roxicodone, sixty dosage units of fifteen milligram Roxicodone, and ninety dosage units of two milligram Xanax. [Govt. Exh. 30 at 24–25]. But Dr. Kennedy testified that E.V.'s patient file contained a lumbar MRI report, which was not consistent with the pain levels reported by E.V. [Tr. 136; Govt. Exh. 30 at 19–20; Govt. Exh. 6 at 55–56]. Similarly, Dr. Kennedy testified that the findings on E.V.'s physical examination did not medically justify the Roxicodone and Xanax prescriptions issued to E.V. [Tr. 136–37; Govt. Exh. 30 at 25, 27; Govt. Exh. 6 at 55]. E.V. also did not report experiencing any anxiety symptoms, but Respondent issued her a prescription for Xanax. [Govt. Exh. 30 at 14]. Thus, Dr. Kennedy found ''nothing in the chart that even minimally supports the prescription of Xanax.'' [Govt. Exh. 6 at 56]. Similar to the other files, Dr. Kennedy noted this patient file failed to reflect any treatment modalities or a treatment plan. [*Id.*]. Nor did this file contain any previous medical records for E.V. [Govt. Exh. 30]. Lastly, Dr. Kennedy found that ''this patient's management [was] unacceptable and [fell] below a reasonable standard of care.'' [Govt. Exh. 6 at 57].

I. Dr. Kennedy's Findings

In conclusion, Dr. Kennedy identified one patient out of the nineteen patient files he examined where Respondent's treatment met the standard of care. [Tr. 60; Govt. Exh. 6 at 23–24].

Dr. Kennedy found that the Respondent failed to maintain appropriate patient records that supported his prescribing of controlled substances. [Tr. 54–55; *see* G.A. Comp. R. & Regs. 360–3-.02(7) (2012)]. To this point, Dr. Kennedy testified that a patient's medical records are needed prior to treatment because the doctor issuing the prescription ''needs to know what medications, what treatment modalities have been used in the past, either successfully or unsuccessfully, to guide [the treating physician's] treatment in the future.'' [Tr. 141]. Dr. Kennedy also concluded, after his review of the patient files, that Dr. Enmon failed to use ''such means as history, physical examination, laboratory, or radiographic studies, when applicable, to diagnose a medical problem'' because in many of the nineteen patient files there was a ''lack of appropriate physical examination or substantial supporting documentation that would support large doses of narcotic medication.'' [Tr. 55; Govt. Exh. 32 at 3; *see* G.A. Comp. R. & Regs. 360–3-.02(14) (2012)].

Similarly, Dr. Kennedy concluded that Respondent also failed to document that he had taken precautions regarding ''adverse reactions, habituation, and the establishment of chemical dependency'' in the patients for whom he prescribed large quantities of controlled substances. [Tr. 56; Govt. Exh. 32 at 3; *see* G.A. Comp. R. & Regs. 360–3-.02(15) (2012)]. Lastly, Dr. Kennedy found that the Respondent failed ''to maintain patient records documenting the course of the patient's medical evaluation, treatment, and response,'' because there were numerous patient files containing charts ''with entirely blank physical examinations combined with entirely blank follow-up visits.'' [Tr. 56; Govt. Exh. 32 at 3; *see* G.A. Comp. R. & Regs. 360–3-.02(16) (2012)]. To this point, Dr. Kennedy credibly testified that physicians are trained to document every physical examination conducted on a patient. [Tr. 164]. If a doctor fails to document a physical examination in the patient's file, Dr. Kennedy explained that there is a ''presumption [that] [the] physical examination did not occur.'' [*Id.*].

Consequently, Dr. Kennedy found that the Respondent did not issue prescriptions for controlled substances to these patients for a legitimate medical purpose in the usual course of professional practice. [Tr. 60; *see* 21 C.F.R. 1306.04(a) (2011)]. Instead, Dr. Kennedy concluded that Respondent's prescribing created ''a great degree of concern about diversion, abuse, [and] overdosage.'' [Tr. 61]. In judging the legitimacy of Respondent's prescriptions, Dr. Kennedy explained that a prescription would have to be valid based upon the history, studies and physical examination of the patient by the treating physician. [Tr. 160]. In addition, Dr. Kennedy credibly explained that MRI reports, alone, do not provide the medical justification for issuing controlled substances, because ''sometimes MRI's have equivocal findings, or findings that don't rise to the level of prescribing controlled medication on their own, and they have to be combined with a physical examination before a patient is started down this road.'' [Tr. 140]. Dr. Kennedy also credibly testified that pain patients warrant a higher level of scrutiny because they ''are taking chronic addictive medications that are used recreationally.'' [Tr. 164]. But he noted that there were ''a fairly large number of cases'' where Dr. Enmon's patients, on their initial visit, ''would be issued prescriptions for in excess of 300-unit doses of narcotic medications'' even though their ''charts had radiographic studies but no medical histories.'' [Tr. 60–61].

