

**BEFORE THE MEDICAL LICENSING BOARD OF INDIANA
CAUSE NO. 2010 MLB 0007**

**IN THE MATTER OF THE
LICENSE OF KAMAL TIWARI, M.D.
LICENSE NO: 01034945A**

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COMPLAINT

This complaint is brought against the medical license of Kamal Tiwari, M.D. (Respondent), by the State of Indiana, by counsel, Deputy Attorneys General, Elizabeth Kiefner Crawford and Christa J. Jewsbury, on behalf of the Office of the Attorney General (Petitioner) and pursuant to Indiana Code § 25-1-7-7, Ind. Code § 25-1-5-3, Ind. Code § 25-22.5 et seq., the Administrative Orders and Procedures Act, Ind. Code § 4-21.5-3 et seq. and Ind. Code § 25-1-9-1 et seq., and in support alleges and states:

FACTS

1. Respondent's address on file with the Medical Licensing Board of Indiana (Board) is 2700 Robins Bow, Bloomington, IN 47401 and he is a licensed medical doctor holding Indiana license number 01034945A.
2. Respondent is the founder and president of the Pain Management Center of Southern Indiana, Inc. (PMC), which has its primary location in Bloomington, Indiana.
3. Respondent is board certified in anesthesiology and pain management.
4. During the course of investigation, Petitioner obtained and reviewed medical records for a sampling of Respondent's patients. The review of Respondent's medical records revealed the following:

Patient A

5. On or about June 1, 2004, Patient A was referred to Respondent by Dr. William Rusche (Dr. Rusche) at the Rheumatology Center of Southern Indiana, P.C. (RCSI). Dr. Rusche's referral letter to Respondent dated June 1, 2004, states, "I have not prescribed controlled substances [to Patient A] since an arrest for driving under the influence May 15, 2004."

6. Dr. Rusche's medical records regarding Patient A's care are contained in Respondent's medical record for Patient A. An RCSI office note dated February 16, 2004 states, "Because of his polysubstance dependence and inability to account for drug intoxication during his hospitalization, I have taken [Patient A] off Oxycontin."

7. On or about June 28, 2004, Patient A signed a Medication Management Agreement (MMA) with PMC. The MMA provides, "6. I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Physician. I understand it is against the law to do so. . . [F]ailure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship."

8. Respondent's medical record contains no documentation that Respondent provided any treatment to Patient A between June 28, 2004 and June 16, 2005.

9. On or about April 13, 2005, Dr. Angie Marshall, Psy.D. (Dr. Marshall) conducted a psychological assessment of Patient A. Dr. Marshall's assessment report states, "[Patient A] was noted to go through detoxification from medication in April of 2004, and it was suspected that he was abusing Soma and Xanax. Benzodiazepine abuse

was also noted in December 2003.” A courtesy copy of this document is contained in Respondent’s medical record for Patient A.

10. On or about June 16, 2005, Respondent referred Patient A to Dr. Betty Watson, Clinical Psychologist, (Dr. Watson) for a full psychological evaluation in order to determine Patient A’s readiness for a morphine pump.

11. Dr. Watson’s Report of Psychological Evaluation states, “[Patient A] states he does not drink alcohol although at times he has experimented. He denies ever being arrested for alcohol use, but this is at odds with records which show an arrest for a DUI in May of 2004. He also denies the difficulty with any substance abuse, but again records indicate that it has been suspected that the may have been abusing Soma and Xanax.” In her Review of Records, Dr. Watson notes, “The record from Bloomington Meadows [hospitalization on 3/15/05] indicates that [Patient A] was referred by Sunrise Counseling for evaluation of polysubstance abuse. The history states that he had been abusing pain pills and benzodiazepines and also had a history of cocaine and methamphetamine dependence. . . [T]he assessment at the Meadows led to a diagnosis of benzodiazepine dependence and opiate dependence.”

12. On or about December 18, 2006, Respondent conducted a Urine Drug Screen (UDS) on Patient A. Patient A tested positive for benzodiazepines, methadone, hydrocodone, and hydromorphone.

13. Respondent’s medical record for Patient A contains no documentation regarding treatment provided by Respondent in 2007.

14. On or about January 11, 2008, Patient A signed a new MMA with PMC. The MMA provides, “6. I will not attempt to get pain medication from any other health

care provider without telling them that I am taking pain medication prescribed by the Physician. I understand it is against the law to do so. . . [F]ailure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship.”

15. On or about February 29, 2008, a UDS was conducted on Patient A. Patient A tested positive for benzodiazepines, methadone, hydrocodone and hydromorphone.

16. Despite knowledge that Patient A had a history of polysubstance abuse, Respondent prescribed Patient A the following:

A. Norco 10/325 mg, a Schedule III narcotic, on March 11, 2008, quantity #120; and March 21, 2008, quantity #120, with 2 refills.

B. Methadone 10 mg, a Schedule II narcotic, on March 11, 2008, quantity #120; March 21, 2008, quantity #240.

17. On or about April 29, 2008, a Follow-up Note contained in Respondent’s medical record for Patient A states, “UDS Again.” The UDS, conducted on April 29, 2008, was positive for benzodiazepines, methadone, opiates, and oxycodone. Respondent was not prescribing Patient A benzodiazepines or oxycodone at that time.

