COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1333

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SAMUEL L. RICE, M.D., LICENSE NO. 18974, P.O. BOX 630, 299A GLASGOW ROAD, BURKESVILLE, KENTUCKY 42717

SECOND AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through the Chair of Inquiry Panel B, and Samuel L. Rice, M.D. ("the licensee"), and, based upon their mutual desire to fully and finally resolve the pending noncompliance investigation without an evidentiary hearing, hereby enter into the following SECOND AMENDED AGREED ORDER:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bses for this Second Amended Agreed Order:

1. At all relevant times, Samuel L. Rice, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is family medicine.
3. On or about June 2, 2011, the licensee entered into an Agreed Order, Case No. 1333, in which he stipulated the following facts:

    - On or about July 9, 2010, the Board received a grievance alleging that the licensee prescribed narcotics to Patient A although he knew that Patient A was a drug addict and after Patient A's family had informed him that Patient A abused the prescriptions and requested that he no longer prescribe narcotics to Patient A.
    - As a result of the grievance, the Board requested that the Drug Enforcement and Professional Practices Branch of the Cabinet for Health Services ("the Cabinet") analyze the licensee's prescribing habits.
    - On or about August 9, 2010, the Cabinet, through Chris Johnson, R.Ph., Office of Inspector General, informed the Board that a KASPER report of the

licensee's prescribing for the period July 1, 2008 until August 1, 2010 had been analyzed and from which twenty (20) patient records were recommended for further review, based upon the patients' ages, addictive drug combinations, polypharmacy, distances traveled to the pharmacy, and use of phentermine for more than four months aggregate in a calendar year.

- Fifteen (15) of the twenty (20) recommended patients records were subpoenaed from the licensee and forwarded to a Board consultant for review.
- Upon reviewing the patient charts and the KASPER report from the Cabinet, the consultant concluded that the licensee failed to conform to or deviated from acceptable and prevailing medical practices for the prescribing of controlled substances in that most cases lacked substantial documentation of diagnosis necessitating the use of controlled substances; many visits had no history of present illness and often only the chief complaint had noted "checkup" or "med refill"; most cases lacked documentation of a rationale for increasing dosages of controlled substances; patients were not monitored for appropriate use of their prescriptions (for example, by use of pill counts, KASPER reviews, or drug screens); warning signs of possible abuse (for example, requests for early refills) did not appear to put up any red flags or were not otherwise addressed; anoretic drugs were prescribed without requiring that the patient lose weight; there was a lack of appropriate labs and diagnostic and monitoring tests; the amount of controlled substances prescribed was large for a primary care physician without getting consults from pain specialists or other specialists.
- In addition, the consultant concluded that general medical care was absent or severely lacking overall, particularly in monitoring ongoing medical problems (for example, diabetes) or health maintenance and preventative medicine. The consultant noted that the practice appeared to be an urgent care practice but many patients came in on a regular routine and regular basis.
- The consultant concluded that the pattern of the licensee's medical practices demonstrated gross negligence, incompetence and/or ignorance in each and every patient chart.
- In the cases of Patients A, B, H and O, the consultant opined that the licensee's departures from acceptable and prevailing medical practices were of such a nature that the Board should act immediately to restrict or suspend the licensee's license to practice to medicine in order to protect patients and the public from imminent danger.

4. Pursuant to the Agreed Order, Case No. 1333, the licensee agreed to successfully complete the "Prescribing Controlled Drugs" course at The Center for Professional Health at Vanderbilt University Health Center or the University of South Florida; enroll in and successfully complete the ProBe Program at the Center for Personalized Education for Physicians (CPEP); enroll in and complete the CPEP

Documentation Seminar and Personalized Implementation Program; maintain a "controlled substances log" for all controlled substances prescribed, subject to Board consultant review; to reimburse the Board's costs in the amount of $3,225.00 within one (1) year; and to not violate any provision of KRS 311.595 and/or 311.597.