Specifically with regard to the Xanax prescriptions, Dr. Kennedy found that Respondent prescribed a varying number of dosage units of two milligram Xanax to all but one of the nineteen patients. [Govt. Exh. 5; Tr. 137–138]. Two milligrams is one of the highest strengths for that medication. [Tr. 138]. Dr. Kennedy opined that he would not prescribe the highest dosage unit of Xanax as a starting level for that medication. [*Id.*]. In Dr. Kennedy's expert medical opinion, combining Xanax and other controlled substances can also have an additive effect upon a patient. [Tr. 141–42]. Dr. Kennedy explained that such combined effects are ''a matter of concern and need to be discussed with the patient.'' [Tr. 142].

Dr. Kennedy also noted that the Respondent routinely prescribed thirty-milligram dosage units of Roxicodone along

with fifteen-milligram dosage units of Roxicodone to his patients. [Govt. Exh. 5]. Dr. Kennedy explained that such prescribing is appropriate for a patient who reports experiencing breakthrough pain or ''pain not responding to the initial dosage.'' [Tr. 139–140]. Yet in his review of the Respondent's medical files, Dr. Kennedy found no indication that there was any documented need for such breakthrough pain medication. [Tr. 140].

IV. STATEMENT OF LAW AND DISCUSSION

A. Position of the Parties

1. Government's Position

The Government asserts that the appropriate remedy in this matter is revocation of the Respondent's registration. [Govt. Brief at 38]. Specifically in addressing the Section 823(f) public interest factors, the Government argues that three of five factors support the revocation of Respondent's registration. [Govt. Brief at 30]. First, the Government cites factors two and four and argues that the Respondent's experience in dispensing controlled substances and his noncompliance with the applicable law relating to controlled substances weighs in favor of revocation. [Govt. Brief at 30–31]. Lastly, the Government cites factor five and argues that Respondent's lack of remorse and his inability to claim any persuasive mitigating factors for his conduct also supports the revocation of his registration. [Govt. Brief at 31].

The Government makes several arguments under factors two and four. First, citing the Xanax prescriptions, which Respondent issued to eighteen of the nineteen patients in the record, the Government argues that Respondent issued these prescriptions without a legitimate medical purpose and outside the usual scope of professional practice in violation of 21 C.F.R. 1306.04(a) (2011). [Govt. Brief at 31]. Specifically the Government noted that nine patient files revealed no complaints of anxiety symptoms yet all nine of these patients received Xanax prescriptions from Respondent. [*Id.*]. While the other nine patients reported anxiety symptoms, the Government noted that their complaints only consisted of checking or circling an entry on a boilerplate form, which the Government argued was insufficient to justify prescribing the strongest possible dosage of Xanax. [Govt. Brief at 32]. To this point, the Government highlighted Dr. Kennedy's expert testimony that these Xanax prescriptions were not medically justified. [*Id.*].

Next, the Government argues that Respondent's issuance of oxycodone and hydrocodone prescriptions to all nineteen patients also violated 21 C.F.R. 1306.04(a) (2011) and correspondingly various Georgia administrative regulations. [Govt. Brief at 30, 32–34]. First, the Government claims that none of the nineteen patient files contained any past medical records in violation of Georgia administrative regulations. [Govt. Brief at 31, 33]. Next, the Government asserts that Respondent failed to adequately document physical examinations for these patients, another violation of Georgia administrative regulations. [*Id.*].

Similarly, the Government contends that neither the physical examinations of the patients nor their MRI reports provided sufficient justification for Respondent's treatment of these patients with large dosages of heavy strength narcotics. [*Id.*]. In addition, the Government argues that Dr. Enmon inappropriately issued multiple prescriptions for controlled substances to treat breakthrough pain, despite the patient files containing no indication that the patients needed such treatment. [Govt. Brief at 34]. Furthermore, the Government claims, and Dr. Kennedy agrees, that Respondent issued prescriptions for high strength controlled substances without attempting any other treatment modalities. [*Id.*].

Lastly, the Government argues that Respondent violated federal law by issuing controlled substances prescriptions from two unregistered locations, namely the Brunswick Wellness Center and the Ocean Care Clinic. [*Id.*]. The Government notes that Respondent issued controlled substances prescriptions from Ocean Care even though the DEA had not approved his change of address request for this location. [*Id.*]. Moreover, the Government asserts that Respondent wrote prescriptions for controlled substances during his employment at BWC, but never submitted an address change request to the DEA for this location. [*Id.*].

