IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff	)	
v.	)	**Case No. 11-08-4376**
MICHAEL EDWARD HUME, P.A., LICENSE NO. PA281,	)	
Defendant.	)	

VOLUNTARY SURRENDER OF LICENSE IN LIEU OF PROSECUTION

State of Oklahoma)
)
Oklahoma County)

I, Michael Edward Hume, P.A., being of lawful age and after first being duly sworn, depose and state as follows:

1. I hereby voluntarily surrender my physician's assistant license no. PA281.

2. The surrender of my license is freely and voluntarily made. I have not been subject to any coercion or duress, and I am fully aware of the consequences of the surrender of my license.

3. I am the subject of an investigation by the Oklahoma State Board of Medical Licensure and Supervision involving allegations that if proven, would constitute grounds for disciplinary action by the Board.

4. The allegations to which I have pled guilty are as follows:

5. Defendant, Michael Edward Hume, P.A., holds Oklahoma physician-assistant license no. PA281 and at the time of the events in question, practiced at Vista Medical Center in Oklahoma City, Oklahoma under the supervision of William M. Valuck, D.O.

6. The Vista Medical Center is owned and operated by Pat Reynolds, a non-physician, who compensates Defendant based solely on his production. At the time of the incidents in question, Defendant treated approximately thirty-seven (37) patients per day.

7. Vista Medical Center does not accept any insurance, Medicare or Medicaid, and accepts only cash. Vista charges $250.00 for the first office visit, $140.00 for the second office visit, and $100.00 per office visit thereafter.

8. Board investigators conducted a chart audit of selected patients of Defendant identifying deficient practices with respect to the lack of medical documentation and follow up care for patients who were prescribed CDS.

9. Defendant met with Board staff on September 27, 2011 and again on February 2, 2012 to discuss the Board's concern regarding the identified deficiencies. Board staff provided education to Defendant and outlined the medical documentation and diagnostic practices expected for patients receiving CDS. Two (2) of the three (3) patient deaths described in Paragraphs 42 through 58 occurred **AFTER** Defendant's two (2) meetings with Board Staff. The third patient death occurred **AFTER** Defendant's first meeting with Board Staff but before the second meeting.

10. After the meeting with Defendant, his prescribing habits and medical documentation and medical care did not change as reflected in follow up chart audits and new complaints received. The three (3) patient deaths described in Paragraphs 42 through 58 further reflect a continuation of prior improper prescribing patterns by Defendant which Board Staff attempted to address in their two (2) meetings with him.

PRESCRIBING VIOLATIONS

PATIENT SWR

11. From December 31, 2010 until February 7, 2012, Defendant wrote or authorized fifty-seven (57) prescriptions for controlled dangerous drugs to Patient SWR for alleged back pain. These prescriptions include seventeen (17) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 2,460 dosage units, and forty (40) prescriptions for Xanax, Soma and Temazepam, Schedule IV controlled dangerous drugs, for 3,540 dosage units, for a total of **6,000 dosage units** for an average of **14.93 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not

maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

12. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #150, Soma #90 and Xanax #90, all without any prior medical records or tests or any documentation to substantiate the alleged back pain. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of these three (3) controlled dangerous drugs for over a year while never obtaining any objective evidence of the patient's pain.

PATIENT FHR

13. From January 6, 2011 until January 26, 2012, Defendant wrote or authorized thirty-six (36) prescriptions for controlled dangerous drugs to Patient FHR for alleged arm pain. These prescriptions include twelve (12) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 1,890 dosage units, twelve (12) prescriptions for Soma, a Schedule IV controlled dangerous drug, for 1,390 dosage units, and twelve (12) prescriptions for Xanax, a Schedule IV controlled dangerous drug, for 1,400 dosage units, for a total of **4,680 total dosage units** at an average of **14.14 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

14. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #120, Soma #90, and Xanax #120, all without any prior medical records or tests or any documentation to substantiate the alleged arm pain. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of Lortab, Soma and Xanax while never obtaining any objective evidence of the patient's complaints.

PATIENT DSR

15. From April 25, 2011 until January 23, 2012, Defendant wrote or authorized twenty-seven (27) prescriptions for controlled dangerous drugs to Patient DSR for alleged pain and anxiety. These prescriptions include nine (9) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 1,430 dosage units, and eighteen (18) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 1,950 dosage units, for a total of **3,380 total dosage units** at an average of **13.63 dosage units**

per day of controlled dangerous drugs. Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

16. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #120, Soma #90 and Xanax #90, all without any prior medical records or tests or any documentation to substantiate the alleged back pain and anxiety. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of these three (3) controlled dangerous drugs while never obtaining any objective evidence of the patient's complaints.