5. On or about August 11-13, 2011, the licensee completed the "Prescribing Controlled Drugs" course.
6. On or about September 30, 2011, the licensee completed the CPEP Documentation Seminar.
7. In or around May 2012, the licensee failed the Personalized Implementation Program ("PIP").
8. In or around November 2012, the licensee participated in a PIP Addendum but again, failed the program. He then failed a second Addendum in or around June 2013.
9. The licensee retook the CPEP Documentation Seminar in or around September 2013.
10. The licensee then failed a third PIP Addendum in or around February 2014 and also failed a fourth PIP Addendum in or around July 2014.
11. In or around July 2015, a Board consultant reviewed twelve (12) of the licensee's patient charts and found that the licensee departed from or failed to conform to acceptable and prevailing standards and that in some instances he demonstrated gross incompetence, gross ignorance, or gross negligence, stating in part

> ... Review of the records shows evidence of disorganization and lack of attention to detail. The inadequate documentation would not allow another

provider to easily assume the care of these patients, based on the physician's documentation alone.

The documentation is oftentimes confusing, with a haphazard listing of diagnoses that do not necessarily match the narrative in the HPI or the findings on the physical exam. Medications are oftentimes duplicated, and more often than not, the rationale for changing from one medication to another is not well explained. As a reviewer, I also get the impression that Dr. Rice runs his office as a "refill station," instead of addressing underlying etiologies of the presenting problems of patients.
One is left with the impression that brevity is of the utmost importance to Dr. Rice. The shortcomings regarding documentation are of particular concern given the fact that the physician has undergone at least two prior interventions of Personalized Implementation Program (PIP) through the Center for Personalized Education for Physicians (CPEP) to address these very issues.
...

Even the physician's template physical exams are riddled with misspellings and meaningless phrases. Given his situation, one would think that he would at least make extra effort to assure that the templates were devoid of such deficiencies.
...

Taken as a whole, the records submitted for review demonstrate that the care provided by Dr. Rice reflects a practice of medicine that is below the minimum standards of care and reflects gross ignorance, gross negligence, and gross incompetence as a result thereof.

The consultant also noted areas of particular concern and danger to include failure to follow up a syncopal event with an appropriate examination; failure to recognize hazards of uses of multiple controlled substances; co-administration of benzodiazepines or hypnotics with opioids; failure to identify and address red flag indications of drug abuse and diversion.

12. On or about March 17, 2016, the licensee appeared before the Panel to address the consultant findings and agreed to enter into an Amended Agreed Order, Case No. 1333, in lieu of the issuance of a Complaint and Emergency Order of Suspension.

13. Pursuant to the Amended Agreed Order, Case No. 1333, the licensee agreed to the following terms and conditions:

a. Beginning immediately, the licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed;

i. The controlled substances log SHALL include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. All log sheets SHALL be consecutively numbered, legible i.e. printed or typed, and SHALL reflect "call-in" and refill information. Prescriptions SHALL be maintained in the following manner: 1) patient; 2) chart; and 3) log;

ii. The licensee SHALL permit the Board's agents to inspect, copy and/or obtain the controlled substance log and other relevant records, upon request, for review by the Board's agents and/or consultant;

iii. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Amended Agreed Order. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Amended Agreed Order;

iv. The licensee expressly understands and agrees that at least two (2) favorable consultant reviews must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Amended Agreed Order;

b. Within twenty (20) days of the filing of this Amended Agreed Order, the licensee SHALL contact LifeGuard, 777 East Park Drive, Harrisburg, Pennsylvania, 17111, Tel. (717) 909-2590, to schedule an individualized clinical competency assessment for the earliest dates available to both LifeGuard and the licensee;

i. Both parties may provide relevant information to LifeGuard for consideration as part of the assessment. In order to permit the Board to provide such relevant information, the licensee SHALL immediately notify the Board's Legal Department of the assessment dates once the assessment is scheduled;

ii. The licensee SHALL travel to LifeGuard and complete the assessment as scheduled, at his expense;

iii. The licensee expressly understands and agrees that LifeGuard will issue its final report, in accordance with its internal policies;

iv. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that Lifeguard will provide a copy of the final report to the Board's Legal Department promptly after its completion;

v. If the final report includes a remediation plan, the licensee SHALL immediately enter into an oversight monitoring agreement with LifeGuard to implement and oversee the remediation plan;