Lastly, under factor five, the Government argues that Respondent has not accepted responsibility or shown any remorse for his alleged unlawful conduct. [Govt. Brief at 31]. Nor, the Government contends, has Respondent presented any persuasive mitigating evidence that supports his continued registration. [Govt. Brief at 35–37]. In conclusion, the Government argues that Dr. Enmon's continued registration with the DEA would be inconsistent with the public interest and that his registration should be revoked. [Govt. Brief at 38].

2. Respondent's Position

Respondent did not file a post-hearing brief.

B. Statement of Law and Analysis

Pursuant to 21 U.S.C. 824(a)(4) (2006),[5] the Administrator may revoke a DEA Certificate of Registration if she determines that such registration would be inconsistent with the public interest as determined pursuant to 21 U.S.C 823(f). In determining the public interest, the following factors are considered:

(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.

[5] The Administrator has the authority to make such a determination pursuant to 28 C.F.R. 0.100(b) (2011).

21 U.S.C. 823(f) (2006).

These factors are to be considered in the disjunctive; the Administrator may rely on any one or a combination of factors and may give each factor the weight she deems appropriate in determining whether a registration should be revoked. *See Robert A. Leslie, M.D.,* 68 Fed. Reg. 15,227, 15,230 (DEA 2003). Moreover, the Administrator is ''not required to make findings as to all of the factors.'' *Hoxie v. DEA,* 419 F.3d 477, 482 (6th Cir. 2005); *see also Morall v. DEA,* 412 F.3d 165, 173–74 (DC Cir. 2005).

The Government bears the burden of proving that the requirements for revocation are satisfied. 21 C.F.R. 1301.44(e) (2011). Once the Government has met its burden of proof, the burden of proof shifts to the Respondent to show why his continued registration would be consistent with the public's interest. *See Medicine Shoppe—Jonesborough,* 73 Fed. Reg. 364, 380 (DEA 2008). To this point, the Agency has repeatedly held that the ''registrant must accept responsibility for [his] actions and demonstrate that [he] will not engage in future misconduct.'' *Medicine Shoppe—Jonesborough,* 73 Fed. Reg. at 387; *see also Samuel S. Jackson, D.D.S.,* 72 Fed. Reg. 23,848, 23,853 (DEA 2007). In short, after the Government makes its *prima facie* case, the Respondent must prove by a preponderance of the evidence that he can be entrusted with the authority that a registration provides by demonstrating that he accepts responsibility for his misconduct and that the misconduct will not re-occur.

1. Factor One: Recommendation of Appropriate State Licensing Board.

Although the recommendation of the applicable state medical board is probative to this factor, the Agency possesses ''a separate oversight responsibility with respect to the handling of controlled substances'' and therefore must make an ''independent determination as to whether the granting of [a registration] would be in the public interest.'' *Mortimer B. Levin, D.O.,* 55 Fed. Reg. 8,209, 8,210 (DEA 1990); *see also Jayam Krishna-Iyer,* M.D., 74 Fed. Reg. 459, 461 (DEA 2009). The ultimate responsibility to determine whether a registration is consistent with the public interest has been delegated exclusively to the DEA, not to entities within state government. *Edmund Chein, M.D.,* 72 Fed. Reg. 6,580, 6,590 (DEA 2007), *aff'd, Chein v. DEA,* 533 F.3d 828 (DC Cir. 2008). So while not dispositive, state board recommendations are relevant on the issue of revoking or maintaining a DEA registration. *See Gregory D. Owens, D.D.S.,* 74 Fed. Reg. 36,751, 36,755 (DEA 2009); *Martha Hernandez, M.D.,* 62 Fed. Reg. 61,145, 61,147 (DEA 1997).

In this case, the Georgia Composite Medical Board (''Georgia Medical Board'' or ''the Board'') has not taken any action against Respondent's medical license or made any recommendations related to this case. Nor has the Board made any recommendation concerning Dr. Enmon's licensure. Nevertheless, the Agency has consistently held that a practitioner's possession of state authority, while a prerequisite to maintenance of a registration, is not dispositive of the public interest

determination. *Mark De La Lama, P.A.,* 76 Fed. Reg. 20,011, 20,018 (DEA 2011). Therefore, I find that this factor does not weigh in favor or against the revocation of Respondent's DEA certificate of registration.

2. Factors Two and Four: Registrant's Experience With Controlled Substances And Compliance With Applicable State, Federal, Or Local Laws Relating To Controlled Substances

Agency regulations provide that a prescription is lawful only if it is ''issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.'' 21 C.F.R. 1306.04(a) (2011). This regulation places the ''responsibility for the proper prescribing * * * of controlled substances'' on the ''prescribing practitioner,'' in this case, Dr. Enmon. *Id.* As the Supreme Court has explained, ''the prescription requirement * * * ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse. As a corollary, [it] also bars doctors from peddling to patients who crave the drugs for those prohibited uses.'' *Gonzales v. Oregon,* 546 U.S. 243, 274 (2006). Likewise, Georgia law contains a similar requirement for controlled substances prescriptions. Ga. Code Ann. 16–13–41(f)(2–3) (2012) (mandating that practitioners must ''act[] in the usual course of [] professional practice'' and only issue controlled substances prescriptions for a ''legitimate medical purpose''); *see also Strong v. State,* 272 SE.2d 281 (Ga. 1980).