PATIENT TRR

17. From October 19, 2010 until February 6, 2012, Defendant wrote or authorized fifty-three (53) prescriptions for controlled dangerous drugs to Patient TRR for alleged back and shoulder pain. These prescriptions include fifteen (15) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 1,920 dosage units, and thirty-eight (38) prescriptions Soma, Xanax, Temazepam, Provigil, and Ambien, Schedule IV controlled dangerous drugs, for 3,730 dosage units, for a total of **5,650 total dosage units** at an average of **13.55 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

18. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #120 and Soma #120, all without any prior medical records or tests or any documentation to substantiate the alleged back and shoulder pain. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of Lortab, continuing Soma, and adding Xanax, Ambien, Provigil and Temazepam, while never obtaining any objective evidence of the patient's complaints.

PATIENT DHR

19. From August 24, 2011 until February 8, 2012, Defendant wrote or authorized fifteen (15) prescriptions for controlled dangerous drugs to Patient DHR for alleged pain. These prescriptions include five (5) prescriptions for Hydrocodone 10 mg., a Schedule III

controlled dangerous drug, for 660 dosage units, and fifteen (15) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 1,200 dosage units, for a total of **1,860 total dosage units** at an average of **13.10 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not obtain an adequate history, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

20. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #120, Soma #120 and Xanax #120, all without any prior medical records or tests or any documentation to substantiate the alleged pain. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe these three (3) controlled dangerous drugs while never obtaining any objective evidence of the patient's pain.

PATIENT JSR

21. From August 24, 2011 until February 8, 2012, Defendant wrote or authorized eighteen (18) prescriptions for controlled dangerous drugs to Patient JSR for alleged pain. These prescriptions include six (6) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 970 dosage units, and twelve (12) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 1,140 dosage units, for a total of **2,110 total dosage units** at an average of **12.41 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not obtain an adequate history, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

22. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Norco 10 mg. #140, Soma #90 and Xanax #90, all without any prior medical records or tests or any documentation to substantiate the alleged pain. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe these three (3) controlled dangerous drugs while never obtaining any objective evidence of the patient's pain.

PATIENT KBR

23. From November 10, 2010 until February 7, 2012, Defendant wrote or authorized forty-two (42) prescriptions for controlled dangerous drugs to Patient KBR for alleged wrist and back pain. These prescriptions include fifteen (15) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 2,010 dosage units, and twenty-seven (27) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 2,880 dosage units, for a total of **4,890 total dosage units** at an average of **12.26 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

24. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #130 and Soma #90, all without any prior medical records or tests or any documentation to substantiate the alleged wrist and back pain. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of Lortab, Soma and Xanax while never obtaining any objective evidence of the patient's complaints.

PATIENT RBR

25. From September 15, 2010 until February 7, 2012, Defendant wrote or authorized thirty-three (33) prescriptions for controlled dangerous drugs to Patient RBR for alleged shoulder and back pain. These prescriptions include fifteen (15) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 2,190 dosage units, and eighteen (18) prescriptions for Soma and Valium, Schedule IV controlled dangerous drugs, for 1,830 dosage units, for a total of **4,020 total dosage units** at an average of **9.41 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

26. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #120 and Soma #90, all without any prior medical records or tests or any documentation to substantiate the alleged shoulder and back pain. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of Lortab and Soma while never obtaining any objective evidence of the patient's complaints.

DEFENDANT'S PRESCRIBING PATTERN AFTER DEFENDANT

MET WITH BOARD STAFF

27. After meeting with Board staff and receiving education outlining the medical documentation and diagnostic practices expected for patients receiving CDS; Defendant's prescribing pattern and medical documentation failed to improve for the above identified patients, Patients DHR, FHR, SWR, RBR and KBR.