18. Despite knowledge that Patient A was obtaining medications from other physicians, in violation of his MMA, Respondent prescribed Patient A the following:

A. Norco 10/325 mg on June 24, 2008, quantity #120, with 2 refills;

B. Methadone 10 mg on April 29, 2008, quantity #240; May 27, 2008, quantity #240, and June 24, 2008, quantity #240.

19. On or about July 7, 2008, Respondent again referred Patient A to Dr. Watson to reevaluate Patient A's readiness for a morphine pump. Dr. Watson's evaluation report, which is contained in Respondent's chart for Patient A, reiterated Patient A's previous history of substance abuse and hospitalization. The report also states, "[Patient A] was not a good historian and did not relate to me accurately either in 2005 or today the difficulties he has had with substance abuse."

20. On or about July 22, 2008, Respondent conducted a UDS on Patient A. Patient A tested positive for benzodiazepines, meprobamate, methadone, hydrocodone, and hydromorphone. Respondent was not prescribing benzodiazepines or meprobamate to Patient A at that time.

21. Despite knowledge that Patient A had a history of substance abuse and was obtaining medications from other physicians, in violation of his MMA, Respondent prescribed Patient A the following:

- A. Norco 10/325 mg on September 23, 2008, quantity #120, with 2 refills; and December 3, 2008, quantity #120, with 2 refills;
- B. Methadone 10 mg on July 22, 2008, quantity #240; August 21, 2008, quantity #40; August 26, 2008, quantity #240; September 23, 2008, quantity #240; October 21, 2008, quantity #240; November 20, 2008, quantity #90; and December 3, 2008, quantity #90.
- C. Fentanyl Duragesic patches 2.55 mg, a Schedule II narcotic, on: November 20, 2008, quantity #10; December 3, 2008, quantity #10.

22. On or about December 31, 2008, Respondent conducted a UDS on Patient A. Patient A tested positive for benzodiazepines, carisoprodol, fentanyl, methadone,

hydrocodone, and hydromorphone. Respondent was not prescribing benzodiazepines or carisoprodol to Patient A at that time.

23. Despite knowledge that Patient A had a history of substance abuse and was obtaining medications from other physicians, in violation of his MMA, Respondent prescribed Patient A the following:

A. Fentanyl Duragesic patches on December 31, 2008, 7.5 mg, quantity #10; and February 5, 2009, 10.2 mg, quantity #10.

24. On or about February 6, 2009, Patient A died at age forty-nine (49). According to the Indiana State Department of Health (ISDH), the cause of Patient A's death was "Polypharmacologic Intoxication." Three days before his death, Patient A filled a prescription for Norco 10/325 written by Respondent. On the day before his death, Patient A filled a prescription for Fentanyl Duragesic patches at an increased dosage of 10.2 mg written by Respondent.

Patient B

25. On or about November 17, 2003, Respondent conducted an initial examination of Patient B with a diagnosis of possible degenerative lumbar spine and possible myofascial pain. Patient B reported that he was taking Tylenol to relieve his pain.

26. Respondent prescribed Elavil 10 mg, quantity #30 with 1 refill; Ultram, quantity #100 with 1 refill; and Flexeril 10 mg, quantity #60 with 1 refill on November 17, 2003. On December 18, 2003, Respondent prescribed Neurontin 300 mg, quantity #30 with 3 refills; and Elavil 25 mg, quantity #30 with 3 refills.

27. On or around January 2004, Patient B stopped seeing Respondent with no explanation.

28. Patient B returned to Respondent's practice on July 19, 2006, and Respondent performed another examination with a diagnosis of radiculitis, possible degenerative disc disease, facet arthropathy, insomnia, depression and chronic pain syndrome. Patient B reported taking Vicodin and Soma.

29. On or about July 19, 2006, Patient B signed a MMA with PMC which indicated, "11) I agree that I will use my medication at a rate no greater than prescribed and that use of medication at a greater rate will result in my being without medication for a period of time. . . [F]ailure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship."

30. Between the dates of July 19, 2006 and June 13, 2007, Respondent administered treatments such as facet joint injections and epidurals to Patient B.

31. Respondent prescribed Patient B Norco 5/325 mg, quantity #60, on August 21, 2006 and September 11, 2006.

32. Respondent changed the medication to Lortab 5 mg, a Schedule III narcotic, and prescribed quantity #90 to Patient B on October 11, 2006 with 2 refills. Respondent increased the Lortab dosage to 7.5 mg on December 29, 2006, quantity #90 with 1 refill; February 23, 2007, quantity #90; March 19, 2007, quantity #90 with 2 refills; and June 7, 2007, quantity #90.

33. Respondent prescribed Methadone 5 mg on the following dates: March 19, 2007, quantity #30; April 11, 2007, quantity #30; May 9, 2007, quantity #30; and June 8, 2007, quantity #60.