1. The licensee SHALL comply with all directives and instructions of LifeGuard during the duration of the remediation plan;
2. If engagement of a preceptor is a component of the remediation plan, the licensee SHALL BE responsible for ensuring that his preceptor(s) comply with all directives and instructions of LifeGuard during the duration of the remediation plan and he SHALL immediately report any noncompliance directly to LifeGuard;
3. The licensee understands and agrees that any failure to comply with the directives and instructions of LifeGuard during the duration of the remediation plan SHALL constitute a violation of this Amended Agreed Order and shall be grounds for immediate suspension of his license to practice medicine in the Commonwealth of Kentucky;
4. In the event that the licensee's LifeGuard remediation plan should be come suspended for any reason, the licensee SHALL immediately cease the "practice of medicine," as that term is defined in KRS 311.550(10), until further order of the Panel. His failure to do so, shall constitute a violation of this Amended Agreed Order and shall be grounds for immediate suspension of his license to practice medicine in the Commonwealth of Kentucky;
5. The licensee SHALL TAKE ALL NECESSARY STEPS, including the execution of waivers and/or releases, to ensure that LifeGuard provides timely written reports to the Board outlining his progression and compliance with the remediation plan;

6. The licensee SHALL SUCCESSFULLY complete all requirements of the LifeGuard remediation plan, at his expense and as directed by LifeGuard;
7. If deemed necessary and appropriate by LifeGuard, the licensee SHALL SUCCESSFULLY COMPLETE any post-remediation assessments, at his expense and as directed by LifeGuard;

vi. The licensee expressly understands and agrees that if LifeGuard opines or recommends that he engage in a "structured retraining program," the licensee SHALL NOT perform any act which would constitute the "practice of medicine or osteopathy," as that term is defined in KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities - unless and until approved to do so by the Panel;

c. Within sixty (60) days of the date of filing of this Amended Agreed Order, the licensee SHALL obtain and submit to the Board a report, from Texas A & M, of his participation in and completion of the Medical Record Documentation Course from the Texas A & M KSTAR program;

d. Pursuant to KRS 311.565(1)(v) and the licensee's 2011 Agreed Order, the licensee SHALL reimburse the Board's investigation (consultant) costs of $5,937.50, on or before April 6, 2016; and

e. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

14. In addition, pursuant to the Amended Agreed Order, Case No. 1333, the licensee agreed that

> ...if he should violate any term or condition of the Amended Agreed Order, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Amended Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Amended Agreed Order would render the licensee's practice an immediate danger to the

> health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Amended Agreed Order.

15. In or around April 2016, the licensee, through his employing hospital, submitted certification from Texas A & M, of the licensee's participation in and completion of the Texas A & M KSTAR Medical Record Documentation Course.

16. In or around May and June 2016, the licensee submitted to an individualized clinical competency assessment through LifeGuard which utilized a battery of modalities to evaluate the licensee's clinical competence in a variety of skills, abilities, and content in the following areas: Family Medicine, Ambulatory Care (Acute), Ambulatory Care (Chronic), Mechanisms of Disease, Pharmacotherapeutics and Ethics & Communication.

- In regard to Family Medicine, the licensee did not perform with in the satisfactory range in the following areas: Test Ordering & Interpretation, Diagnosis, and Blood & Hematologic Disorders.

- In regard to Ambulatory Care (Acute), the licensee's area of deficiency was in ordering of diagnostic studies.

- In regard to Ambulatory Care (Chronic), LifeGuard noted

> Dr. Rice's performance in this module was well below satisfactory. It is noted that Dr. Rice's performance on this module is somewhat consistent with the findings of the Board's independent consultant's review of medical records. Content area scores, particularly in extra large proportion of total test items, was well below acceptable scoring ranges. These content areas include content related to the practice of family medicine and internal medicine.
>
> In all content areas, Dr. Rice performed well below the acceptable score. Given a typical family medicine practice population and the chronicity of the general patient population, the results of these module are concerning.