COMPLAINTS RECEIVED AFTER DEFENDANT MET WITH BOARD STAFF

PATIENT KAR

28. From April 10, 2012 until September 7, 2012, Patient KAR was under the care and treatment of Defendant and other physicians at the Vista Medical Center. Defendant's chart reflects that on the patient's **first** visit to Defendant on April 10, 2012, he prescribed Lortab 10 mg, #100, Xanax #90 tablets, Flexeril #90, and Trazadone #30, all without any prior medical records or tests or any documentation to substantiate the alleged back pain. Defendant had no initial patient intake form for Patient KAR and no objective information regarding prior medical history. Subsequent monthly visits had no stated purpose for the return appointment. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe Lortab, Xanax and Soma without obtaining objective evidence of patient's complaints.

29. From April 10, 2012 until September 7, 2012, a six month time period, Patient KAR received a total of eighteen (18) prescriptions for controlled dangerous drugs from Vista Medical Center for alleged back pain including prescriptions for Lortab 10 mg, a Schedule III controlled dangerous drug for 850 dosage units, and six (6) prescriptions for Xanax for a total of 590 dosage units and five (5) prescriptions for Soma for a total of 450 dosage units, Schedule IV controlled and dangerous drugs. Of these eighteen prescriptions, Defendant wrote eleven of these eighteen prescriptions. The remaining 7 prescriptions were written by other medical providers at Vista Medical Center. Defendant failed to order imaging tests or other appropriate tests, he did not obtain appropriate consultations, and he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

30. Prior to coming under the care and treatment of Defendant, Patient KAR had no significant prior prescribing for any CDS for pain management. In the **two years** preceding April, 2012, the **only** CDS pain medicine prescribed for Patient KAR was Lortab 10mg #25, Lortab 7.5mg #38 and Lortab 5 mg #45. The total number of Lortab (most of which was the much lower strength Lortab) prescribed for this ***entire* 24 months period was 108 tablets** and the average **monthly** Lortab prescribed for Patient KAR during 2011 and 2012 was **less than 5 per month.** Defendant's prescribing pattern for Patient KAR represents in excess of a 2900% increase over the prior 2 years. Defendants

medical chart is void of any objective medical documentation to support this increase in CDS pain medication being prescribed to Patient KAR.

31. Defendants' chart contains a document titled "Drug Test Dates", with one hand written date of 3/11 (Patient KAR did not become a patient until April 10, 2012, so it is unknown if this is even Patient KAR record); and two date stamped dates of JUN 05 2012 and SEP 06 2012, but the chart contains no results of any drug testing. There is no evidence that drug testing was done on Patient KAR as Defendant's chart is void of any drug testing results for Patient KAR from April 10, 2012 through September 6, 2012.

PATIENT CNR

32. From February 24, 2011 through August 16, 2012, Patient CNR was under the care and treatment of Defendant and other physicians at the Vista Medical Center. Defendant's chart reflects that on the patient's **first** visit to Defendant on February 24, 2011, at the time she was 30 years old, presenting with neck and back pain. Based on Patient CNR's reported medical history of "back pain after baby" and "1 yr ago in MVA", Defendant prescribed Lortab 10 mg, #120 and Soma 350 #60 and diagnosed "cervical disc disease" and "lumber DJD w/ sciatica R leg" without any prior medical records or tests or any documentation to substantiate the alleged neck and back pain. Defendant's medical records state no purpose for Patient CNR's return appointment or the reason was simply listed as "refills".

33. Defendant increased the number of CDS Hydrocodone to 180 tablets on Patient CNR's 4th return visit on June 29, 2011, without any objective medical evidence to support this increase. Patient CNR continued to receive this amount of CDS at each prescription refill while under the care of Defendant and Vista Medical Center.

34. From February 24, 2011 through August 16, 2012, Patient CNR received a total of forty-eight (48) prescriptions for controlled dangerous drugs from Vista Medical Center for alleged neck and back pain including prescriptions for Hydrocodone (Lortab or Norco) 10 mg, a Schedule III controlled dangerous drug for 3,270 dosage units, and Diazepam (Valium) 10 mg for a total of 1,050 dosage units and Carisoprodol (Soma) 350 mg for a total of 1,860 dosage units, Schedule IV controlled and dangerous drugs. Of these forty-eight (48) prescriptions, Defendant wrote thirty-six (36) of these prescriptions. The remaining twelve (12) prescriptions were written by other medical providers at Vista Medical Center. Defendant failed to order imaging tests or other appropriate tests, he did not obtain appropriate consultations, and he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

