

1 **BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS**

2 **IN MEDICINE AND SURGERY**

3 IN THE MATTER OF:

4 **PHILO ROGERS, D.O.,**
5 Holder of License No. 2809

6 For the practice of osteopathic medicine in
7 the State of Arizona

) **Cases No.: DO-09-0154A and DO-10-0069A**

) **Consent to Entry of Findings of Fact,**
) **Conclusions of Law And Order for a Decree of**
) **Censure and Probation**

8
9 By mutual agreement and understanding, between the Arizona Board of Osteopathic
10 Examiners in Medicine and Surgery ("Board") and Philo Rogers, D.O. ("Respondent" or "Dr.
11 Rogers"), the parties agree to the following disposition of this matter.

12 1. Respondent has read and understands this Consent Agreement and the
13 stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent
14 acknowledges that he has the right to consult with legal counsel regarding this matter and has
15 done so or chooses not to do so.

16 2. By entering into this Consent Agreement, Respondent voluntarily relinquishes
17 any rights to a hearing or judicial review in state or federal court on the matters alleged, or to
18 challenge this Consent Agreement in its entirety as issued by the Board, and waives any other
19 cause of action related thereto or arising from said Consent Agreement.

20 3. This Consent Agreement is not effective until approved by the Board and signed
21 by its Executive Director.

22 4. Respondent admits to the findings of fact and conclusions of law contained in
23 the Consent Agreement and Order.

24 5. This Consent Agreement, or any part thereof, may be considered in any future
25 disciplinary action against Respondent.

26 6. This Consent Agreement does not constitute a dismissal or resolution of other
27 matters currently pending before the Board, if any, and does not constitute any waiver, express

1 or implied, of the Board's statutory authority or jurisdiction. The acceptance of this Consent
2 Agreement does not preclude any other agency, subdivision or officer of this State from
3 instituting other civil or criminal proceedings with respect to the conduct that is the subject of
4 this Consent Agreement.

5 7. All admissions made by Respondent are solely for final disposition of this matter
6 and any subsequent related administrative proceedings or civil litigation involving the Board,
7 Respondent and the State of Arizona. Therefore, admissions by Respondent are not intended
8 or made for any other use, such as in the context of another state or federal government
9 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any
10 other state or federal court.

11 8. Upon signing this agreement, and returning this document (or a copy thereof) to
12 the Board's Executive Director, Respondent may not revoke the acceptance of the Consent
13 Agreement. Respondent may not make any modifications to the document. Any modifications
14 to this original document are ineffective and void unless mutually approved by the parties.

15 9. This Consent Agreement, once approved and signed, is a public record that will
16 be publicly disseminated as a formal action of the Board and will be reported to the National
17 Practitioner Data Bank and to the Board's website.

18 10. If any part of the Consent Agreement is later declared void or otherwise
19 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force
20 and effect.

21 11. If the Board does not adopt this Consent Agreement, (1) Respondent will not
22 assert as a defense that the Board's consideration of the Consent Agreement constitutes bias,
23 prejudice, prejudgment or other similar defense; and (2) the Board will not consider content of
24 this Consent Agreement as an admission by Respondent.

25 REVIEWED AND ACCEPTED THIS 24th DAY OF September, 2011.
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1 Philo Rogers, D.O.
2 Philo Rogers, D.O.
3 Respondent

4 Heather Hendrix
5 Heather Hendrix, Esq.
6 Attorney for Respondent

7 **JURISDICTION**

8 1. The Board is empowered, pursuant to A.R.S. § 32-1800, *et seq.* to regulate the
9 licensing and practice of osteopathic medicine in the State of Arizona.

10 2. Respondent, Philo Rogers, D.O., holds license No. 2809 issued by the Board to
11 practice as an osteopathic physician.

12 **FINDINGS OF FACT**

13 **Case DO-09-0154A**

14 1. In September 2009, the Board initiated case number DO-09-0154A after
15 receiving a complaint from the father of patient F.B. that Respondent had inappropriately
16 prescribed pain medication to F.B., following an overdose.

17 2. On December 2, 2008, F.B., then a 38 year old female, first saw Respondent for
18 middle and upper back pain. F.B. reported a prior history significant for a drug overdose, deep
19 vein thrombosis, hypertension, fatigue, asthma, attention deficit disorder with hyperactivity,
20 depression, back pain and lumbar neuropathy, and that she was taking the following
21 medications: Lexapro, Adderall and ibuprofen. There is no evidence in Respondent's records
22 that Respondent reviewed this history with her. Respondent's records do not contain the
23 names of the health care practitioners who prescribed the listed medications, or the names of
24 other health care practitioners whom she was seeing at that time.