34. On or about June 13, 2007, Patient B signed a second MMA with PMC. Between the dates of June 13, 2007 and January 9, 2008 Respondent continued to prescribe the following:

A. Lortab 7.5 mg, on the following dates: July 5, 2007, quantity #90; August 3, 2007, quantity #90 with 1 refill; October 1, 2007, quantity #90; October 7, 2007, quantity #90; December 5, 2007, quantity #90 with 1 refill.

B. Methadone 5 mg, on the following dates: July 5, 2007, quantity #60; August 3, 2007, quantity #90; August 27, 2007, quantity #90; October 1, 2007, quantity #90; October 23, 2007, quantity #90; November 11, 2007, quantity #90; and December 26, 2007, quantity #90.

C. Soma 350 mg, a Schedule IV controlled substance in Indiana, on the following dates: October 19, 2007, quantity #60; November 9, 2007, quantity #60; and December 15, 2007, quantity #60.

35. On or about January 9, 2008, Patient B signed a third MMA with PMC. The language of the third MMA indicated, “3) I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. . . ; 11) I agree that I will use my medication at a rate no greater than prescribed and that use of medication at a greater rate will result in my being without medication for a period of time. . . [F]ailure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all

prescribed medication by the Physician and the termination of the Physician/Patient relationship.”

36. On or about January 9, 2008, a UDS conducted at Respondent’s office was positive for methadone and hydrocodone, which Respondent was prescribing at that time.

37. Between the dates of January 9, 2008 and February 21, 2008, Respondent continued to prescribe Lortab, Methadone, and Soma on the following dates:

- A. Lortab 7.5, quantity #90, on January 28, 2008;
- B. Methadone 5 mg, quantity #90, on January 23, 2008;
- C. Soma 350 mg, quantity #60, on January 9, 2008 with 2 refills.

38. On or about February 21, 2008, Patient B was admitted to the Bloomington Hospital Emergency Department (Bloomington ER) due to an acute overdose on narcotics. The Bloomington ER medical records state, “[T]he patient’s ex-wife said he actually took a handful of Xanax, Lortab, and Soma. His urine drug screen shows positive for narcotics and Xanax. . . [H]e is also on Methadone from a pain clinic here in town.” Patient B was discharged from Bloomington Hospital on February 25, 2008. Documentation of Patient B’s February 21 - 25, 2008, hospitalization was contained in Patient B’s medical record at Respondent’s office as Respondent received a courtesy copy of the Bloomington ER admission.

39. Despite his knowledge of Patient B’s documented overdose and abuse of the medications prescribed to him, Respondent continued to prescribe Lortab, Methadone and Soma to Patient B. Respondent prescribed Lortab 7.5, quantity #90 with 2 refills, on March 3, 2008; Methadone 5 mg, quantity #90, on March 3, 2008; and Patient B obtained

a refill on March 3, 2008 of the Soma prescribed to him by Respondent on January 9, 2008.

40. On or about March 11, 2008, Patient B was arrested and charged with driving under the influence of substances other than alcohol.

41. On or about April 7, 2008, Patient B died at age thirty-seven (37), due to an accidental overdose of Lortab and Methadone. The Monroe County Coroner's report states the cause of death was, "Polysubstance Abuse." The Postmortem Toxicology indicated Patient B was positive for benzodiazepines, methadone, and hydrocodone. An original prescription for Lortab 7.5 mg, quantity #90, dated March 3, 2008, written by the Respondent was found with Patient B at the scene of his death.

Patient C

42. On or about May 2, 2003, another physician in Respondent's practice, Dr. Douglas Molin, M.D. (Dr. Molin) conducted an initial examination of Patient C, who was referred by Dr. Rowland for medical management of her pain due to sacral fracture and chronic low back pain. Patient C reported not taking any medication at that time. Dr. Molin prescribed Methadone 5 mg t.i.d., quantity #42. Dr. Molin referred Patient C to PMC's psychologist and ordered a UDS.

43. On or about July 17, 2003, Dr. Molin stated in a Progress Note, "[Patient C] comes in to resume medical management for her chronic pain. I last saw her on 5/2/03. . . [S]he did not get the urine drug screen and did not show up for her appointment with me. She comes back in seeking to resume medical management of her pain. I have told her I can not take care of her at this point."

44. On or about August 5, 2003, Respondent conducted an initial consultation with Patient C, based upon a referral from Dr. Bergman for back and tailbone pain. Patient C reported that she had tried Lortab and that she was currently taking Ambien and Zanaflex for pain relief. Respondent's Plan states, "I will start her on Amitriptyline 25 mg p.o. q.h.s., Effexor 37 mg increased to 75 mg p.o. q.d. Continue taking Soma, Lortab and Zanaflex from Dr. Bergman. I would like to have her decrease the amount of Lortab she is taking and start her on Methadone 5 mg p.o. b.i.d. and a 15-day supply was given."

45. On August 5, 2003, Patient C and Respondent signed a MMA which indicated, "4) I will not use any illegal substances, including marijuana, cocaine, etc. . . 5) I will not share, sell, or trade my medication for money, goods or services. . . 11) I agree that I will use my medication at a rate no greater than prescribed and that use of my medication at a greater rate will result in being without medication for a period of time. . . [F]ailure of the patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship."