35. In August, 2012, Patient CNR was receiving an average of 13 CDS tablets per day.

36. Prior to coming under the care and treatment of Defendant, Patient CNR had no significant prior prescribing for any CDS for pain management. In the **fourteen months** preceding becoming Defendant's patient, the **only** CDS pain medicine prescribed for Patient CNR **for the entire year,** was Hydrocodone 5 mg (1/2 the strength prescribed by Defendant) #40 and Acetaminophen and Codeine Phosphate 300mg/30mg, #20. The total number of Hydrocodone (5mg, ½ strength than Defendant prescribed) prescribed for this ***entire 14*** **month period was 40 tablets** and the average **monthly** dose of less than 3 tablets per month. Defendant's prescribing pattern for the initial Hydrocodone dose of **10 mg** for **120 tablets** to Patient CNR represents in excess of a 4100% increase over the prior 14 months. Defendant's medical chart is void of any objective medical documentation to support this increase in CDS pain medication being prescribed to Patient CNR.

37. Defendant's chart is void of any evidence of drug testing on Patient CNR during the time she is a patient of Defendants and receiving large quantities of CDS.

38. During the above stated time period, Patient CNR who is 5 feet 3 inches tall, went from 108 pounds at the initial visit, to a weight loss down to 92.4 pounds. Defendant failed to note this significant weight loss and failed to follow up with appropriate tests, consultations or order any additional testing of the patient.

PATIENT DNR

39. From September 17, 2010 through August 15, 2012, Patient DNR was under the care and treatment of Defendant and other physicians at the Vista Medical Center. Defendant's chart reflects that on the patient DNR's **first** visit to Defendant on September 17, 2010, he was 27 years old, presenting with knee and lower back pain. Based on Patient DNR's reported medical history of knee pain from back pain injuries arising from motor vehicle accidents occurring in January 2009 and January 2003. Defendant prescribed Lortab 10 mg, #130 and Soma 350 #120 and diagnosed "T-L-S chronic pain and Right knee ligament injury without any prior medical records or tests or any documentation to substantiate the alleged knee and back pain. Defendant's medical records state no purpose for Patient DNR's return appointment or the reason was simply listed as "refills".

40. Defendant increased the number of CDS Hydrocodone to 180 tablets on Patient DNR's 3rd return visit on November 11, 2010, without any objective medical evidence to support this increase. Patient DNR continued to receive this amount of CDS at each prescription refill while under the care of Defendant and Vista Medical Center.

41. From September 17, 2010 through August 15, 2012, 24 month time period, Patient DNR received a total of seventy-nine (79) prescriptions for controlled dangerous drugs from Vista Medical Center for alleged knee and back pain including prescriptions for Hydrocodone 10 mg, a Schedule III controlled dangerous drug for 3,700 dosage units, and

Diazepam (Valium) 10 mg for a total of 750 dosage units and Alprazolam (Xanax) 1 mg for a total of 600 dosage units and Carisoprodol (Soma) 350 mg for a total of 2,280 dosage units, Schedule IV controlled and dangerous drugs and Temazepam 30 mg for a total of 300 dosage units. Of these seventy-nine (79) prescriptions, Defendant wrote sixty-eight (68) of these prescriptions. The remaining eleven (11) prescriptions were written by other medical providers at Vista Medical Center. Defendant failed to order imaging tests or other appropriate tests, he did not obtain appropriate consultations, and he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

42. In August, 2012, Patient DNR was receiving an average of 15 CDS tablets per day.

43. Prior to coming under the care and treatment of Defendant, Patient DNR had no significant prior prescribing for any CDS for pain management. In the **thirty-three months months** preceding becoming Defendant's patient, the **only** CDS pain medicine prescribed for Patient CNR **for this entire time,** was Hydrocodone (10 mg, 7.5 and 5mg) total tablets #113 and Oxycodone 7.5mg #30. The total number of Hydrocodone and Oxycodoneprescribed for this ***entire 33*** **month period was 143 tablets** and the average **monthly** dose of less than 4.3 tablets per month. Defendant's prescribing pattern for the initial Hydrocodone dose of **10 mg** for **130 tablets** to Patient DNR represents in excess of a 3000% increase over the prior 33 months. Defendant's medical chart is void of any objective medical documentation to support this increase in CDS pain medication being prescribed to Patient DNR.

44. Defendant's chart contains evidence of only two urine drug screens conducted on January 10, 2011 and February 11, 2011, reflecting that the urine drug screen was ***negative for opiates.*** There is no evidence that the finding of "no opiates" in the urine drug screen was discussed with Patient DNR. Defendant continued prescribing CDS in the same quantities.