Under the Controlled Substances Act (''CSA'' or ''the Act''), it is fundamental that a practitioner establish and maintain a good faith doctor-patient relationship in order to act ''in the usual course of * * * professional practice'' and to issue a prescription for a ''legitimate medical purpose.'' *Laurence T. McKinney,* 73 Fed. Reg. 43,260, 43,265 n. 22 (DEA 2008). The CSA, however, generally looks to state law to determine whether a doctor and patient have established a good faith doctor-patient relationship. *Kamir Garces-Mejias, M.D.,* 72 Fed. Reg. 54,931, 54,935 (DEA 2007).

The Georgia Medical Board has determined that in Georgia it constitutes ''unprofessional conduct'' for a physician to ''fail[] to maintain appropriate patient records whenever Schedule II, III, IV or V controlled substances are prescribed.'' G.A. Comp. R. & Regs. 360–3-.02(7) (2012). Appropriate patient records are defined as containing: ''the patient's name and address; the date, drug name, drug quantity, and patient's diagnosis necessitating the Schedule II, III, IV, or V controlled substances prescription; and records concerning the patient's history.'' G.A. Comp. R. & Regs. 360–3-.02(7)(a–c) (2012). It is also ''unprofessional conduct'' for a Georgia physician to ''fail[] to maintain patient records documenting the course of the patient's medical evaluation, treatment, and response.'' G.A. Comp. R. & Regs. 360–3-.02(16) (2012). Records which must be maintained include ''history and physical, progress notes…and laboratory reports.'' G.A. Comp. R. & Regs. 360–3-.02(16)(a) (2012).

Additionally under Georgia administrative rules, ''unprofessional conduct'' further includes:

Failing to use such means as history, physical examination, laboratory, or radiographic studies, when applicable, to diagnose a medical problem; and

Failing to use medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation, or addiction in the treatment of patients.

G.A. COMP. R. & REGS. 360–3-.02(14–15) (2012).

a. Recordkeeping Violations

In this case, Respondent concedes that the nineteen patient files from his Ocean Care Clinic fail to record when physical examinations were conducted and the specific results of those examinations in support of his diagnoses. While Respondent testified that he performed a physical examination on all Ocean Care patients, he also testified that the charts introduced at the hearing revealed that ''an [physical] exam [was] not documented.'' [Tr. 343; Govt. Exh. 12–30]. By not documenting a patient's physical examination in his charts, Respondent violated Georgia law which mandates that physicians maintain patient records, which specifically include the results of a history and physical examination. G.A. Comp. R. & Regs. 360–3-.02(16) (2012). Despite Respondent's self-serving testimony that the busy nature of his practice somehow excused him from complying with this regulation, I find that Respondent, by failing to document physical examinations, violated Georgia law. [Tr. 345].

Furthermore, Respondent does not dispute that the nineteen patient files from his Ocean Care Clinic were incomplete and lacking in the required patient history records in violation of Georgia regulations. [Govt. Exh. 12–30; Tr. 357–358]. Instead Respondent testified that many of his patients came from clinics that had been shut down and that Ocean Care could not obtain their records. [Tr. 357]. But Respondent admitted that he did not document any efforts to obtain these past medical records. [Tr. 358]. An examination of the nineteen patient files reveals that while Dr. Enmon wrote controlled substances prescriptions to all nineteen patients, their Ocean Care patient file lacked any of their past medical records, or even documentation of efforts to obtain these records. [Govt. Exh. 12–30]. Therefore, I find that Respondent violated Georgia law by issuing controlled substance prescriptions to these nineteen patients without obtaining their past medical records. G.A. Comp. R. & Regs. 360–3-.02(7) (2012).

Related to these findings, I note that Dr. Kennedy concluded, after his review of the patient files, that Dr. Enmon failed to use ''such means as history, physical examination, laboratory, or radiographic studies, when applicable, to diagnose a medical problem'' because in almost all of the nineteen patient files there was a ''lack of appropriate physical examination or substantial supporting documentation that would support large doses of narcotic medication.'' [Tr. 55; Govt. Exh. 6]. Therefore, in light of the Respondent's failure to document physical examinations or obtain any patient records beyond an MRI report, I find that Respondent violated Georgia law by failing to utilize these means to properly diagnose his patients. G.A. Comp. R. & Regs. 360–3-.02(14) (2012).