46. On or about August 14, 2003, Respondent ordered a MRI of Patient C's lumbar spine. The MRI results state, "Impression: Mild mid lumbar facet joint arthropathy. Otherwise generally normal appearance of the lumbar spine."

47. Respondent prescribed Patient C the following medications:

- A. Methadone 5 mg on August 22, 2003, quantity #60; and September 8, 2003, quantity #90;
- B. Klonopin 0.5 mg, a Schedule IV depressant, quantity #60, on September 8, 2003;

C. Soma 350 mg, quantity #60, on September 8, 2003.

48. On or about September 17, 2003, Dr. Anne Leach, M.D., at Bloomington Hospital conducted a psychiatric evaluation of Patient C. The evaluation states, “[Patient C] says that she has passive thoughts that she would be better off dead and in the past has overdosed on available pills twice, but says that she is convinced she will never again make an attempt. She reports being hospitalized eight years ago at Meadows Hospital and 3-4 times since then at Bloomington Hospital, none of which were any help. She apparently never followed up with outpatient care.” In the report, Dr. Leach also stated she was, “concerned about [Patient C] being on Methadone, Klonopin and Soma. In particular, she is really looking to increase the Klonopin a lot. I would recommend only short-term use in low dose.” A courtesy copy of this document is contained in Respondent’s medical record for Patient C.

49. Despite Dr. Leach’s concern about Patient C’s medication use, Respondent prescribed the following to Patient C:

- A. Klonopin 0.5 mg on October 7, 2003, quantity #60; November 4, 2003, quantity #60; December 4, 2003, quantity #60; December 31, 2003, quantity #60; January 30, 2004, quantity #60; February 25, 2004, quantity #60; March 8, 2004, quantity #60; April 26, 2004, quantity #60; and May 25, 2004, quantity #60;
- B. Soma 350 mg, quantity #60, on October 9, 2003;
- C. Methadone 5 mg on October 14, 2003, quantity #90; increased to 10 mg on November 4, 2003, quantity #120; December 5, 2003, quantity #120; December 31, 2003, quantity #120; January 30, 2004, quantity

#120; and February 25, 2004, quantity #120; and March 24, 2004, quantity #40;

D. Lortab 7.5 mg on April 8, 2004, quantity #90; May 25, 2004, quantity #90; and Lortab 10 mg, quantity #60, on April 30, 2004.

E. During this time, Respondent also prescribed Patient C several different muscle relaxers such as Flexeril, Baclofen and Norflex in addition to the medications already listed.

50. On or about June 2, 2004, a Supplemental or Treatment Note in Respondent's medical record for Patient C states, "A caller states that [Patient C] is selling drugs."

51. Despite knowledge that Patient C may be selling her medications, Respondent continued to prescribe Patient C the following:

A. Lortab 10 mg on June 25, 2004, quantity #30; July 7, 2004, quantity #90; August 4, 2004, quantity #90; August 26, 2004, quantity #90; September 24, 2004, quantity #90; and October 25, 2004, quantity #120;

B. Klonopin 0.5 mg on June 25, 2004, quantity #22; August 19, 2004, quantity #60; September 13, 2004, quantity #60; and October 14, 2004, quantity #60.

C. Respondent continued to prescribe Patient WB muscle relaxers as well as anti-seizure medications such as Gabitril during this time in addition to the medications already listed.

52. On or about October 28, 2004, Respondent conducted a UDS on Patient C which was positive for cannabinoids (THC) and negative for all other substances despite the fact that Respondent was prescribing Lortab and Klonopin at this time.

53. Despite Respondent's knowledge of Patient C's use of illegal substances, notice of an allegation that Patient C was selling drugs, and her failure to test positive for the medications being prescribed to her, Respondent continued to prescribe the following to Patient C:

- A. Klonopin 0.5 mg on November 11, 2004, quantity #30; December 2, 2004, quantity #30; December 23, 2004, quantity #30; January 19, 2005, quantity #60; February 16, 2005, quantity #60; March 14, 2005, quantity #60; April 18, 2005, quantity #60; May 17, 2005, quantity #60; June 14, 2005, quantity #60; July 13, 2005, quantity #60; July 29, 2005, quantity #60; September 9, 2005, quantity #60; October 7, 2005, quantity #60; November 4, 2005, quantity #60; December 8, 2005, quantity #60; January 5, 2006, quantity #60; February 2, 2006, quantity #90; February 22, 2006, quantity #60; March 1, 2006, quantity #90; and March 24, 2006, quantity #90;
- B. Lortab 10 mg on November 24, 2004, quantity #120; December 23, 2004, quantity #120; January 19, 2005, quantity #120; February 16, 2005, quantity #120; March 14, 2005, quantity #120; April 18, 2005, quantity #120; May 17, 2005, quantity #120; June 14, 2005, quantity #60; and July 13, 2005, quantity #60;

