BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

PAUL A. BUDNICK, M.D.  

Case No.  MD-15-1008A
MD-16-0240A

HOLDER OF LICENSE NO. 34093
FOR THE PRACTICE OF ALLOPATHIC MEDICINE
IN THE STATE OF ARIZONA.

ORDER FOR LETTER
OF REPRIMAND AND PROBATION;
AND CONSENT TO THE SAME

Paul A. Budnick, M.D. ("Respondent"), elects to permanently waive any right to a hearing and appeal with respect to this Order for a Letter of Reprimand and Probation; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 34093 for the practice of allopathic medicine in the State of Arizona.

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4. SK, a 24 year-old male patient, was treated by Respondent from November, 2013 through July, 2015 for various complaints including low back pain, attention deficit hyperactivity disorder ("ADHD"), erectile dysfunction ("ED"), and hypogonadism.

5. On November 15, 2013, SK saw Respondent for his first visit. Respondent prescribed Percocet for back pain. SK did not have a prior prescription for this medication.

6. SK returned on December 11, 2013 and reported that the Tylenol in his Percocet hurt his stomach so he threw the medication out. SK further reported that he had
been prescribed Oxycodone 30 mg in California. Respondent prescribed SK Oxycodone
30 mg twice a day.

7. On January 10, 2014, SK reported that he hurt is back. Respondent
increased SK’s prescription for Oxycodone 30 mg from twice a day to three times a day.
SK refused a request to release prior medical records.

8. On February 13, 2014, SK reported that the Oxycodone was not working, but
he refused a referral from Respondent to a pain management specialist.

9. On April 11, 2014, a urine drug screen was positive for both opiates and
oxycodone. Respondent’s record does not show any action taken to confirm the results.

10. At a visit on August 8, 2014, Respondent prescribed Percocet again in
addition to Oxycodone.

11. On November 20, 2014, Respondent reviewed a repeat Lumbar MRI. The
impression was mild changes with mild foraminal stenosis that had improved since SK’s
last MRI.

12. On January 15, 2015, SK reported that he had gone through withdrawal and
had “bought some oxy off the street.” Respondent renewed SK’s Oxycodone prescription
at 30 mg every 6 hours as needed, with a total of 120 pills.

13. On February 5, 2015, Respondent began prescribing Adderal to SK, which
he had been previously prescribed by another provider. Respondent’s records show that
an ADHD questionnaire was completed.

14. On March 5, 2015, SK reported that he had been on #240 Oxycodone 30 mg
in the past. Respondent increased the quantity of SK’s Oxycodone from #130 to #140.
Respondent did not document any information regarding SK’s pain relief effectiveness and
duration.

15. On June 26, 2015, SK reported to Respondent that he was using marijuana.
16. On July 23, 2015, SK’s urine drug screen showed opiates, oxycodone and its metabolites, but was negative for Adderall.

17. On July 28, 2015, SK attempted suicide by overdose on prescription medications and illegal drugs. He was subsequently admitted to a drug rehabilitation facility where he listed his drugs of abuse as those prescribed by Respondent, as well as cocaine, heroin, methamphetamine and Xanax. Respondent further reported that he had been using cocaine for three years, with last use on July 26, heroin for six months, with last use on July 31 and methamphetamines for five years with last use on July 30.

18. The standard of care required Respondent to obtain prior patient records in order to screen for aberrancy and corroborate the patient’s report of medications previously prescribed. Respondent deviated from this standard of care by failing to treat SK’s refusal to release his prior medical records as aberrancy, and discharging the patient until he agreed to provide some way for Respondent to confirm his reported medications and treatment.

19. The standard of care required Respondent to review the Controlled Substance Prescription Monitoring Program ("CSPMP") for evidence of multiple providers, early refills and corroboration of SK’s reported medications. Respondent deviated from this standard of care by failing to review the CSPMP either at the initiation of treatment or while treatment was ongoing.

20. The standard of care required Respondent to obtain image studies to show pathology warranting controlled substance prescriptions. Respondent deviated from this standard of care by failing to obtain SK’s old imaging studies and continuing to prescribe controlled substances despite new imaging showing only mild findings that did not warrant ongoing prescribing.
21. The standard of care required Respondent to ask SK about illegal drug use and take action if SK admitted to the use of illegal drugs. Respondent deviated from this standard of care on June 25, 2015 when SK admitted to his use of marijuana by failing to take appropriate action by discharging SK from his practice with a 30 day prescription of his mediations to prevent patient abandonment.

