BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS

IN MEDICINE AND SURGERY

IN THE MATTER OF: **MICHAEL SHING, D.O.** Holder of License No. **005367** For the practice of osteopathic medicine in the State of Arizona	**Case No.: DO-11-0061A** **SATISFACTION AND TERMINATION OF PROBATIONARY ORDER**

On January 25, 2014, Dr. Shing appeared before the Board. As a result of that meeting, IT IS HEREBY ORDERED that the Consent Agreement to Findings of Fact, Conclusions of Law and Order dated January 10, 2013, has been satisfied in full and thus terminated, and that a full and unrestricted license (active license status) is reinstated to Michael Shing, D.O. effective January 25, 2014.

ISSUED THIS 28th DAY OF JANUARY 2014.

STATE OF ARIZONA
BOARD OF OSTEOPATHIC EXAMINERS IN
MEDICINE AND SURGERY

SEAL

By: _____
Jenna Jones, Executive Director

Original filed this 28th day of January, 2014 with the:

Arizona Board of Osteopathic Examiners in Medicine and Surgery
9535 East Doubletree Ranch Road
Scottsdale AZ 85258-5539

Copy of the foregoing sent by U.S. mail
this 28th day January, 2014 to:

Michael Shing, D.O.
Address of record

_____

BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS

IN MEDICINE AND SURGERY

IN THE MATTER OF: **Michael Shing, D.O.** Holder of License No. **005367** For the practice of osteopathic medicine in the State of Arizona	**Case No.: DO-11-0061A** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER FOR DECREE OF CENSURE AND PROBATION**

On April 27, 2011, the Arizona Board of Osteopathic Examiners (hereafter "Board") received a complaint against the license of Michael Shing, D.O. (hereafter "Respondent"). On May 3, 2011, the Board noticed Respondent of an investigation into that complaint. On May 20, 2011, the Board received Respondent's response to the complaint.

The Board duly noticed an Investigative Hearing on this matter for July 30, 2011. Respondent was present and participated in the Investigative Hearing. The Investigative Hearing was continued to November 17, 2012, when Respondent was present and represented by counsel.

After hearing testimony from the Respondent and considering the documents and evidence submitted, the Board voted to enter the following Findings of Fact, Conclusions of Law, and Order for Decree of Censure and Probation.

JURISDICTIONAL STATEMENTS

1. The Board is empowered, pursuant to A.R.S. § 32-1800 *et seq.*, to regulate the practice of osteopathic medicine in the State of Arizona, and the conduct of the persons licensed, registered, or permitted to practice osteopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 005367 issued by the Board for the practice of osteopathic medicine in the State of Arizona.

FINDINGS OF FACT

3. On April 27, 2011, for the Board received an anonymous complaint alleging that Respondent prescribed controlled substances inappropriately and that patients were receiving multiple narcotic prescriptions from Respondent written on the same day for the same drug.

4. The Board's medical consultant performed a chart audit on the medical records of fifteen (15) of Respondent's patients. All of the medical records reviewed seemed sparse and it appeared that Respondent had a large number of chronic pain patients. Respondent performed very cursory exams on the patients chosen for the chart review. Almost all of these patients came to him requesting pain medications and were given pain medications on their first office visit. The patients were often given large amounts and were often given two prescriptions at once. Respondent rarely ordered lab work, even if he had seen the patient for over a year. He did not routinely order consultations or request diagnostic studies to be performed. There were no controlled substance contracts signed by patients and no urine drug screens performed. Patients were not queried about their functional status and physical exams were not routinely performed.

5. Patient S.C., a 49 year-old male was first seen by Respondent on April 3, 2011. He was there for pain management due to neck, thoracic spine and lumbar spine pain for the last 26 years due to work injuries. He claimed he could not take morphine. A cursory exam was performed and Respondent prescribed 300 Oxycodone IR 30mg tablets. Respondent gave S.C. two scripts for 300 tablets each, or a two month supply. He also wrote prescriptions for Prednisone 10mg a day and Viagra 100mg. One of the Oxycodone prescriptions was filled on April 3, 2011 and the other was filled at a different pharmacy on April 4, 2011. Respondent failed to indicate the earliest date on which the pharmacy may fill the second prescription as required by CFR 1306.12 (b)(1)(ii). No prior medical records were available or requested by Respondent. Respondent did not order a lab draw and he did not order diagnostic studies. There was no controlled substance contract with patient S.C.