- C. Methadone 5 mg on June 14, 2005, quantity #30; June 29, 2005, quantity #30; July 1, 2005, quantity #60 July 29, 2005, quantity #90; August 16, 2005, quantity #120; September 9, 2005, quantity #16; October 19, 2005, quantity #120; November 11, 2005, quantity #120; December 8, 2005, quantity #120; January 10, 2006, quantity #84; February 2, 2006, quantity #90; February 22, 2006, quantity #120; March 1, 2006, quantity #90; and March 24, 2006, quantity #90.
- D. Soma 350 mg, on September 9, 2005, quantity #30; October 7, 2005, quantity #30; October 26, 2005, quantity#60; November 18, 2005, quantity #60; December 8, 2005, quantity #60; and January 18, 2006, and quantity #60.
- E. Respondent also prescribed Patient C muscle relaxers and anti-seizure medications during this time in addition to the medications listed above.

54. On or about April 25, 2006, a Supplemental or Treatment Note in Respondent's medical record for Patient C states, "[Patient C's] mother called requested patient's medication refills. Patient's mother also stated patient was incarcerated. . ."

55. On or about April 27, 2006, a Supplemental or Treatment note in Respondent's medical record for Patient C states, "Spoke with Paula at Monroe Co. Jail. Patient was in jail for failure to appear, driving while intoxicated and positive for marijuana in her UDS. Patient has been incarcerated since April 6, 2006 and has received no meds while in jail."

56. Despite knowledge of Patient C's recent incarceration due to driving while intoxicated and testing positive for illegal substances, both of which are in violation of Patient C's MMA, Respondent prescribed Patient C Methadone 5 mg, quantity #30, on May 31, 2006.

57. On or about June 8, 2006, a Supplemental or Treatment note in Respondent's medical record for Patient C states, "[Patient C's] probation officer Valerie called wanting medication list. Valerie sent signed info release form. Med list given. Patient refuses to give probation officer UDS stating she has kidney problems. Dr. Tiwari ordered for blood draw to be done at next pick up and probation officer told we can do one. Officer stated patient has been called and is always out of it and has slurred speech – wanted us to know."

58. On or about June 15, 2006, a Supplemental or Treatment note in Respondent's medical record for Patient C states, "Probation officer called to let us know that while patient was in jail she never had seizures, but did have fainting spells due to refusing to eat. Patient also was found in bathroom between toilet and another item close due to falling over. Patient was given a UDS and jail found methadone and marijuana even though patient had not been receiving any meds since April 6 and occurrence happened on April 14. Probation officer believes someone brought methadone and marijuana to jail and snuck in to patient. . . Patient did admit to probation officer she was always taking pills, but not as prescribed but anytime she wanted to take it." Another Supplemental note dated the same date states, "Dr. Tiwari made aware of probation officers comment and report on patient. Also made aware that would like non-narcotic treatment."

59. On or about August 25, 2006, a Supplemental or Treatment note in Respondent's medical record for Patient C states, "[Patient C] still in jail per her step-father."

60. On or about October 11, 2006, a Supplemental or Treatment note in Respondent's medical record for Patient C states, "[Patient C's] mother had office visit today, per [Dr. Tiwari] OK to release daughter's Rx to her so she can deliver to the jail." Respondent prescribed Elavil 100 mg, quantity #30, and Zanaflex 4 mg, quantity #60 on this date.

61. On or about September 26, 2007, Respondent conducted a follow-up office visit with Patient C. Respondent's follow-up note for Patient C states, "just got out of jail for possession of marijuana."

62. On or about September 26, 2007, Patient C signed a new MMA which indicated, "4) I will not use any illegal controlled substances, including marijuana, cocaine, etc. . . 5) I will not share, sell, or trade my medication for money, goods or services. . . 11) I agree that I will use my medication at a rate no greater than prescribed and that use of my medication at a greater rate will result in being without medication for a period of time. . . [F]ailure of the patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship."

63. Despite knowledge of Patient C's documented history of drug abuse and overdose, at least two UDS positive for marijuana, incarceration due to driving while intoxicated and possession of marijuana, an allegation that Patient C is selling her

medications, and his own recommendation that non-narcotic treatment be used for Patient C, Respondent continued to prescribed the following:

- A. Lortab 7.5 mg on September 26, 2007, quantity #60; November 2, 2007, quantity #90 with 2 refills; and January 19, 2008, quantity #90 with 2 refills;
- B. Soma 350 mg, on November 2, 2007, quantity #60 with 2 refills; and January 21, 2008, quantity #60 with 2 refills.

64. On or about May 14, 2008, Patient C died at age twenty-seven (27). The Monroe County Coroner's case report, contained in Respondent's medical record for Patient C, states, "Cause of Death: Respiratory arrest, secondary to polysubstance abuse."

Patient D

65. On or about September 29, 2003, based on a referral from Dr. Hrismolas, Respondent conducted an initial examination of Patient D, with a diagnosis of myofascial pain, possible cervical and lumbar degenerative spine, insomnia, and depression with chronic pain. Patient D reported being prescribed Vicodin, Celebrex, Flexeril, Valium, and Trazadone by another physician. On September 29, 2003, Respondent prescribed the following:

- A. Elavil 10 mg, quantity #30;
- B. Effexor 37.5 mg, quantity #30;
- C. Zanaflex 4 mg, quantity #30;
- D. Norco 7.5 mg, quantity #90.

