COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2052

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY AMY S. HENRY, D.O., LICENSE NO. 03103, 232 SOUTH GARLAND LANE, SANTA CLAUS, INDIANA 47579

AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, and Amy S. Henry, D.O. ("the licensee"), and based upon their mutual desire to allow the licensee to resume prescribing controlled substances, hereby ENTER INTO the following **AMENDED AGREED ORDER**:

STIPULATIONS OF FACT

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

1. At all relevant times, the licensee was licensed by the Board to practice osteopathy within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Family Medicine.
3. On or about June 7, 2021, the Board received a written grievance from Patient A. In the grievance, Patient A alleged that he was a longtime friend of the licensee who recently re-connected with the licensee after years of no contact. Patient A alleged that the licensee over-prescribed him controlled substances and took some of his medicines for her personal use. With his grievance, Patient A included patient prescription summaries that showed prescriptions for controlled substances written to him by the licensee from August 2020 through March 2021, the majority of which were oxycodone/acetaminophen.

4. During an interview with the Board investigator, the licensee stated that she was friends with Patient A in high school and had recently renewed their friendship. She described an event in which Patient A accompanied her to Lexington, fell over some luggage in a hotel room and she took him back to Evansville to the emergency room in her personal vehicle.

5. The licensee submitted a written response to the Board, in which she further responded to the grievance. In her response, the licensee stated that she was trying to help an old friend by taking him to medical appointments and becoming his caretaker. She stated "[h]e was never my patient. Yes, I did prescribe for him because he could not carry on a conversation due to pain and asked me to do so." She stated that following his fall over luggage in a hotel and subsequent visit to the emergency room, she wrote him a prescription for pain medicine because Patient A told her the doctors at the hospital did not give him any pain medicine and she saw him in pain. The licensee described another event in which Patient A fell and broke his arm, and that she prescribed Percocet in addition to the prescription for Lortab that Patient A received from his orthopedist because Patient A told her the Lortab wasn't helping. In her written response, the licensee stated that she knew Patient A suffered long-standing alcoholism and lived in a "very shady part of town" where he left his house doors unlocked and people came into his home without his knowledge or permission. The licensee stated that she backed away from Patient A after it occurred to her that he saw her as more than a friend.

6. A board consultant reviewed five (5) patient charts from the licensee. The Board consultant found two (2) charts were borderline and three (3) charts were below the

minimum standards of practice in the medical community at large due to the lack of documentation. Regarding the chart of Patient A, the Board consultant noted that the "chart contained 18 pages, of which 12 are copies of prescriptions and 1 page has a handwritten note about the patient's appointment with orthopedic and the broken ribs. There are no pages containing history or physical exam, no follow-up notes, no documentation of injuries (i.e. x-rays, scans, etc.)." The Board consultant's report is attached and incorporated in its entirety.

7. The licensee responded in writing to the Board consultant's report on or about January 28, 2022. The licensee addressed her care of each of the patient charts reviewed by the consultant and included additional documentation.

8. The Board consultant issued a final report in which he replied that he may have missed some documentation in the licensee's handwritten office notes due to some portion of the records being illegible. In addition, he noted that while he observed a cell phone picture of a human back in the chart, he was looking for x-rays, CT scans, MRI, previous notes, etc.

9. On April 21, 2022, the Board's Inquiry Panel A reviewed the investigation. The licensee, with counsel, appeared before and was heard by the Panel before it deliberated. The Panel and the licensee agreed to enter into an Agreed Order in lieu of the issuance of a Complaint and Emergency Order of Restriction.

10. On or about May 17, 2022, the licensee met with the Foundation. The licensee submitted to its standard testing, the results of which were positive for multiple controlled substances and alcohol metabolites at a level indicative of a problematic

relationship with alcohol. The Foundation directed her to undergo a residential evaluation.

11. The licensee chose to do her evaluation at Positive Sobriety Institute's MCAP program and arrived on June 26, 2022. Her evaluating team found that she met the criteria for substance use disorders and recommended that she refrain from clinical practice until such time as she had successfully completed a residential treatment program.