- In regard to Mechanisms of Disease, LifeGuard noted

> Dr. Rice's performance indicates that his knowledge of disease processes, organ systems and processes, and task objectives, such as identification of natural history or characteristics of disease processes, recognition of underlying disease processes, and recognition of findings related to diagnostic technologies are above average, yet his practice-based knowledge as exhibited is far below satisfactory. There appears to be a significant disconnect between Dr. Rice's knowledge versus practice patterns.

- In regard to Pharmacotherapeutics, LifeGuard noted

> Dr. Rice's overall performance in this module was satisfactory; however, there were a number of content areas that were below the satisfactory scoring range: organ systems and processes impacted specifically the cardiovascular system. In the clinical task content area, applying basic principles and identifying drug effects and interactions were on the low range of satisfactory. In the drug class content area, the nervous system, analgesics including narcotics were also on the low range of satisfactory. The performance in these areas appears to be consistent with the prescribing issues previously identified in the Board order. The low scores regarding narcotics are also troubling since Dr. Rice recently completed course work to bolster his knowledge of proper opioid use.

- In regard to Ethics & Communication, LifeGuard noted

> Dr. Rice's performance in this knowledge test module was satisfactory. Dr. Rice scored well in the ACGME competency areas of Communication, Professionalism and Patient Care. Systems based practice scoring was on the low end of the acceptable scoring range.

17. In or around September 2016, the licensee entered into an oversight monitoring agreement with LifeGuard to implement and oversee a remediation plan.

18. As part of the remediation plan, the licensee submitted to 12 months of on-site (announced and unannounced) practice monitoring by LifeGuard at Cumberland County Hospital.

19. In or around September 2017, LifeGuard conducted an opioid and controlled substance audit as part of its oversight agreement and found the following:

- There was evidence that the controlled substance and opioids ordered were properly documented according to the Kentucky prescribing guidelines in 10 of the 10 cases. In 62% of the charts there was no documentation that non-addictive medication regimens were inadequate prior to the initiation of opioids for pain relief; however, it was noted the all of the patients for whom records were selected for audit have been on long-term opioid therapy so that non-addictive medication regimens, if attempted, would have been reflected many years prior to this audit.
- Pain scales were documented in 8 out of the 10 cases reviewed.
- Pain management contracts were noted for 9 or the 10 records reviewed for patients receiving opioids for pain control.
- There were no records reviewed that indicated an increase in dosages of opioids and/or controlled substances.
- Urine drug screens were documented in 6 or the 10 cases reviewed which is an increase from the previous audit.
- Pill counts were noted in 4 of the 10 cases reviewed, representing an another increase from previous audit. No early refills were noted.
- Evidence of periodic review of medication regimens for effectiveness toward stated goals of treatment is difficult to determine, as goals of treatment are difficult to locate in the record. It is noted that the majority of these patients' records reviewed indicated longterm opioid and controlled substance use (Benzodiazepines) and there is little to no evidence of initial treatment goals established. However, there were 6 of 10 cases in which there was documentation reflecting "discussed with patient proper use of narcotics and sedatives" and "discussed the need to limit use of pain medications and sedatives".
- There was evidence of continuing pain management referrals; however, neither followup with the patient related to the treatments provide by pain specialists (i.e. pain injections and additional appointments with specialists) nor a consultation letter from the pain management specialists was not found in any of the records.
- There was evidence in 100% of the cases reviewed that a patient specific KASPER report was reviewed prior to refill of an opioid/controlled substance.

LifeGuard additionally noted that many patients to whom the licensee was prescribing opioids and controlled substances had been taking these medications long-term (many for decades); there were seldom any notes in the record of any increase in dosage and/or frequency of administration; and the data suggests that these patients are likely "dependent" on these medications and opportunities to decrease dosages and/or wean the patient may be limited.