Respondent directed Patient D to continue taking her other prescribed medications.

Patient D signed a MMA with PMC on this date. The MMA provided, “4. I will not use any illegal controlled substances, including marijuana, cocaine, etc. 6. I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Physician. I understand it is against the law to do so. . . [F]ailure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship.”

66. Between the dates of September 29, 2003 and April 4, 2004, Respondent administered lumbar facet injections and conducted follow-up office visits approximately one (1) to two (2) times per month with Patient D. On April 1, 2004, Respondent added Soma 350 mg, quantity #28, to the medications he was prescribing to Patient D.

67. Respondent prescribed Norco 7.5 mg to Patient D on the following dates: October 9, 2003, quantity #90; November 25, 2003, quantity #90; December 16, 2003, quantity #90; January 22, 2004, quantity #90; February 20, 2004, quantity #90; March 10, 2004, quantity #90; April 1, 2004, quantity #42.

68. On or about April 4, 2004, Dr. Hrisomalos notified Patient D that he would no longer be able to serve as Patient D’s physician or prescribe medication to Patient D.

69. Respondent prescribed Patient D the following:

A. Soma 350 mg, on the following dates: April 15, 2004, quantity #60; June 1, 2004, quantity #90; July 1, 2004, quantity #90; July 28, 2004, quantity #90; August 27, 2004, quantity #90; September 16, 2004,

quantity #90; October 18, 2004, quantity #6; October 28, 2004, quantity #90;

B. Norco 7.5 mg, on the following dates: April 15, 2004, quantity #90; May 10, 2004, quantity #90; June 9, 2004, quantity #90; July 12, 2004, quantity #48; July 28, 2004, quantity #120; August 24, 2004, quantity #120; September 16, 2004, quantity #120; October 18, 2004, quantity #20; October 28, 2004, quantity #90.

70. Documentation Dr. Hrisomalos' decision to discontinue treatment of Patient D was contained in Patient D's medical record at Respondent's office as Respondent received a faxed copy from Dr. Hrisomalos on October 28, 2004. A "Supplemental or Treatment Note," dated October 28, 2004, states, "Hrisomalos discontinue patient due to patient get (sic) medications at different pharmacies and different doctors."

71. Despite the fact that Respondent was aware that Patient D was terminated from Dr. Hrisomalos practice for obtaining medications from different physicians and pharmacies, Respondent prescribed Patient D the following:

- A. Soma 350 mg, quantity #90, on November 18, 2004; December 13, 2004; January 21, 2005; February 18, 2005; March 9, 2005; April 18, 2005; May 10, 2005; June 9, 2005; and July 14, 2005.
- B. Norco 7.5 mg, on November 18, 2004, quantity #90; December 13, 2004, quantity #90; January 21, 2005, quantity #120; February 18, 2005, quantity #120; March 9, 2005, quantity #120; April 18, 2005,

quantity #120; May 10, 2005, quantity #120; June 9, 2005, quantity #120; and July 14, 2005, quantity #120.

72. On or about July 11, 2005, a “Supplemental or Treatment Notes” contained in Patient D’s medical record states, “Called pharmacy to call in Norco and Soma. Pharmacist on duty stated he had a phone call in June and July stating patient [D] was selling medication. Pharmacist was told we would check with doctor [Tiwari] and call back.” Despite the pharmacist’s statements indicating Patient D was selling medications, Respondent prescribed Norco 7.5, quantity #120, and Soma 350 mg, quantity #90, which was called in to the pharmacy on July 14, 2005.

73. On or about August 15, 2005, Bloomington Hospital Laboratory conducted a UDS on Patient D. The UDS was positive for cannabinoids (THC), benzodiazepines, and opiates. Respondent was not prescribing benzodiazepines at this time.

74. Despite his knowledge of Patient D’s documented use of illegal substances, an allegation the Patient D was selling medications, both of which violated the MMA signed by Patient D, Respondent continued to prescribe Norco 10 mg, quantity #56, and Soma 350 mg, quantity #42, to Patient D on August 19, 2005.

75. On or about September 2, 2005, the Center for Behavioral Health (CBH) in Bloomington, Indiana, sent Respondent a letter advising him that Patient D was being treated there for substance abuse. The letter indicated that the CBH addiction therapist had been in contact with Patient D’s probation officer and house arrest officer who had probable cause to suspect that Patient D had been abusing her medications. Finally, the letter stated, “during a home visit on the day that [Patient D] picked up her prescriptions

she was found to have had only 30 of 56 Hydrocodone and 25 of 42 Soma left. Her house officer reported to me that [Patient D] appeared very intoxicated.”