25 3. Respondent's records of treatment start on December 8, 2008 and state that F.B.
26 was taking Coumadin, Atnedol, Singulair, Albuterol inhaler, Flovent, Tesalon Pearls, Depo
27 Provera, Neurontin, Flexeril 3x a day, and Norco 5/325. The records do not contain comment
about whether those medications are in addition to the medications F.B. listed on December 2,
2008 or whether they are a corrected list. Respondent's records do not list the names of the

1 health care practitioners who prescribed those medications or the names of other health care
2 practitioners whom F.B. was seeing at that time.

3 4. On December 8, 2008, and again on April 21, 2009, Respondent and F.B. signed
4 an Agreement for Controlled Substances Therapy for Chronic Pain. Part of that Agreement was
5 that all controlled substances were to be prescribed only by Respondent; that all controlled
6 substances were to be filled at one pharmacy, and that unannounced urine or serum toxicology
7 screens may be requested. Respondent's records do not contain evidence of discussion
8 regarding changes in prescribers of the controlled substances F.B. reported already being
9 prescribed.

10 5. The standard of care in use of contracts for management of chronic pain patients
11 is not only to have pain contracts, but to enforce the terms. Respondent deviated from
12 standard of care in that he did not verify that F.B. was only receiving pain medications from
13 him, by accessing either the Board of Pharmacy's Controlled Substance Prescription Monitoring
14 Program, or by accessing her AHCCCS records. Respondent also violated this standard of care in
15 that, during the nine months he treated her, he did not request a urine or serum toxicology
16 screen to verify F.B. was following his medication regime.

17 6. Beginning with F.B.'s first visit on December 8, 2008, through her last visit on
18 August 21, 2009, Respondent prescribed narcotic medication on each visit, steadily increasing
19 the potency of the medication and the numbers of pills prescribed. Respondent did this despite
20 patient F.B. having an MRI in March 2009 showing no significant adverse findings; despite
21 knowledge of her past drug overdose, and despite having written in F.B.'s chart on December 8,
22 2008, and repeated in the record of every visit that "narcotic of all forms should be limited for
23 this patient."

24 7. On August 21, 2009, Respondent saw F.B., and despite there being no
25 documentation in the medical records that she was experiencing increased pain, Respondent
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1 increased her Norco prescription to 360 pills, and also prescribed her 90 MS Contin extended
2 release 60 mg pills (morphine), to be taken once every 8 hours.

3 8. On August 23, 2009, F.B. overdosed on the MS Contin she had received from
4 both Respondent and another health care practitioner, and was taken to a hospital in full code.

5 9. Respondent stated he learned after her overdose that F.B. had been seeing
6 other physicians and obtaining controlled substances prescriptions from them, despite having
7 signed a pain management contract that she would be prescribed controlled substances only by
8 Respondent.

9 10. In early 2011, the Board's staff reviewed 25 patient charts; the patients were
10 chosen from those to whom Respondent was prescribing narcotic pain medications. The charts
11 contained new patient histories, though without evidence that Respondent had reviewed those
12 histories. The most frequently cited reason for visit was "medication refill." Respondent
13 conducted focused examinations, and ordered appropriate diagnostic tests and procedures. No
14 overprescribing was found in the 25 patient charts reviewed.

15 11. Respondent appeared to rely solely on patients' self reports of pain levels; there
16 were no functional assessments recorded in the charts, nor any short and long term goals for
17 increased functionality. Not all charts included pain contracts. Not all charts contained
18 evidence that Respondent consulted the Controlled Substances Prescription Monitoring
19 Program to verify patients' self reports of medication they were taking, or to determine
20 patients' compliance with pain contracts.

21 **Case No. DO-10-0069A**

22 12. On April 29, 2010, the Board initiated case no. DO-10-0069A, after receiving a
23 complaint from the mother of a patient H.C., stating that Respondent had inappropriately
24 prescribed pain medication to H.C., without apparent medical reason.

25 13. On October 14, 2009, H.C., then a 22 year old female, presented to Respondent
26 as a new patient, complaining of right shoulder and right hip pain from a motor vehicle accident
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1 six years prior. Patient H.C. said her current medications, Ultram and Vicodin, were not
2 effective for pain. Respondent's records do not contain the names of the health care
3 practitioners who prescribed the listed medications, or the names of other health care
4 practitioners whom patient H.C. was seeing at that time.