b. Respondent's Prescribing Practices

Respondent issued Xanax prescriptions to all but one of the patients whose files were introduced into the record. [Govt. Exh. 5; Govt. Exh. 12–30]. Xanax is clinically indicated for the treatment of anxiety and panic disorders. [Tr. 45–46; Govt. Exh. 11]. But nine of these patient files revealed no self-reports or complaints of anxiety or panic attack symptoyms. [Govt. Exh. 13, 15–18, 23–24, 27, 30]. Dr. Kennedy, an expert in the use of such medication, concluded that these Xanax prescriptions lacked any legitimate medical purpose. [Tr. 59, 60; Govt. Exh. 6 at 5, 11, 14, 17, 20, 35, 38, 47, 56]. In light of Dr. Kennedy's uncontroverted expert testimony that these Xanax prescriptions were issued outside the usual scope of professional practice and without a legitimate medical purpose, I consequently find that that Respondent's issuance of these nine prescriptions violated the prescription requirement of both federal and state law. 21 C.F.R. 1306.04(a) (2011); **GA. CODE ANN.** 16–13–41(f) (2012).

Respondent also issued Xanax prescriptions to the other nine patients, however, these patients did report experiencing anxiety and panic attack symptoyms. [Govt. Exh. 12, 14, 19–22, 25–26, 28]. But Dr. Kennedy credibly testified that prior to treating a patient with Xanax, the patient's file should contain ''substantial documentation'' that would support the assignment of a psychiatric diagnosis to the patient. [Tr. 123, 171]. As the Government rightly notes though, these patient files failed to contain any information justifying these prescriptions except for a boilerplate form filled out by the patient. [Govt. Brief at 32; Govt. Exh. 12, 14, 19–22, 25–26, 28]. Dr. Kennedy also questioned Respondent's initial choice of Xanax as a frontline anxiety treatment and the corresponding high dosage unit of Xanax which he prescribed to these patients. [Tr. 171–172]. He credibly concluded that these Xanax prescriptions could not be medically justified. [Tr. 60; Govt. Exh. 6 at 2, 8, 23, 26, 29, 32, 41, 44, 50]. Respondent did not challenge Dr. Kennedy's expert medical conclusion regarding these prescriptions. Accordingly, I find that Respondent issued these Xanax prescriptions for other than a legitimate medical purpose in violation of both federal and state law. 21 C.F.R. 1306.04(a) (2011); **GA. CODE ANN.** 16–13–41(f) (2012).

Respondent further prescribed oxycodone or hydrocodone to all of the nineteen patients whose files were introduced into the record. [Govt. Exh. 5; Govt. Exh. 12–30]. While Dr. Kennedy testified that chronic pain patients warrant a higher level of scrutiny because they ''are taking chronic addictive medications that are used recreationally,'' he noted that there were ''a fairly large number of cases'' where Dr. Enmon's patients, on their initial visit, ''would be issued

prescriptions for in excess of 300-unit doses of narcotic medications.'' [Tr. 60–61, 164]. Even though Respondent's patients typically reported experiencing high levels of pain, Dr. Kennedy concluded that their MRI reports and physical examination findings did not support Respondent's prescription of narcotic pain medications. [Tr. 60, 140–141; Govt. Exh. 12–30; Govt. Exh. 6]. Specifically he testified that ''the numbers and strengths of the narcotic medications that were prescribed were not valid for legitimate medical practice.'' [Tr. 160].

Thus, Dr. Kennedy, who was qualified as expert in the use of controlled substances for pain management, concluded that there was only one patient out of the nineteen where Respondent's issuance of oxycodone or hydrocodone prescriptions met the standard of care. [Tr. 59–60, 141; Govt. Exh. 6]. Dr. Enmon failed to introduce any evidence or make any argument that his treatment of these patients with narcotic pain medication was consistent with the Georgia standard of care or the federal and state prescription requirement. Nor did he challenge Dr. Kennedy's expert medical opinion regarding his treatment of these patients with large numbers of high dosage units of oxycodone and Xanax. Therefore I find that Respondent issued prescriptions for oxycodone and Xanax to these patients in violation of the prescription requirement of both federal and state law. 21 C.F.R. 1306.04(a) (2011); **GA. CODE ANN.** 16–13–41(f) (2012)

Dr. Kennedy also highlighted two patients' files where Respondent issued prescriptions for oxycodone, Xanax, and Soma. [Govt. Exh. 6 at 2–3, 9]. In Dr. Kennedy's expert opinion, ''the unsupported coadministration of oxycodone, Xanax, and Soma'' to these patients ''could represent a significant risk.'' [*Id.*]. Specifically he testified that ''benzodiazepines and the opiates do have an addictive effect'' and that ''the combined effects of these medications is a matter of concern and needs to be discussed with the patient.'' [Tr. 141–142]. Despite the potentially dangerous addictive effect of combining these scheduled medications, Dr. Kennedy did not find any evidence in the patient files that Dr. Enmon took ''any precautions…about adverse reactions, habituation, [or] the establishment of chemical dependency'' for these patients. [Tr. 56; Govt. Exh. 12, 14]. Nor did Dr. Enmon provide any relevant testimony or proffer any evidence to rebut Dr. Kennedy's expert medical conclusion on this point. Therefore I find that Respondent violated Georgia law by issuing controlled substance prescriptions to these two patients without ''proper precautions to avoid..habituation or addiction in the treatment of patients.'' **G.A. COMP. R. & REGS.** 360–3-.02(15) (2012).