PATIENT DEATHS

45. Board Investigator RR recently received information regarding the deaths of three (3) of Defendant's patients. The three (3) patients are SRR, LHR and BPR. Information obtained consisted of reports from the Office of the Chief Medical Examiner for the State of Oklahoma on all three (3) deaths. Those reports were received on August 16, 2013. Further, Investigator RR obtained medical records on all three deceased patients from Defendant's clinic. Those records were obtained August 20, 2013.

PATIENT SRR

46. From November 29, 2010 until November 7, 2011, Defendant wrote or authorized twenty-six (26) prescriptions for CDS to Patient SRR for alleged pain. Additionally,

Defendant had knowledge of six (6) prescriptions for CDS written in his clinic by his supervising physician, Dr. Valuck. These prescriptions included eight (8) prescriptions for Xanax by the Defendant and two (2) prescriptions for Xanax by Defendant's supervising physician, Dr. Valuck. Defendant's prescriptions to Patient SRR for Xanax were initially .25 mgs later increasing to .50 mgs and finally 1 mg dosages. On the first three occasions Defendant prescribed Xanax to Patient SRR. he prescribed ninety (90) dosage units. He increased his prescription to 120 dosage units in May of 2011.

47. Defendant prescribed Soma to Patient SRR on nine (9) separate occasions. On each occasion Defendant prescribed Soma 350 mgs in 120 dosage units. Additionally, Defendant's supervising physician, Dr. Valuck, prescribed 350 mgs of Soma in 120 dosage units on two occasions to Patient SRR.

48. Defendant prescribed Lortab to Patient SRR on nine (9) separate occasions. Defendant's supervising physician, Dr. Valuck, prescribed Lortab to Patient SRR on two (2) occasions. The dosage units varied from 120 dosage units to 180 dosage units.

49. Defendant prescribed and had knowledge of prescriptions from his supervising physician totaling **thirty-two (32) prescriptions for 4,050 dosage units for an average of 10.8 dosage units per day of CDS to Patient SRR.** Defendant's chart on Patient SRR reveals that he failed to perform an adequate physical exam on his patient prior to prescribing the CDS, that he did not order appropriate tests, that he did not obtain proper consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of Patient SRR.

50. Defendant's chart reflects that on the patient's first visit to Defendant, he prescribed Lortab 10 mg #120 and Soma #120 all without any prior medical records or tests or any documentation to substantiate the alleged back pain and ankle pain. Defendant's medical chart on Patient SRR further reflects that the patient was on no CDS at the time of the first visit on November 29, 2010. Subsequent monthly visits by Patient SRR to the Defendant were for either the stated purpose of "refills" as noted in the chart or the chart is entirely silent as to the reason for the monthly visit. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of CDS while never obtaining any objective evidence of the patient's complaint.

51. Patient SRR died on November 9, 2011 only two days after his final visit to Defendant. According to the report of the Office of the Chief Medical Examiner of the State of Oklahoma, Patient SRR died of acute Hydrocodone intoxication.

PATIENT LHR

52. Patient LHR was a patient at Defendant's clinic from October 20, 2011 until November 2, 2012, the date of her death.

53. During the time Patient LHR was under the care of Defendant, he wrote or authorized thirteen (13) prescriptions for CDS to Patient LHR for alleged pain and anxiety. These prescriptions include seven (7) prescriptions for Hydrocodone 10 mgs for 1,140dosage units as well as six (6) prescriptions for Xanax for 720 dosage units. Further, Defendant's supervising physician, Dr. Valuck, wrote or authorized twelve (12) prescriptions for CDS to Patient LHR for alleged pain and anxiety. These prescriptions include five (5) prescriptions for Xanax for 600 dosage units, four (4) prescriptions for Lortab for 660 dosage units, one (1) prescription for Flexeril for 90 dosage units and two (2) prescriptions for Oxycodone for 180 dosage units.