76. Respondent noted receipt of the letter from CBH in a “Supplemental or Treatment Note” dated September 9, 2005.

77. Despite knowledge that Patient D was being treated for an addiction to prescription medications, concerns from her criminal probation officer documenting abuse of medications, documented use of illegal substances, allegations that Patient D was selling her medication, and knowledge that Patient D was obtaining medications from multiple physicians and pharmacies, all of which are violations of the MMA signed by Patient D, Respondent continued to prescribe the following:

- A. Norco 10 mg, quantity #120, on September 27, 2005 and October 24, 2005; and
- B. Soma 350 mg, quantity #90, on September 27, 2005.

78. On or about October 27, 2005, a “Supplemental or Treatment Note” in Patient D’s patient file states, “Fax received from Bloomington Hospital. Patient delivered baby. Report sent for our records.” The records from Bloomington Hospital state, “This patient is a 30 year-old well known to us from previous admission for abruption secondary to cocaine use. She was released to home in stable condition several days ago.”

79. Respondent’s treatment notes indicate that Patient D was “no show” to her scheduled appointments in November 2005. No further office visits or treatments are noted in Respondent’s patient records.

Patient E

80. On or about July 30, 1999, Respondent conducted an initial examination of Patient E based on a referral from another physician. Patient E's right leg was amputated above the knee, he was diagnosed with Buerger's disease, and he reported being prescribed Coumadin, Keflex, Remeron, Duragesic patch, and Ativan. Respondent's documented patient history states, "[Patient E] has been taking narcotics to the point where he got dependent on them." Respondent's plan of care stated, "Wean [Patient E] off Duragesic patch. Start him on two Lortab a day with 0.25 Klonopin x 4 to tolerate withdrawal. Continue Remeron. Add Ambien to the regimen to help insomnia. Start him on Neurontin." Patient E and Respondent signed a Narcotic Agreement (NA) dated July 29, 1999. The NA provided, "I agree that I will take narcotics only as prescribed by Dr. Tiwari, and that I will not take any narcotics prescribed by another physician. I will not increase the dose of narcotic(s) I am taking, without Dr. Tiwari's prior consent. If any part of this agreement is violated, Dr. Tiwari will no longer prescribe narcotic(s) for me."

81. On or about August 4, 1999, Patient E called Respondent's office requesting a refill of his Lortab prescription. Dr. Prillaman, another physician in Respondent's office, informed Patient E that he could not have a refill as he was scheduled to receive an injection the next day. Respondent conducted Patient E's office visit on August 5, 1999, at which time he prescribed Patient E the following:

A. Klonopin 0.5 mg ½ tab, quantity #60;

B. Lortab 5 mg; quantity #20.

82. Respondent prescribed Lortab 5 mg to Patient E on the following dates: August 9, 1999, quantity #20; August 17, 1999, quantity #20; August 23, 1999, quantity

#20; August 30, 1999, quantity #20; dosage was increased to Lortab 7.5 on August 31, 1999, quantity #15; September 7, 1999, quantity #14, and September 10, 1999, quantity #14.

83. Respondent prescribed Klonopin 0.5 mg ½ tablet to Patient E on the following dates: August 17, 1999, quantity #40; and August 30, 1999, quantity #60.

84. Respondent added Soma 350 mg to Patient E's prescribed medications on the following dates: August 23, 1999, quantity #20; August 30, 1999, quantity #20; and September 7, 1999, quantity #14.

85. On or about August 31, 1999, a "Supplemental or Treatment Notes," contained in Respondent's medical record for Patient E states, "Patient says he has been taking 2 Lortab a day due to dental pain."

86. On or about September 8, 1999, a "Supplemental or Treatment Notes" contained in Respondent's medical record for Patient E states, "CVS pharmacist in Mitchell called to see if we still wanted to fill Lortab refill called in last night. Apparently, patient received #24 Lortab 7.5 mg from Dentist on 9/3/99. . . Notified Dr. K. Tiwari of above, he said to ask pharmacy to fill RX for Lortab that we called in last night."

87. On or about September 10, 1999, a "Supplemental or Treatment Notes" contained in Respondent's medical record for Patient E states, "Spoke to [Patient E's] Mom who says [Patient E] acts really strange when he takes Lortab and Soma."

88. On or about September 20, 1999, Patient E was admitted to the Bloomington ER with complaints of pain due to Buerger's disease. The Bloomington ER report states, "[Patient E] says that he is not still addicted to narcotics, even though he

only wants Percocet, since he went through detoxification in July. . . . [I]n July, he was detoxified for alcohol, barbiturates (sic), and narcotics . . .” Patient E was released home without narcotics, though he was given 2 mg of Dilaudid IM in the Bloomington ER. A copy of the Bloomington ER record is contained in Respondent’s medical record for Patient E.

89. Despite his knowledge that Patient E had previous dependencies on controlled substances which required detoxification just months before, Respondent continued to prescribe Soma 350 mg, quantity #14, and Lortab 7.5, quantity #14 to Patient E on September 22, 1999.

90. Patient E left Respondent’s practice for approximately one year (from September 1999 to October 2000) but returned for an office visit on October 20, 2000. During that visit, Respondent prescribed Patient E Ambien 5 mg, a Schedule IV depressant, quantity #30, and Mexiletene 150 mg, quantity #30.