12. The licensee was admitted to Positive Sobriety Institute on or about July 12, 2022, and discharged on or about September 6, 2022. Her Axis I diagnoses upon discharge included Opioid Use Disorder – Severe, Sedative/Hypnotic & Anxiolytic Use Disorder – Severe, Tobacco Use Disorder – Moderate, Major Depressive Disorder, Unspecified Trauma and Stressor Related Disorder, Unspecified Alcohol-Related Disorder, Cannabis Use Disorder – mild to moderate, and ADHD by history. It provided the following Continuing Care Recommendations:

    - Dr. Amy Henry-Terry is recommended to participate in weekly Continuing Care groups for a minimum duration of 2 (two) years.

    - Dr. Henry-Terry is recommended to be professionally monitored via frequent random urine drug screens for a minimum duration of five years by the Kentucky Physician's Health Program.

    - Dr. Henry-Terry began 90 meetings in 90 days while in treatment. Upon completion she is recommended to attend a minimum of 4-5 recovery meetings per week for the first year of recovery, identify a home group, and work closely with a local sponsor to maintain support, accountability, and growth.

    - Dr. Henry-Terry is currently utilizing psychotropic medications. She is recommended to follow-up with a PHP approved addiction-informed psychiatrist for continued care and medication management.

    - Dr. Henry-Terry is recommended to follow-up with a PHP approved primary care physician for routine medical care and she is encouraged to be

transparent with her PCP of her entire medical history, including recovery from substance use disorder. It is recommended that all specialists and prescription medications be cleared through her PHP and psychiatrist. Additionally, Dr. Henry-Terry's providers must be allowed to have clear communication with each other for collaborative care, including communication with her PHP. She is recommended to avoid the use of controlled substances in the future.

- It is recommended that Dr. Henry-Terry begin individual therapy with a PHP approved therapist. Dr. Henry-Terry's therapeutic work benefits from focus on emotional identification, communication, trauma resolution, and relapse prevention.

- Dr. Henry-Terry is recommended to return to PSI for a one-day follow up visit 3 months post discharge (Zoom session available).

- Dr. Henry-Terry is not medically cleared to return to work at this time. She will need to retake a formal neurocognitive evaluation, and pass all domains, to be medically cleared for practice.

13. By letter dated September 8, 2022, Dr. Simpson informed the Board that the licensee successfully completed her residential treatment and entered into a 5-year monitoring contract. Components include the following:

    - Documented attendance at no less than 12 AA meetings per week;

    - Ongoing relationship with a 12 Step Sponsor;

    - Participation in a healthcare professionals aftercare group;

    - Individual therapy;

    - Medication Management with an addiction psychiatrist; and

    - Once her Agreed Order has been modified to an instrument that allows her to return to the active practice of medicine, the Foundation will also establish professional accountability with a contact at her primary worksite.

14. CPEP informed the Board by letter dated October 13, 2022, that the licensee attended its PROBE Program in September 2022 and unconditionally passed. She attended all sessions, completed all assignments, and appeared prepared for participation.

15. According to the Associate Medical Director of Positive Sobriety Institute, the licensee's initial neurocognitive testing in June 2022 with a neuropsychologist reflected deficits in multiple domains. Follow-up testing in October 2022 revealed interval improvement on select measures. It was recommended that the licensee undergo repeat neuropsychological testing in six to twelve months to determine if further improvement is noted with her continued abstinence.

16. By letter dated January 27, 2023, Vanderbilt University Medical Center informed the Board that the licensee completed its Maintaining Professional Boundaries course. She fully participated in all assignments and discussions.

17. By letter dated February 3, 2023, Vanderbilt informed the Board that the licensee completed its Proper Prescribing of Controlled Substances course. Again, she fully participated in all assignments and discussions.

18. The licensee attended CPEP's Medical Record Keeping Seminar on October 28, 2023. She then initiated the six-month Personalized Implementation Program ("PIP"), in which CPEP completed three chart reviews over the course of six months.

19. On or about April 2, 2024, CPEP issued a Final Report indicating that the final charts reviewed contained adequate documentation, and she passed the PIP.

20. Ali A. Farooqui, M.D. with Integrative Psychiatry, PLLC, has provided medical care to the licensee since September 2022. Dr. Farooqui advised that the licensee's medication has been optimized, and repeat cognitive testing was performed in February 2024. The licensee did not show impairment in the categories apart from response inhibition, which could be attributed to mild ADHD symptoms.