5 14. On October 14, 2009, Respondent conducted a physical examination that was
6 significant only for tenderness in the right shoulder and right hip, spasms in the spine and
7 tenderness in the lumbosacral region. Respondent took an x-ray of the right hip and shoulder,
8 and ordered blood work. He prescribed Percocet, 10/325, one every six hours as needed, #60;
9 Flexeril 10 mg, one each night, #30. He gave her #28 samples of Lexapro, 10 mg, to be taken 1
10 a day. According to the AZ Board of Pharmacy Controlled Substance Prescription Monitoring
11 Program (CS/PMP), H.C. filled the prescription for Percocet that same day, October 14, 2009.

12 15. On October 14, 2009, Respondent and H.C. signed an Agreement for Controlled
13 Substances Therapy for Chronic Pain. Part of that Agreement was that all controlled substances
14 were to be prescribed only by Respondent; that all controlled substances were to be filled at
15 one pharmacy, and that unannounced urine or serum toxicology screens may be requested.
16 Respondent's records do not contain evidence of discussion regarding changes in prescribers of
17 the controlled substances F.B. reported already being prescribed.

18 16. The standard of care in use of contracts for management of chronic pain patients
19 is not only to have pain contracts, but to enforce the terms. Respondent deviated from
20 standard of care in that he made no attempt to verify that H.C. received pain medications only
21 from him, nor during the time he treated her did he request a urine or serum toxicology screen
22 to verify H.C. was following his medication regime.

23 17. On October 20, 2009, H.C. returned to the office with a police report, stating the
24 Percocet prescribed to her at her first visit on October 14, 2009, had been stolen. Respondent
25 wrote her a replacement prescription for Endocet, 10/325, #60, and recorded in the chart that
26 H.C. was to return to the office 2-4 weeks later. Despite that entry, H.C. was seen nine days
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1 later, on October 29, 2010, at which time Respondent prescribed her an additional 60
2 Oxycodone which H.C. filled the same day. According to the CD/PMP report, Respondent had
3 prescribed and patient H.C. had been dispensed 180 pills in the two week period between
4 October 14 and 29, 2009.

5 18. Between her initial visit on October 14, 2009, and her final visit on April 26, 2010,
6 Respondent saw H.C. approximately once a week, and prescribed her 60 to 120 Oxycodone at
7 each visit. Respondent did this despite sending H.C. for an MRI of her right hip and pelvis in
8 April 2009 that found nothing remarkable; and despite referring H.C. to a pain specialist in
9 March 2009 who found soft tissue but not orthopedic involvement, and who recommended
10 intensive physical therapy.

11 19. Respondent stated in his response to the Board that in April 2010 H.C.'s "pain
12 was diminishing as was her use of narcotics." This statement is not consistent with the CS/PMP
13 report, which shows Respondent prescribed H.C.'s prescriptions 660 Oxycodone pills in April,
14 an increase from the 360 prescribed to her in March 2010.

15 20. Respondent stated in his response to the Board that in H.C. was doing physical
16 therapy, despite there being no notes in his medical records to corroborate that statement.

17 21. On May 2 and again on May 25, 2010, H.C. was admitted to in-patient treatment
18 for drug abuse and addiction.

19 Dr Rogers' Prior Disciplinary History

20 22. On September 11, 2004, the Board issued a Decree of Censure against Dr.
21 Rogers' license, for his failure to see a patient newly admitted to a nursing home or to write any
22 orders for that patient in a reasonable period of time.

23 23. On December 13, 2001, the Board issued an Order for Probation to Dr. Rogers,
24 ending the summary suspension of his license that had begun on August 25, 2001; issued a
25 Decree of Censure, and placed his license under Probation for five years. The terms of the
26 Probation included a Practice Restriction, restricting Dr Rogers from prescribing Schedule II
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1 medications, and also requiring him to complete a mini-residency in quality of care, and to
2 submit to chart reviews by staff. This action was taken as a result of a chart of review of
3 patients done pursuant to an earlier Order for Probation (see paragraph 24, below). The Board
4 found that Dr. Rogers "prescribe(s) extremely large doses of narcotics for low back pain . . .
5 which are usually reserved for terminally ill patients." This Probation was satisfied in full and
6 terminated on June 24, 2006.

7 24. On January 25, 2000, the Board found that, in three separate cases, Dr. Rogers
8 had prescribed "large amounts of narcotics without sufficient documentation on a number of
9 patients." The Board issued an Order for Probation to Dr. Rogers, for two years. The terms of
10 the Probation were that Dr. Rogers was 1) to obtain 10 hours of Continuing Medical Education
11 in each of the following areas: appropriate prescribing for the management of chronic pain, and
12 in record keeping, and 2) to submit to periodic chart reviews. As a result of a chart review, on
13 August 25, 2001, the Board summarily suspended Dr. Rogers' license; the summary suspension
14 was resolved in another action (see #23, above).