Lastly, while the Government introduced evidence concerning another of Respondent's patients, M.B.S., I find that the Government has failed to prove, by a preponderance of the evidence, that Respondent's treatment of M.B.S. violated the Georgia standard of care. The Government did not introduce any expert medical testimony concerning Respondent's treatment of this patient. *C.f. Jack A. Danton, D.O.,* 76 Fed. Reg. 60,900, 60,901 (DEA 2011). The only evidence in the record pertaining to this patient is DI Sikes' testimony regarding the complaint he received from a physician at a local hospital and the patient's medical records which the hospital faxed to the DEA. [Tr. 371–381; Govt. Exh. 7]. Despite the serious allegations regarding Respondent's treatment of M.B.S. contained in Government Exhibit 7, I note the hearsay nature of this complaint and consequently decline to give it substantial weight in this matter. Furthermore, I find that Respondent properly documented his physical examination of M.B.S., in sharp contrast to the other patient records introduced in this proceeding. [Govt. Exh. 7 at 5–6]. Thus, I conclude that the Government has failed to prove that Dr. Enmon's treatment of M.B.S. violated the applicable Georiga standard of care.

c. Prescribing From An Unregistered Location

The CSA and DEA regulations also require registrants to obtain separate registrations for each principal place of business or professional practice where controlled substances are manufactured, distributed, or dispensed. 21 U.S.C. 822(e) (2006); 21 C.F.R. 1301.12(a) (2011). The Agency, however, has provided a limited exemption for practioners from this requirement. 21 C.F.R. 1301.12(b)(3) (2011). Specifically, a practitioner who is already registered at a location in one state is not required to obtain a separate registration for another office located in that same state if the practioner only prescribes controlled substances from that second office and also does not maintain any supplies of controlled substances at that second office. *Id.* Agency regulations, however, also specify that a registrant's certificate of registration ''shall terminate'' if the registrant ''discontinues business or professional practice'' 21 C.F.R. 1301.52(a) (2011).

In addition, any registrant may apply to modify his registration in order to, among other things, change his address, by submitting a request to the Agency. 21 C.F.R. 1301.51 (2011). The regulation further provides that ''the request for modification shall be handled in the same manner as an application for registration.'' *Id.; see also Wedgewood Vill. Pharm., Inc. v. Ashcroft,* 293 F. Supp. 2d 462, 469 (D.N.J. 2003) (''There is no provision at any other place in either the CSA itself, or in DEA's regulations, that indicates or even suggests that the approval of a modification to a registration by the DEA is anything other than permissive.''). Therefore, while the address change request is pending with the DEA, the registrant is not authorized to handle controlled substances at the new location until the DEA approves the modification. *See* 21 C.F.R. 1301.13(a) (2011) (''No person required to be registered shall engage in any activity for which registration is required until the application for registration is granted and a Certificate of Registration is issued by the Administrator to such person.''); *Richard A. Herbert, M.D.,* 76 Fed. Reg. 53,942, 53,959 (DEA 2011).

Here the Government argues that Respondent violated federal law by issuing prescriptions for controlled substances from two unregistered locations, the Brunswick Wellness Center and the Ocean Care Clinic. [Govt. Brief at 31, 34]. The Government does note that Dr. Enmon ceased issuing prescriptions from Ocean Care after he received notification from the DEA that he was not allowed to handle controlled substances at that location. [Govt. Brief at 34].

I find, by a preponderance of the evidence, that Respondent issued controlled substances prescriptions while working at BWC from approximately May 2011 to July 2011. [Tr. 180, 184, 333–335, 363–365; Govt. Exh. 33]. I also find that Dr. Enmon did not seek or obtain a certificate of registration from the DEA which would have authorized him to practice at this location. [Govt. Exh. 3; Tr. 180–181]. In addition, I find that Respondent's registered address in Atlanta does not trigger the exemption in 21 C.F.R. 1301.12(b)(3) (2011), because Dr. Enmon had ceased practicing at his original registered address in approximately 2009. [Tr. 177, 204–205; *see also* 21 C.F.R. 1301.52(a) (2011)]. Thus because Dr. Enmon was neither authorized by the DEA to prescribe at BWC, nor entitled to the relevant exemption for practitioners, I find that he violated federal law by issuing controlled substance prescriptions from BWC. 21 U.S.C. 822(e) (2006); 21 C.F.R. 1301.12(a) (2011).