6. Patient A.N., a 21 year-old male was first seen by Respondent on January 26, 2011. His chief complaint was right hand pain and low back pain. He had a history of a car accident one year previously and a fracture of his fifth metacarpal at age 12. Respondent performed a cursory physical examination and he prescribed Soma and Oxycodone 15mg, #90, with a two month supply for both prescriptions. A.N. was seen again on March 4, 2011, for a refill. Respondent again performed a cursory exam and the patient was prescribed Oxycodone 15mg, #150, Soma 350mg; Respondent again gave A.N. a two month supply for both prescriptions. The pharmacy audit shows the patient filled all four Oxycodone prescriptions within a two month period utilizing four different pharmacies.

7. Patient C.T., a 38 year-old male, was first seen by Respondent's office on November 20, 2009. C.T. reported he was doing well but needed refills of his medications for chronic pain due to herniated lumbar discs. He also reported he was an insulin dependent diabetic. A cursory history and physical was performed and he was given refills of his insulin, as well as Percocet, OxyContin and Ambien. C.T. was seen approximately every month and his Oxycodone was refilled at each visit. At each visit, his history and physical were cursory if the physical occurred at all. There was no physical exam noted for C.T.'s visits on 3/16/10, 4/13/10, 5/7/10, 6/4/10, 7/2/10, 7/30/10, 8/27/10, 9/24/10, 10/7/10, 10/26/10, 11/19/10, 12/17/10, 2/4/11 and 3/29/11. At each visit he reported he was doing well and just needed refills. At each visit, C.T. was often given two prescriptions for Oxycodone immediate release 30mg #180 then later #240, and Percocet #90. C.T. used two pharmacies for his prescriptions. The partial pharmacy audit shows C.T. filled prescriptions from Respondent for Oxycodone 30mg #240 on 11/19/10, 12/14/10, 12/17/10, 2/4/11, 2/22/11, 3/29/11, and 4/5/11.

7. Patient D.M., a 19-year old female, was first seen in Respondent's office on March 18, 2010, to become a new patient. She stated she wanted to change her pain medications. Her medical records did not document any reason that she suffered from chronic pain but it

appears that she was on Methotrexate, prednisone, had a rheumatologic condition and was using a power scooter for mobilization. She listed her medications as Oxycodone 30mg and morphine SR 30mg. Respondent added OxyContin to the patient's regimen. D.M. was seen approximately two weeks later at which time Respondent diagnosed her with rheumatoid arthritis, scoliosis, fibromyalgia and Crohn's disease. Respondent warned her about the dangers of self-medicating and advised to take her medications as directed. She was given another prescription for Oxycodone 30mg #180. She was seen approximately one week later and Dilaudid 4mg was added to her regimen. Her physical exam showed her within normal limits other than tachycardia. On May 11, 2010, D.M.'s medications were refilled but her Oxycodone 30mg IR was increased to #240. On June 11, 2010, her Oxycodone 30mg IR was increased to #360, then later to #390. She was seen on 6/28/10, 8/23/10, 9/13/10, 11/22/10, 12/20/10, 1/17/11, and 4/11/11 but physical exams were not performed. Respondent saw D.M. every 2 to 4 weeks and he performed physical exams on her occasionally. D.M. was seen on November 22, 2010, and it was noted that she had been recently admitted to the hospital through the emergency room and found that she was a brittle diabetic even though Respondent's records showed no indication that D.M. was diabetic. Although D.M. was seen by Respondent from March 18, 2010 through May 3, 2011, no lab work was ever run. From November 22, 2010 until April 11, 2011, she received Oxycodone 30mg #390 per month, along with morphine sulfate ER 30mg #60, as well as Xanax 2mg, #30.