15 Mitigation

16 25. Dr. Rogers voluntarily attended the Second Annual West Coast Symposium on
17 Addictive Disorders held June 2-5, 2011, and completed twenty (20) hours of CME.

18 26. Dr. Rogers voluntarily has been working to refer out his present patients that
19 require the discussed schedule of medications. All chronic pain patients (more than two dozen)
20 either have been referred to pain management, discharged, or will be placed with new
21 physicians for their Schedule II chronic pain medications. This was a permanent decision for Dr
22 Rogers' practice of medicine.

23 CONCLUSIONS OF LAW

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

3 2. The conduct described above is a violation of unprofessional conduct pursuant
4 to A.R.S. § 32-1854(38), which prohibits “Any conduct or practice that endangers a patient's or
5 the public's health or may reasonably be expected to do so.”

6 3. The conduct described above is a violation of unprofessional conduct pursuant
7 to A.R.S. § 32-1854(44), which prohibits, “Conduct that the board determines constitutes gross
8 negligence, repeated negligence or negligence that results in harm or death of a patient.”

9 **ORDER**

10 IT IS HEREBY ORDERED THAT Philo Rogers, D.O., holder of License Number 2809 for the
11 practice of osteopathic medicine in the State of Arizona, is issued a DECREE OF CENSURE and
12 placed on PROBATION for a period of five (5) years, from the effective date of this Order, with
13 the following terms:

14 1. Effective October 1, 2011, Respondent's practice shall be restricted in that he
15 shall no longer prescribe any Schedule II medications, Schedule III morphine combinations (DEA
16 # 9810), Schedule III hydrocodone combinations (DEA #9806), or Schedule III buprenorphine
17 (DEA # 9064), to any patient, nor shall such medications be prescribed by any health care
18 practitioner supervised, employed or contracted by Respondent at his practice.

19 2. Notwithstanding the preceding paragraph, Respondent may prescribe Adderral,
20 Vyvance and Ritalin for pediatric patients who have been diagnosed with Attention Deficit
21 Disorder. The diagnosis shall meet the current standard of care. Respondent shall ensure that
22 the pediatric patient consult a psychiatrist every six months.

23 3. Notwithstanding paragraph one, Respondent may prescribe a Schedule III
24 hydrocodone combination not to exceed forty tablets at 5 mg per thirty days not to exceed
25 three months of treatment.

1 4. Respondent shall employ a Board approved practice reviewer and monitor
2 ("Practice Monitor"), such as Affiliated Monitors, Inc. or an equivalent Arizona licensed
3 osteopathic or allopathic physician monitoring service if pre-approved by the Board, within
4 thirty (30) days from the effective date of this Order for a period of not less than eighteen (18)
5 months.

6 a. Respondent shall make available to the Practice Monitor the medical records of
7 the selected patients, which includes office visits, consultations, and diagnostic and treatment
8 procedures, and the superbills or equivalent billing records for those encounters.

9 b. The Practice Monitor shall provide to the Board a report containing an initial
10 assessment and recommendations within sixty (60) days from the effective date of this Order,
11 and thereafter on a quarterly basis. The Practice Monitor may provide to Respondent interim
12 assessments and recommendations. The reports shall comment on:

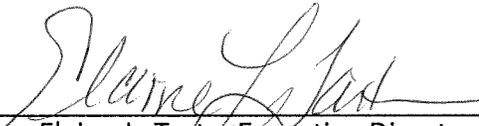
- 13 i. Any deviations from standard of care
- 14 ii. Any inadequacies in the medical recordkeeping
- 15 iii. Any inadequacies in the billing records.

16 c. After the receipt of the final report from the Practice Monitor, Physician may
17 come before the Board after eighteen (18) months to request termination of paragraph 4 of
18 this Order.

19 Any violation of this Consent Agreement and Order constitutes unprofessional conduct
20 and may result in disciplinary action and or referral to the appropriate criminal agency.



21 ISSUED THIS 24th DAY OF SEPTEMBER, 2011.
22 STATE OF ARIZONA
23 BOARD OF OSTEOPATHIC EXAMINERS
24 IN MEDICINE AND SURGERY

25 By: 
26 Elaine LeTarte, Executive Director

27 Original filed this 24th day of September, 2011 with:

1 Arizona Board of Osteopathic Examiners
2 In Medicine and Surgery
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4 Scottsdale AZ 85258-5539

5 Copies of the foregoing sent via regular mail
6 this 24 day of September, 2011 to:

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