Similarly, I find, by a preponderance of the evidence, that Respondent issued prescriptions for controlled substances while he operated the Ocean Care Clinic from approximately August 2011 to December 2011. [Tr. 188, 192–193; Govt. Exh. 12–30]. While Respondent requested to change his DEA registered address to Ocean Care on August 31, 2011, I find that the DEA did not approve Dr. Enmon's address change request. [Govt. Exh. 3; Tr. 175–176]. While Dr. Enmon's address change request was pending with the DEA, he lacked the necessary authority to issue prescriptions for controlled substances from Ocean Care. 21 C.F.R. 1301.13(a) (2011); *Herbert,* 76 Fed. Reg. at 53,959 (''Unlike a renewal application, which, when timely filed, remains in effect past the registration expiration date while the DEA makes a final determination on the application, a request for a modification is treated as a new application; a registrant, therefore, is not authorized to dispense or prescribe controlled substances at his new location pending approval of a modification request to change a DEA registered address.''). Consequently, I find that Respondent violated federal law by issuing controlled substance prescriptions from Ocean Care without a DEA registration. 21 U.S.C. 822(e) (2006); 21 C.F.R. 1301.12(a) (2011).

In summary, I find that Respondent violated Georgia law by failing to adequately document physical examinations in his patient files and by prescribing controlled substances to patients without attempting to obtain their past medical records. Next, I find that Respondent was at the very least, reckless or grossly negligent in issuing narcotic and benzodiazepine prescriptions for other than a legitimate medical purpose in violation of both federal and state law. Lastly, I find that Respondent violated federal law by issuing prescriptions for controlled substances from two unregistered

locations. The scope and severity of Dr. Enmon's illicit conduct weighs strongly in favor of a finding that Respondent's continued registration would be inconsistent with the public interest. Accordingly under factors two and four, I find that the grounds do exist for revoking the Respondent's DEA Certificate of Registration.

3. Factor Three: Applicant's Conviction Record Relating to Controlled Substances

The record contains no evidence that the Respondent has been convicted of an offense related to the manufacture, distribution or dispensing of controlled substances. While this factor may support the continuation of Respondent's registration, the Agency has held that this factor is not dispositive to the public interest determination. *Morris W. Cochran, M.D.,* 77 Fed. Reg. 17,505, 17,517 (DEA 2012).

4. Factor Five: Other Factors Affecting the Public Interest

After the Government ''has proved that a registrant has committed acts inconsistent with the public interest, a registrant must 'present sufficient mitigating evidence to assure the Administrator that [he] can be entrusted with the responsibility carried by such a registration.' '' *Medicine Shoppe—Jonesborough,* 73 Fed. Reg. 364, 387 (DEA 2008) (*quoting Samuel S. Jackson, D.D.S.,* 72 Fed. Reg. 23,848, 23,853 (DEA 2007). ''Moreover, because 'past performance is the best predictor of future performance,' *Alra Labs., Inc. v. DEA,* 54 F.3d 450, 452 (7th Cir. 1995), [DEA] has repeatedly held that where a registrant has committed acts inconsistent with the public interest, the registrant must accept responsibility for [his] actions and demonstrate that [he] will not engage in future misconduct.'' *Medicine Shoppe—Jonesborough,* 73 Fed. Reg. at 387; *see also Samuel S. Jackson, D.D.S.,* 72 Fed. Reg. 23, 848, 23,853 (DEA 2007); *John H. Kennedy, M.D.,* 71 Fed. Reg. 35,705, 35,709 (DEA 2006); *Prince George Daniels, D.D.S.,* 60 Fed. Reg. 62,884, 62,887 (DEA 1995). *See also Hoxie v. DEA,* 419 F.3d 477, 483 (6th Cir. 2005) (''admitting fault'' is ''properly consider[ed]'' by DEA to be an ''important factor[]'' in the public interest determination).

Here, I find that Respondent has neither admitted responsibility for his actions nor shown any remorse for his unlawful conduct. Respondent testified at the hearing and denied violating any federal or state law while practicing at Ocean Care. [Tr. 341]. Instead, Respondent testified that he was the victim of a conspiracy which involved both local and federal law enforcement, whose objective, according to Dr. Enmon, was closing Respondent's pain clinic in order to benefit a competing pain clinic. [Tr. 342–43]. In light of the ample evidence in the record showing Respondent's numerous violations of both federal and state law, I do not find Dr. Enmon's allegations of a conspiracy to be credible.