21. On August 15, 2024, the Board's Inquiry Panel A reviewed a request from the licensee to resume prescribing. The Panel and the licensee agree to enter into this Amended Agreed Order.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's Kentucky osteopathic 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(6), (7) and (9), as illustrated by KRS 311.597(4). Accordingly, there are legal grounds for the parties to enter into this Amended Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending investigation without an evidentiary hearing by entering into an informal resolution such as this Amended Agreed Order.

AMENDED AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and based upon their mutual desire to allow the licensee to resume prescribing controlled substances, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER:**

1. The license to practice osteopathy in the Commonwealth of Kentucky held by AMY S. HENRY, D.O., is hereby PLACED ON PROBATION FOR A PERIOD

OF FIVE (5) YEARS, with that period of probation to become effective immediately upon the filing of this Amended Agreed Order;

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

    a. The licensee SHALL enter into and maintain a contractual relationship with the Kentucky Physicians Health Foundation and shall fully comply with all requirements of that contractual relationship;

        i. The licensee SHALL completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. The licensee SHALL ensure that any such medical treatment and prescribing is reported directly to the Board in writing by his treating physician within ten (10) days after the date of treatment. The licensee SHALL inform the treating physician of this responsibility and ensure timely compliance. The licensee's failure to inform the treating physician of this responsibility SHALL be considered a violation of this Amended Agreed Order;

        ii. The licensee SHALL be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis as desired by the Board, and under the conditions specified by the Board's testing agent, the purpose being to ensure that the licensee remain drug and/or alcohol-free. The cost of such breathalyzer, blood and urine alcohol and/or drug analyses and reports SHALL be paid by the licensee, and the licensee SHALL pay those costs under the terms fixed by the Board's agent for testing. The licensee's failure to fully reimburse the Board's agent within that time frame SHALL constitute a violation of this Amended Agreed Order;

    b. Beginning immediately, the licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized. 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. Note: All log sheets shall be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions shall be maintained in the following manner: 1) patient; 2) chart; and 3) log;

i. 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 consultants;

ii. 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;

iii. The licensee 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;

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

3. The licensee expressly agrees that if she should violate any term or condition of this 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 she 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.

4. The licensee understands and agrees that any violation of the terms of this Amended Agreed Order would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13).

SO AGREED on this 28th day of August, 2024.

FOR THE LICENSEE:

AMY S. HENRY, D.O.

COUNSEL FOR LICENSEE
(If Applicable)

FOR THE BOARD:

W. Saleem.

WAQAR A. SALEEM, M.D.
CHAIR, INQUIRY PANEL A

Nicole A. King
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Tel. (502) 429-7150

Summary letter

I have reviewed five charts from the medical practice of Dr. Amy Henry and found two charts were borderline to the minimal standard of practice in the medical community at large. The other three charts were below the minimum standard of practice in the medical community at large. The reason the three charts where clearly below the standard was mainly due to the lack of documentation available in the patient medical records.

[redacted] was given prescriptions of oxycodone 7.5 mg (01/16/2021) #12, (01/20/2021) #30, (01/25/2021) #30, (01/31/2021) #30, (02/07/2021) #30, (02/14/2021) #30,(02/19/2021) #30,(02/25/2021)#30, (03/21/2021) #30 and (03/25/21) #30, with no chart documentation other than a handwritten note. This is explained in the patients review worksheet.

[redacted] chart was below the standard for the lack of documentation because I could not find anywhere in the chart documentation of the quantity of the controlled prescriptions that were given to the patient. This is explained in the patient's review worksheet.

The reason the third chart [redacted] was below the standard was also due to a lack of documentation in the patient's medical records. This patient was given prescription for hydrocodone 10 mg per Kasper (05/18/2021) #30, (05/25/2021) #45 and (06/05/2021) #45 and the only documentation of back pain I could find was what looked to be a cellphone picture of a man's back that was scanned into the chart. Also there was no record of the quantities of the controlled prescriptions in the handwritten office notes and /or the medication log. This explained in the patient's review worksheet. Also there was no billing information available in any of the above records.