9. Patient J.H., a 27 year-old male, was first seen by Respondent on April 22, 2011, for shoulder, thoracic and lumbosacral pain. He stated he had been out of pain medications for about 3 months and his pain was 10 out of 10. He claimed he had been in an accident from holding a garage door seven months previously. Respondent noted that J.H. said his blood work was ok because he had recently donated blood and that it was too costly for him to do lab

work or see a cardiologist. Respondent performed a cursory exam and gave J.H. two prescriptions for Oxycodone IR 30mg #200 and one prescription for Soma 350 #120.

10. Patient H.C., a 31 year-old male, was seen by Respondent for the first time on November 20, 2009, for a refill of medications. After a cursory exam, H.C. was prescribed Percocet, number not listed, and OxyContin 40mg #90. After that visit, H.C. was seen monthly and his prescriptions were refilled. Exams were not performed on each visit; exams were not performed on 1/20/10, 9/29/10, 10/29/10, 11/23/10, 12/23/10, 2/22/11, and 4/22/11. When Respondent did perform a physical exam, he documented H.C. as falling within normal limits. According to the pharmacy audit, H.C. filled prescriptions from Respondent for Xanax 2mg #60, Soma #90, and Oxycodone 30mg #180 each month from October 2010 until April 2011. H.C. used four pharmacies to fill the prescriptions.

11. Patient B.R., a 58 year-old female, was first seen by Respondent on April 21, 2011, for pain management. At that time, her physical exam results were marked as within normal limits. She was diagnosed with psoriatic arthritis, insomnia, migranes, neuropathy, fibromyalgia, narcolepsy, anxiety. She was prescribed Oxycodone 15mg #180 and morphine sulfate ER #60. The patient was noted to see a psychiatrist, a neurologist, and a rheumatologist.

12. Patient B.C., a 33 year-old male, was first seen on December 11, 2009, for a refill of his medications. He stated he had thoracic spine pain due to an injury approximately 10 years prior and that he took Oxycodone for his pain. Respondent's exam of B.C. noted all normal results and Respondent prescribed B.C. Oxycodone IR 30mg #180. The patient was seen approximately once per month after that but Respondent did not complete any more physical exams. Ambien was added as the patient started to have problems with insomnia. He reported he had been released from jail in August 2010. In October 2010, Respondent gave him two prescriptions because B.C. was going under house arrest. In November 2010, B.C.'s medical

record noted that B.C. completed house arrest and he told Respondent that he was self-medicating and doubling up his medications. The medications were continued until April 2011, when Respondent completed disability paperwork for B.C. and increased B.C.'s Oxycodone to 300 tablets per month. There were no prior medical records, no laboratory work, and no studies done on the patient. A pharmacy audit revealed B.C. filled prescriptions from Respondent for Oxycodone 30mg #210 in November of 2010, #480 in December of 2010, #480 in February of 2011, and #600 in April of 2011. B.C. utilized two pharmacies to fill his prescriptions.

13. Patient A.M., a 49 year-old male, was first seen by Respondent on January 10, 2011, to become a new patient. He stated he needed refills on his medications of Dilantin, Percocet and Morphine ER 15mg. The patient's physical exam was noted to be within normal limits. A.M. was diagnosed with seizure disorder, epilepsy, chronic pain and diabetes. Respondent prescribed Robaxin and Flexeril. He also ordered lab work but did not include any drug screens. The following month, A.M. returned complaining of blurry vision and wanted to increase his morphine dosage. Respondent increased the patient's morphine dosage to 30mg #90. The patient was seen each month until May 17, 2011, and each month, Respondent refilled his prescription for morphine sulfate 15-30mg #90, and Percocet 10/325 #180. Physical exams were not performed during most office visits and when they were done, everything was marked within normal limits.

CONCLUSIONS OF LAW

14. The conduct described above is a violation of unprofessional conduct pursuant to A.R.S. § 32-1854(6), which states "Engaging in the practice of medicine in a manner that harms or may harm a patient or that the board determines falls below the community standard."

15. The conduct described above is a violation of unprofessional conduct pursuant to A.R.S. § 32-1854(35), which states "Violating a federal law, a state law or a rule applicable to the practice of medicine."

16. The conduct described above is a violation of unprofessional conduct pursuant to A.R.S. § 32-1854(36), which states "prescribing or dispensing controlled substances or prescription-only medications without establishing and maintaining adequate patient records."