In addition, Respondent has failed to demonstrate any remedial measures he has undertaken to prevent the reoccurrence of his unlawful conduct. Respondent chose not to address any of the nineteen patient files which the Government had introduced into evidence or challenge Dr. Kennedy's expert medical opinion that Respondent's treatment for eighteen of the nineteen patients violated the Georgia standard of care. Nor did Dr. Enmon offer any persuasive assurance that he would modify his treatment of chronic pain patients. Dr. Enmon testified that the only change he would make to his practice would be to better document efforts to obtain patients' past medical records. [Tr. 358]. Therefore, there is no evidence in the record that Dr. Enmon will alter his practice of medicine in order to bring himself into compliance with federal and state law. *C.f. Jayam Krishna-Iyer, M.D.,* 74 Fed. Reg. 459, 459 (DEA 2009) (highlighting remedial measures undertaken by a physician including conducting criminal background checks on patients and developing new procedures to recognize and discharge likely drug abusers).

The only specific allegation Respondent attempted to rebut involved the documentation of the physical examinations he claimed to conduct on his patients. But Dr. Enmon's rebuttal only further demonstrates the danger his continued registration poses to the public interest. While Respondent acknowledged his patient files contained charts where ''a [physical] examination [was] not documented,'' he claimed that while he tried to ''do [his] best to document * * * sometimes days get busy.'' [Tr. 345]. As Dr. Kennedy testified, however, ''[e]very physician knows from being taught in medical school that if [a physical examination] is not documented it did not happen.'' [Tr. 164]. Respondent's cavalier approach to a fundamental requirement of medical practice, the documentation of treatment, poses a continuing danger to the public interest. [Tr. 165].

Respondent also failed to introduce any persuasive mitigating evidence under factor five. Respondent's contention that narcotic therapy was the only cost-effective treatment for his low-income patient base, a claim that other practitioners have advanced, has been squarely rejected by the Agency. *Bienvenido Tan, M.D.,* 76 Fed. Reg. 17,673, 17,680 (DEA 2011) (noting that despite the physician's claim regarding his patient base, ''given that some of these patients had the ability to purchase more drugs (and sometimes multiple drugs) on numerous occasions within a month, it seems likely that they had the ability to pay for some tests and/or consultations''). Indeed as the Government rightly points out, Respondent's own patient files do not reflect any discussions of any alternative treatments, regardless of their cost, besides the seemingly automatic prescription of scheduled medications. [Govt. Brief at 35; Govt. Exh. 12–30]. Similarly, Respondent's complaint that his entire practice could not properly be judged only on the nineteen patient files introduced into evidence also has been rejected by the Agency. [Tr. 345; *see Jacobo Dreszer, M.D.,* 76 Fed. Reg. 19,386, 19,387 (DEA 2011) (''Moreover, where the Government has seized files, it can review them and choose to present at the hearing only those files which evidence a practitioner's most egregious acts.'')]. In fact, the Agency has revoked ''other practitioners' registrations for committing as few as two acts of diversion.'' *Krishna-Iyer,* 74 Fed. Reg. at 463 (*citing Alan H. Olefsky,* 57 Fed. Reg. 928, 928–29 (DEA 1992)).

Therefore, I find that Respondent has failed to present any evidence demonstrating his acceptance of responsibility for his unlawful acts. Likewise, I find that Respondent has failed to proffer any evidence demonstrating remedial measures that he has undertaken to prevent the reoccurrence of his violations. Lastly, I find that Respondent has not presented any persuasive mitigating factors under factor five that would justify his continued registration.

V. CONCLUSION AND RECOMMENDATION

Therefore, I conclude that the DEA has met its burden of proof and has established that grounds exist for revoking the Respondent's DEA registration. The record contains ample evidence that Respondent violated federal and state law in his practice at both BWC and Ocean Care. These violations range from issuing medically illegitimate prescriptions and failing to properly document patient treatment to prescribing from an unregistered location. In light of Respondent's numerous serious violations of both federal and state law and his corresponding refusal to accept responsibility for his unlawful conduct or adopt remedial measures to prevent their reoccurence, I find that Respondent's continued registration with the DEA would be inconsistent with the public interest. Consequently, I recommend that Respondent's controlled substances registration be revoked and his application for renewal and modification of his DEA registration be denied.

Date: April 26, 2012

s/Gail A. Randall

Administrative Law Judge.

[FR Doc. 2012–22848 Filed 9–14–12; 8:45 am]

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DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Henri Wetselaar, M.D.; Decision and Order

On September 27, 2011, I, the Administrator of the Drug Enforcement Administration, issued an Order to Show Cause and Immediate Suspension of Registration to Henri Wetselaar, M.D. (Respondent), of Las Vegas, Nevada. The Show Cause Order proposed the revocation of Respondent's DEA Certificate of Registration as a practitioner, and the denial of any application to renew or modify his registration, on the ground that Respondent's ''continued registration is inconsistent with the public interest.'' Show Cause Order at 1 (citing 21 U.S.C. 823(f) & 824(a)(4)).

The Show Cause Order alleged that from April through August 2010, law