20. In or around November 2017, the licensee completed the remediation plan. Upon conclusion, LifeGuard noted

> Significant improvement has been noted in preventative care attention and documentation. Dr. Rice at times performed examinations that were not documented on the chart. There was no noted emphasis on some of the longterm preventive care measures, such as ace inhibitors and discussion of aspirin use in diabetic patients. It was noted that some of Dr. Rice's diabetic patients were already on these medications; however, education as to the reasoning behind the use of these medications was not noted. In reference to the issue of opioids prescribing, Dr. Rice tends to limit the discussion of opioids use with his patients.
>
> ... significant improvement in chronic care and preventative maintenance. Dr. Rice has limited the prescribing of "new" opioid/controlled substances. Increased use of non-narcotic therapies has been in evidence.
>
> The EHR system continues to hamper and limit the monitor's survey ability to review qualities, refills, dates of refills, etc. The system provider has still not been able to correct the issues with the problem list - indicating inactive when the problem is being actively treated.
> ...
> ... Dr. Rice is providing compassionate and quality of care to his patients at the current time. He and the practice have implemented a significant number of the recommendations that have been offered over the course of the last 12 months. He is attempting to limit his prescribing of narcotics; ... it is difficult to wean patients off narcotics and benzodiazepines entirely after they have been on these medications for a number of years. Although Dr. Rice needs to discuss goals for the ongoing treatment of chronic pain with opioids with his patients, realistic goals are not to increase medications and to attempt to limit polypharmacy situations due to the cross-reactivity of these medications.

21. Following completion of the remediation plan, LifeGuard made the following recommendations for the licensee's continue practice:

- In regard to documentation:
  - Develop and implement policies and procedures to improve patient flow and intake, chart structure (recognizing EHR limitations and exceptions), the role of a scribe, use of chronic care flowsheet, providing evidence of review of medications at every visit.

- In regard to opioid monitoring:

- Discuss narcotics, their use, their side effects, hyperalgesia, and the need to wean or limit those narcotics and reflect these discussions in the documentation on the patient record.
- Frequency which the patient is take a prescribed medication is to be documented. Prescriptions for opioids for pain relief are noted not to include this information. It is noted that when calculating the number of pills and days supplied, it is obvious that the medication is to be taken q4h PRN or q6h PRN for example. However, the frequency is not documented.
- Treatment goals for patients receiving opioids for pain relief need to be not only reviewed with the patient, but also established; documentation must reflect those goals and discussion.
- Continue with documentation of pain scales, but consider the use of functional examination (i.e. how does pain impact the patient's activities of daily living, what can't they do now that they could do before pain occurred?) in conjunction with subjective, self-reported pain scales.
- Continue the use of pill counts during medication reviews, especially if aberrant drug-related behaviors are noted.
- Continue UDS/oral screens on a randomized basis, ensuring documentation of issues related to unanticipated findings and resolution of same.
- Consider changing the pain management agreements to a more inclusive "Medication Management Agreement" which would encompass all controlled substances, not just opioids.
- Record all prescriptions in the electronic record - inclusive of all refills, dates and number of pills prescribed/supplied.
- Document conversations on decreasing, weaning narcotics, benzodiazepines, etc., when occurring.
- Ensure that musculoskeletal and neurologic examinations are documented related to patient complaints (i.e. chronic low back pain, tenderness, loss of function).
- Consider pain management-only visits. Use of a pain assessment and documentation tool would ensure a focused and thoroughly examination and discussion of pain control.

- In regard to patient care:
  - Ensure that all procedures are consented and a procedure note is documented including the procedure completed, the medication, amount and route (if an injection), how the patient tolerated the procedure and any education that was provided based on the procedure completed.

22. After the licensee completed the prescribed remedial education, the Board undertook its first consultant review of his practice. In or around November 2019,

a Board consultant completed a review of twelve (12) of the licensee's patient charts for the period of January 1 through August 1, 2018. The consultant found

> In summary, Dr. Rice has submitted twelve charts for review for the time frame of January 2018 through August 2018. He did leave the practice at which he was working, and from which the patient charts were generated, In April 2018. While the majority of the patients' charts fall within standard of care, there were several charts where I was unable to form an opinion due to scarcity or complete lack of office notes submitted. I find that Dr. Rice's care, based on my review of all submitted Information, is within the minimum standard of care as set by law and by protocol for the use of controlled substances though some improvement needs to be made regarding usage of urine drug testing and documentation of patient-provider discussion regarding the prescribing of combinations of Benzodiazepines and Opiates. Overall, I have no concerns regarding the prescribing habits and patient care provided by Dr. Samuel Rice.