17. The conduct described above is a violation of unprofessional conduct pursuant to A.R.S. § 32-1854(38), which states "Any conduct or practice that endangers the public's health or may reasonably be expected to do so."

18. The conduct described above is a violation of unprofessional conduct pursuant to A.R.S. § 32-1854 (48), which states "Prescribing, dispensing or furnishing a prescription medication or a prescription-only device to a person if the licensee has not conducted a physical examination of that person or has not previously established a physician-patient relationship."

ORDER

Pursuant to the authority vested in the Board,

IT IS HEREBY ORDERED that Michael Shing, D.O, holder of osteopathic medical License number 005367 is issued a **DECREE OF CENSURE**.

IT IS HEREBY FURTHER ORDERED that Michael Shing, D.O., holder of osteopathic medical License number 005367 is placed on **PROBATION for a period of Five (5) Years** from the effective date of this Order, with the following terms:

1. Respondent shall be restricted from providing opioid management and from prescribing tramadol to chronic pain patients.

2. Respondent shall be restricted from prescribing opioid medications and tramadol, to patients not included in Paragraph 1 on this Order for more than thirty (30) days during a six month period.

3. Respondent is subject to periodic chart reviews by the Board. Respondent shall provide a patient list to the Board every six (6) months in which random charts will be selected for review. In addition, Respondent shall provide to the Board, written evaluations from his supervisory physician each six (6) months that shall include a review of:

a. Proper completion of History and Physicals,

b. Appropriate plan and follow up, and

c. Medical record keeping.

4. **Costs:** Respondent shall bear all costs incurred regarding compliance with this Order.

5. **Obey All Laws:** Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in the State of Arizona.

6. **Ceasing Practice in the State of Arizona:** In the event that Respondent ceases to practice medicine in the State of Arizona, by moving out of state, failing to renew his license, or maintaining an Arizona license but ceasing to practice clinical medicine or administrative medicine requiring licensure, Respondent shall notify the Board that he has ceased practicing in Arizona, in writing, within 10 days of ceasing to practice. In its sole discretion, the Board may stay the terms of this Order until such time as the Respondent resumes the practice of medicine in Arizona, or may take other action to resolve the findings of fact and conclusions of law contained in this Consent Agreement and Order for Probation.

7. **Failure to Comply / Violation**: Respondent's failure to comply with the requirements of this Order shall constitute an allegation of unprofessional conduct as defined at A.R.S. § 32-1854(25) and proven violations may be grounds for further disciplinary action (e.g., suspension or revocation of license).

ISSUED THIS 10th DAY OF JANUARY 2013.
ARIZONA BOARD OF OSTEOPATHIC EXAMINERS
IN MEDICINE AND SURGERY

By: _____
Jenna Jones, Executive Director

NOTICE OF RIGHT TO REQUEST REVIEW OR REHEARING

Any party may request a rehearing or review of this matter pursuant to A.R.S. § 41-1092.09. The motion for rehearing or review must be filed with the Arizona Board of Osteopathic Examiners within thirty (30) days. If a party files a motion for review or rehearing, that motion must be based on at least one of the eight grounds for review or rehearing that are allowed under A.A.C. R4-22-106(D). Failure to file a motion for rehearing or review within 30 days has the effect of prohibiting judicial review of the Board's decision. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Original "Findings of Fact, Conclusions of Law and Order for Decree of Censure and Probation" filed this 10th day of January, 2013 with:

Arizona Board of Osteopathic Examiners
In Medicine and Surgery
9535 East Doubletree Ranch Road
Scottsdale AZ 85258-5539

Copy of the "Finding of Fact, Conclusions of Law and Order for Decree of Censure and Probation" sent by certified mail, return receipt requested, this 10th day of January, 2013 to:

Michael Shing, D.O.

Address of Record

Copies of this "Findings of Fact, Conclusions of Law and Order for Decree of Censure and Probation" filed/sent this 10th day of January, 2013 to:

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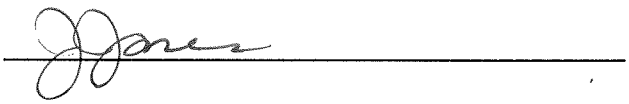
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