The reason the two charts were borderline was also due to the lack of documentation available in the patient's charts as discussed in the patient's review worksheets. If Dr. Henry has any more available information or if I have overlooked some of the above information, I would be glad to review any further available information or documentation.

Sincerely,

L. Daniel Hall DO., MBA

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._____ Patient Name[redacted]

Expert's Name L.Daniel Hall D.O.,MBA

1. Brief description of symptom, dx and course of treatment: _____

[redacted] is a [redacted] y/o patient of Dr Henry that was apparently being treated for history of rib pain s/p rib fracture per hand written note in chart dated 12/29/20. this was the only documenation per chart notes.

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

__X__ Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

X Below minimum standards

_____ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

X Below minimum standards

_____ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

X Below minimum standards

_____ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

X Clearly below minimum standards.

_____ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

The reason this chart is below the minimal standard of practice in the medical community at large is due to the lack of proper documention. The chart contains 18 pages of which 12 pages are copies of prescriptions and 1 page has a handwritten notes about the patient's appointment with orthopedic and the broken ribs. There are no pages containing history or physical exam, no follow-up notes, no documentation of injures (ie x-rays, scans etc). Also , no billing information and the Kasper report from 1/18/2021-03/26/2021 reveals oxydocone 75mg/325 mg prescriptions 1/16/2021, #12, 01/20/21, #30, 01/25/21 #30, 01/31/2021 #30, 02/07/2021 #30, 02/14/2021 #30, 02/19/2021 #30, 02/25/2021 #30, 03/21/21 #30, 03/26/2021 #30 and prescripation for tramdol 50mg #45 on 03/08/2021 with no chart documentation.

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._____ Patient Name[redacted]

Expert's Name L.Daniel Hall D.O.,MBA

1. Brief description of symptom, dx and course of treatment: _____

[redacted] is a patient of Dr.Henry that was being treated for history of nephrolithiasis per handwritten note dated 08/14/2021.

2. **Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?**

X **Yes, I can form an opinion.**

_____ **No, I cannot form an opinion.**

_____ **I need more information (specify):** _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X___ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X___ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_X___ Below minimum standards

_____ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_X___ Clearly below minimum standards.

_____ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

The reason this chart is below the minimum standards of practice in the medical community at large is due to lack of documentation in the chart. I could not find anywhere in the chart of 14 pages any documentation of the quantity of controlled prescriptions that were given to the patient. This includes the 06/14/2021 handwritten note, the 06/15/2021 phone call note, the 06/25/2021 phone call note and the medication log included in the chart. Also could not find any any billing information in the patient records.

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._____ Patient Name [redacted]

Expert's Name L.Daniel Hall D.O.,MBA

1. Brief description of symptom, dx and course of treatment: _____

[redacted] is a patient of Dr.Henry that is being treated for history of back pain do to scoliosis surgery and post traumatic headaches per handwritten note dated 05/18/2021.

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

X Below minimum standards

_____ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

X Below minimum standards

_____ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

X Below minimum standards

_____ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

X Clearly below minimum standards.

_____ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

T
The reason this chart is below the minimum standards of practice in the medical community at large is due to lack of documentation in the patients medical records. The only documentation of back pain I could find was a cellphone picture of man's back that was scanned into the chart. Also there where no record of the quantities of controlled prescriptions in the office notes 05/18/2021,11/04/201,and 06/24/2021. Also could not find documentation of quenlity in the medication log and did not find any billing information in patient's record.

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._____ Patient Name [redacted]

Expert's Name L.Daniel Hall D.O.,MBA

1. Brief description of symptom, dx and course of treatment: _____

[redacted] is a patient of Dr. Henry that is being treated for a history of plantar fasciitis and laceration of left axilla per handwritten office note 06/09/2021.

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X___ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X___ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_X___ Below minimum standards

_____ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_____ Clearly within minimum standards

_X___ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

The reason this chart has borderline to the minimal standard of practice in the medical community at due large is due to the lack of available billing information and for documentation.

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._____ Patient Name [redacted]

Expert's Name L.Daniel Hall D.O.,MBA

1. Brief description of symptom, dx and course of treatment: _____

[redacted] is a patient of Dr. Henry that is being treated for a history of chronic back pain among other medical conditions.

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

__X__ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

__X__ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

__X__ Below minimum standards

_____ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_____ Clearly within minimum standards

__X__ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).