23. In or around March 2021, the Board undertook its second consultant review of the licensee's practice. A Board consultant completed a review of twelve (12) patient charts, with focus on 1-2 encounters per patient. Because the licensee was no longer practicing in an outpatient clinic setting and encountered patients in an emergency department, the review was conducted from the perspective of family medicine practitioner in an emergency department setting. The Board consultant found, in part,

> Only 4/12 were felt to be within the minimum standards for diagnosis, treatment and record keeping. [Patient CW] had 2 visits, 4 weeks apart, for different complaints and received Norco prescription on each visit, neither prescription indicated by today's opioid standards. Seven of the 12 patients' charts had at least one visit with a violation of 201 KAR 9:260 sect 9 (1) (d) and (e). There was one violation of 201 KAR 9:260 sect 6 (5). One patient had a prescription for Norco written but the prescription was not noted in the medical record with the other medications prescribed (only a copy of the Rx).
>
> Review of the KASPER prescriber report reveals the following, which are at the very least questionable and concerning given the history and

amended order, even if these were written as part of a collaborative agreement with an NP.

1. [Patient IA] prescribed Fentanyl patches, 30 day supply on 2 occasions in 2020.
2. [Patient DD] prescribed Adderall, 30 day supply.
3. [Patient LE] prescribed Ritalin, 30 day supply on 2 occasions in 2020.
4. [Patient JG1] prescribed 30 day supply of Halcion.
5. [Patient JG2] prescribed Halcion and Librium.
6. [Patient CK] prescribed Adderall 30 day supply 7 times.
7. [Patient JL] prescribed Xanax 30 day supply 3 times.
8. [Patient MS] prescribed oxycodone 30 day supply 5 times in 2020.
9. [Patient CW] received 4 different prescriptions for hydrocodone in a 5 month period.

Dr. Rice has failed to meet the acceptable standards of medical care and documentation. In addition, there are pervasive issues related to his controlled substance prescribing decisions and regulatory compliance. I consider this review to be unfavorable. Dr. Rice has already been afforded an extended period of time to participate in numerous opportunities for remedial training and evaluation, and thus it is my opinion that the board should suspend his license in order to protect the public and his patients.

I find it to be especially unacceptable that, given the nature of the prior complaints against him, and that he should have been aware that his controlled substance prescribing would be carefully monitored and scrutinized, that he was routinely unable to comply with 201 KAR 9:260 completely and to the "letter of the law."

24. In or around November 2022, the Board undertook a third consultant review of the licensee's practice. A Board consultant completed a review of twelve (12) patient charts and found four (4) to be within minimum standards, five (5) to be clearly below minimum standards and three (3) to be borderline. The consultant stated in part

> I believe that several patients were prescribed Norco (very difficult to read and did not see any evidence of the required written consent of the patient as required by 201 KAR 9:260 section 9 (1) (e).
>
> [Patient SL] was diagnosed with colitis despite the history and CT scan not consistent with the diagnosis. There is very scant charting on the

patient and it is mostly not legible. By today's standards hydrocodone is difficult to justify in the patient.

[Patient JA] had 2 visits, 4 weeks apart, for different complaints and received Norco prescription on one visit and Percocet for the other. Both of these prescriptions are questionable by today's opioid standards. KASPER review reveals opioid dependence in the patient.

[Patient BM] chart reveals inadequate history and physical exam for a 73 year old with back pain.

[Patient TD] visit for abdominal pain had zero HPI.

[Patient MW] presented with shortness of air and a headache. The documentation is grossly inadequate (HPI, ROS, and PE) for the complaint of headache and eye pain. There is no visual acuity documented. The headache apparently warranted a head CT scan but there is no neurologic exam documented.