54. **Defendant either prescribed CDS or had knowledge of his supervising physician's prescriptions of CDS to Patient LHR in a total amount of twenty-five (25) prescriptions for 3,390 dosage units for an average of 9.04 dosage units per day of CDS.**

55. Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the CDS, that he did not order appropriate tests and that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

56. Patient's final visit to Defendant occurred on October 31, 2012. On that visit Defendant prescribed 180 dosage units of Hydrocodone 10 mgs. Defendant also prescribed 120 dosage units of Xanax to Patient LHR on October 31, 2012. Defendant's supervising physician, Dr. Valuck, prescribed 90 dosage units of Oxycodone to Patient LHR on October 31, 2012. Defendant was aware of Dr. Valuck's prescription of Oxycodone on the same date he prescribed Xanax and Lortab to Patient LHR.

57. Patient LHR died on November 2, 2012, two days following her final visit to Defendant's clinic. According to the Office of the Chief Medical Examiner of the State of Oklahoma, her probable cause of death was acute alprazolam, methamphetamine and hydrocodone toxicity.

PATIENT BPR

58. Patient BPR was a patient in Defendant's clinic from October 13, 2011 until his final visit on September 12, 2012.

59. During the time Defendant saw Patient BPR in his clinic, he wrote or authorized thirty (30) prescriptions for CDS to Patient BPR for alleged pain and anxiety. These prescriptions included ten (10) prescriptions for Xanax for 930 dosage units, nine (9) prescriptions for Soma for 810 dosage units, and eleven (11) prescriptions for Hydrocodone for 1,340 dosage units. **Defendant prescribed a total of thirty (30)**

prescriptions for 3,080 dosage units at an average of 9.625 dosage units per day of CDS to Patient BPR.

60. Defendant's chart on Patient BPR reveals he failed to perform an adequate physical examination on this patient prior to prescribing any CDS, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of Patient BPR.

61. Patient BPR's final visit to Defendant's clinic occurred on September 12, 2012. On that office visit Defendant prescribed 140 dosage units of Hydrocodone, an increase over the prior prescription of 120 dosage units. Further, on the same office visit Defendant prescribed ninety (90) dosage units of Soma. Further, on that office visit Defendant prescribed 120 dosage units of Xanax, an increase over the 90 dosage units previously prescribed.

62. Patient BPR died on September 30, 2012, eighteen (18) days following his final visit to Defendant's clinic. According to the report of the Office of the Chief Medical Examiner of the State of Oklahoma, Patient BPR died as a result of acute combined intoxication with hydrocodone and alprazolam.

63. Defendant is guilty of unprofessional conduct in that he:

A. Engaged in dishonorable or immoral conduct which is likely to deceive, defraud or harm the public in violation of 59 O.S. § 509 (8) and OAC 435:10-7-4 (11).

B. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509 (13), OAC 435:10-7-4(39), and OAC 435:15-5-11(7).

C. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509 (18) and OAC 435:10-7-4(41).

D. Prescribed or administered a drug or treatment without sufficient examination and the establishment of a valid physician patient relationship in violation of 59 O.S. §509 (12).

E. Prescribed, dispensed or administered a controlled substance or narcotic drugs in excess of the amount considered good medical practice, or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. 509(16).

F. Engaged in the indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of OAC 435:10-7-4(1).

G. Prescribed, dispensed or administered controlled substances or narcotic drugs in excess of the amount considered good medical practice or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standard in violation of OAC 435:10-7-4(2) and (6).

64. I hereby submit my wallet card and wall certificate as evidence of my intent to surrender my license.

65. I hereby agree that I will not apply for reinstatement of my Oklahoma physician's assistant license for a minimum of one year from the entry of the Order Accepting Voluntary Surrender in Lieu of Prosecution, and that if the Board ever reinstates my Oklahoma physician's assistant license, it will be under terms of probation to be set by the Board at the time of reinstatement.

66. As a condition to accepting my surrender of license in lieu of prosecution, I acknowledge that the Board may require me to pay all costs expended by the Board for any legal fees and costs, expended by the Board for any legal fees and costs, and any investigation, probation and monitoring fees, including but not limited to staff time, salary and travel expense, witness fees and attorney fees.

DATED this 30 day of Oct, 2013.

Michael Edward Hume, PA 281

Subscribed and sworn before me this 30th day of October, 2013.

JANA LANE NOTARY PUBLIC IN AND FOR STATE OF OKLAHOMA EXP: 06-26-2016 COMMISSION #12005910

Jana Lane
Notary Public

My commission expires on 06-26-2013.

ACCEPTED:

Gerald C. Zumwalt, M.D.
Secretary Oklahoma State Board of Medical
Licensure and Supervision

Date: 11-1-13