22. The standard of care required Respondent to document SK’s early refills of medications and the reasons for the early refills in order to screen for medication overuse. SK had several early refills of his controlled substance prescriptions and Respondent deviated from this standard of care for early appointments by failing to use appropriately timed fill dates on the prescriptions, obtaining pill counts, and by failing to discharge the patient when he prevented a pill count by reporting that he threw his pills out.

23. The standard of care required Respondent to appropriately address criminal activity by discharging SK when he reported criminal activity. Respondent deviated from this standard of care by failing to discharge SK and refer him for addiction management or even to discuss addiction issues when SK reported that he bought Oxycodone off the street.

24. The standard of care required Respondent to address aberrant requests for specific medication, including the reason for and response to current dosages. Respondent deviated from this standard of care by prescribing Oxycodone at the request of SK when SK reported that the Tylenol upset his stomach, when Tylenol does not typically have that effect. At the time SK made the request to discontinue Percocet, Respondent should have started at the minimum dosage of Oxycodone and titrated up if necessary. Respondent started at the highest dose available at 30 mg.

25. The standard of care required Respondent to utilize urine drug screens to screen for misuse of controlled substances. Respondent deviated from this standard of
care by failing to conduct a sufficient number of urine drug screens. Additionally, when
SK’s April 11, 2014 urine drug screen showed opiates and Oxycodone, Respondent failed
to order additional screening that would have clarified whether SK was taking opiates other
than the Oxycodone as prescribed by Respondent.

26. The standard of care required Respondent to document the reason for
discontinuing patient care if required. Respondent deviated from this standard of care by
failing to document the reason that patient care was discontinued.

27. There was the potential for patient harm in that with SK’s history of
polysubstance abuse and the chemical interaction of all of these medications, he is at risk
of a drug overdose and respiratory depression.

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28. The Board initiated case number MD-16-0240A after receiving a complaint
regarding Respondent’s care and treatment of a 32 year-old female patient (“JH”) alleging
inappropriate prescribing.

29. JF had a history of chronic pain syndrome and anxiety disorder and began
treatment with Respondent in early 2014. Respondent prescribed JH Oxycodone 30 mg
#90 which was an amount and dosage consistent with a previous physician’s prescription.
A medical consultant (“MC”) found that the prescription of Oxycodone was medically
indicated and appropriately managed. However, the MC noted that Respondent did
deviate from the standard of care by prescribing controlled substances in excessive
dosages and by failing to refer JH to a pain management specialist.

30. The standard of care required Respondent to prescribe controlled
substances appropriately and refer JH to a specialist when necessary. Respondent
deviated from this standard of care by overprescribing narcotics and failing to refer JH to a
pain management specialist.
31. There was potential for patient harm in that JH was at risk for the side effects of excessive or improper prescribing of controlled substances.

CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described above in case MD-15-1008A constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").

c. The conduct and circumstances described above in cases MD-15-1008A and MD-16-0240A constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

2. Respondent is placed on Probation for a period of 6 months with the following terms and conditions:

   a. **Continuing Medical Education**

      Respondent shall within 6 months of the effective date of this Order obtain no less than 15 hours of Board staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, in-person course regarding controlled substance prescribing. Respondent shall within thirty days of the effective date of this Order submit her request for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in
addition to the hours required for the biennial renewal of medical licensure. The Probation
shall terminate upon Respondent’s proof of successful completion of the CME.

b. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the
practice of medicine in Arizona, and remain in full compliance with any court ordered
criminal probation, payments and other orders.

3. The Board retains jurisdiction and may initiate new action against
Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(r).

DATED AND EFFECTIVE this 6th day of April, 2017.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the
stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent
acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely
and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to
a hearing or judicial review in state or federal court on the matters alleged, or to challenge
this Order in its entirety as issued by the Board, and waives any other cause of action
related thereto or arising from said Order.
4. The Order is not effective until approved by the Board and signed by its Executive Director.

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

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board’s Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner’s Data Bank and on the Board’s web site as a disciplinary action.

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board’s consideration of the Order constitutes bias, prejudice, prej udgment or other similar defense.

10. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § 32-1401(27)(r) (Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.”) and 32-1451.
11. Respondent has read and understands the conditions of probation.

[Signature]

PAUL A. BUDNICK, M.D.

DATED: 7-26-17

EXECUTED COPY of the foregoing mailed this [6th] day of April, 2017 to:

Paul A. Budnick, M.D.
Address of Record

ORIGINAl of the foregoing filed this [6th] day of April, 2017 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

[Signature]

Board staff