[Patient PG] is noted to have "degenerative cervical arthritis" (if I read the handwriting correctly) and of having pain. There is no mention of the duration of the pain (is this her chronic pain or if this is an acute exacerbation). Questionable opioid prescription in the emergency department for chronic conditions.

In the 4 PC charts reviewed there is clear indication for measuring the INR as the patient is on Coumadin and had trauma related complaints, yet never was this ordered even on visits where other serum lab tests were ordered! These charts are again very difficult to read. One visit resulted in a hydrocodone prescription with no acute injury. It appears that the patient was also prescribed Elavil, which is not typically within the emergency physician's scope.

It appears to me that Dr. Rice again fails to meet the acceptable standards of medical care and documentation. This is unfortunate and there is a continuation of concerns of questionable compliance with 202 KAR 9:260 such as the lack of written informed consent for the many hydrocodone prescriptions. I consider this an unfavorable review.

In light of the present and historical facts, I believe that the care and documentation by Dr. Rice regularly falls below the expected minimums. This may be either gross ignorance or gross negligence or both. I defer to the board to determine what the appropriate actions to take.

25. On or about May 18, 2023, the licensee appeared before and was heard by the Panel. The licensee agreed to enter into this Agreed Order in lieu of the issuance of a Complaint and Emergency Order of Restriction.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Second Amended Agreed Order:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(3) and (4), and KRS 311.595(12) and (13). Accordingly, there are legal grounds for the parties to enter into this Second Amended Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending grievance without an evidentiary hearing by entering into an informal resolution such as this Second Amended Agreed Order.

SECOND AMENDED AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve this pending noncompliance investigation without an evidentiary hearing, the parties hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER:**

1. The license to practice medicine within the Commonwealth of Kentucky held by Samuel L. Rice, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE

PERIOD OF TIME, effective immediately upon the filing of this Second Amended Agreed Order.

2. During the effective period of this Second Amended Agreed Order, the licensee's medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:

    a. The licensee SHALL ONLY practice within the specialty of emergency medicine and while physically located within an emergency department of a Kentucky-licensed hospital in the Commonwealth of Kentucky. The licensee SHALL NOT practice as a hospitalist or practice within a long term care facility, a health clinic or within any other specialty or any other setting;

    b. The licensee SHALL ONLY prescribe, dispense, administer or otherwise professionally utilize controlled substances to persons who are registered patients of the emergency department, during the time the patient is admitted to the emergency department and, when medically necessary, for up to a 72-hour period following their discharge from the emergency department. The licensee SHALL NOT prescribe, dispense, or otherwise professionally utilize controlled substances in any other context and/or for any other person(s);

        i. The licensee SHALL NOT countersign any prescriptions for other healthcare professionals; and

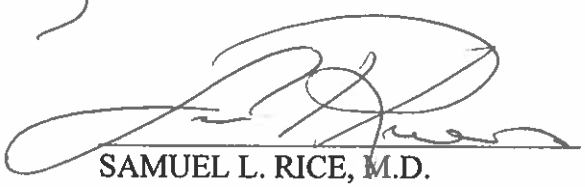
    c. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. As an express condition for the entry of this Second Amended Agreed Order and in lieu of a Complaint and Emergency Order of Restriction, each party understands and agrees that the Board will never consider any petition for termination or modification of this Second Amended Agreed Order. Any communication by the licensee and/or his agents to the Board attempting to revive this matter or modify or terminate the terms set forth in this Second Amended Agreed Order will be returned without being provided or forwarded to any Board member.

4. The licensee expressly agrees that if he should violate any term or condition of this Second Amended Agreed Order, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that the licensee has violated any term or condition of this Second Amended Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Second Amended Agreed Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Second Amended Agreed Order.
5. The licensee understands and agrees that any violation of the terms of this Second Amended Agreed Order would provide a legal basis for additional disciplinary action, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 26 day of May, 2023.

FOR THE LICENSEE:



SAMUEL L. RICE, M.D.

COUNSEL FOR THE LICENSEE
(If applicable)

FOR THE BOARD:

DALE E. TONEY, M.D.
CHAIR, INQUIRY PANEL B

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