91. On or about October 24, 2000, Respondent prescribed Patient E Soma 350 mg, quantity #60, and Methadone 10 mg, quantity #20.

92. Respondent continued to prescribe Patient E Methadone 10 mg, on the following dates: November 9, 2000, quantity #20; December 4, 2000, quantity #20; and Soma 350 mg on November 27, 2000, quantity #60.

93. On or about December 11, 2000, Patient E was admitted to the Bloomington ER after he was found in a motel room confused and agitated, then unconscious. The Bloomington ER “History and Physical Examination” states, “[Patient E] has a history of alcohol and drug abuse. . . [T]here was cocaine found in the room. There are needle marks on his arm where he has been shooting up. He is currently

treated for pain with Methadone and a Duragesic patch per his physician.” The Assessment & Plan states, “When he is more awake and alert, we will transfer him to Med-Psych for treatment for drug abuse.” Respondent received a courtesy copy of Patient E’s December 11, 2000 Bloomington ER admission.

94. On or about December 18 through 23, 2000, Patient E was hospitalized at BHC Meadows Hospital (BHC) due to a diagnosis of polysubstance abuse and dependence. The BHC discharge summary states, “The patient reports he has been using a variety of drugs consistently since age 12 and shooting up since he was 18. He has been in treatment several times. He was in Meadows Hospital in 1995. He was in the Bedford Regional Center in the past. He had been detoxed at Bloomington Hospital twice. He was detoxed once at Terre Haute.” Respondent received a courtesy copy of Patient E’s hospitalization notes at BHC.

95. On or about August 23, 2001, Respondent conducted an office visit with Patient E and stated in the Progress Note, “have not seen [Patient E] since October of 2000.” Patient E signed a new NA on this date. The NA provided, “I agree that I will take narcotics only as prescribed by Dr. Tiwari, and that I will not take any narcotics prescribed by another physician. I will not increase the dose of narcotic(s) I am taking, without Dr. Tiwari’s prior consent. If any of this agreement is violated, Dr. Tiwari will no longer prescribe narcotic(s) for me.” Respondent prescribed Patient E Methadone 10 mg, quantity #30, on this date.

96. Despite Respondent’s knowledge of Patient E’s history of polysubstance abuse and dependence, Respondent continued to prescribe the following medications:

- A. Methadone 10 mg po bid, quantity #60, on the following dates: September 5, 2001; September 26, 2001; September 28, 2001; October 5, 2001; October 19, 2001; October 31, 2001; November 14, 2001; and November 28, 2001.
- B. Soma 350 mg on the following dates: September 5, 2001, quantity #60; October 5, 2001, quantity #16; October 19, 2001, quantity #30; November 15, 2001, quantity #60; December 15, 2001, quantity #60.

97. On or about December 15, 2001, Respondent conducted a follow up office visit with Patient E. Respondent's Progress Note states, "[Patient E] claims methadone is not working as well and would like to change the medication to something different. We will go ahead and put him on Percocet 10 mg PO b.i.d." Respondent prescribed Patient E Percocet 10 mg, quantity #60, and Soma 350 mg, quantity #60 on this date.

98. Patient E was a "no show" to his scheduled office visits in 2002.

99. On or about May 13, 2003, Respondent conducted an office visit with Patient E. Again, despite Respondent's knowledge of Patient E's history of polysubstance abuse and dependence, Respondent prescribed Patient E Methadone 10 mg, quantity #120, on this date.

100. On or about August 2, 2003, Patient E died at the age of thirty-six (36). Respondent's patient chart documents Patient E as "Deceased, 8/03." The ISDH lists Patient E's cause of death as "accidental poisoning by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified."

Patient F

101. On or about June 10, 2005, Respondent conducted an initial examination of Patient F with a diagnosis of low back and left leg pain. Patient F reported being prescribed Lortab, Ibuprofen and a muscle relaxant by another physician. On June 10, 2005, Respondent prescribed the following: (1) Gabatril 4 mg to be increased to 8 mg after seven days, quantity #30; (2) Ultracet, quantity #90; (3) Lortab 7.5 mg, quantity #60; and (4) Flexeril 10 mg, quantity #30.

102. On or about July 6, 2005, Patient F signed a MMA with PMC. The MMA stated in part, "4) I will not use any illegal substances, including marijuana, cocaine, etc."

103. Between the dates of June 2005 and June 2006, Respondent administered treatments such as transforaminal epidurals and injections, and conducted follow-up visits approximately once every month.

104. Respondent prescribed Patient F. Lortab 7.5 mg on the following dates: July 6, 2005, quantity #60; August 3, 2005, quantity #90; September 2, 2005, quantity #90; September 30, 2005, quantity #90; October 24, 2005, quantity #90; November 11, 2005, quantity #90; December 28, 2005, quantity #90; January 25, 2006, quantity #90. Respondent increased the dosage of Lortab and prescribed 10 mg on the following dates: February 15, 2006, quantity #90; March 20, 2006, quantity #90; April 19, 2006, quantity #90; May 15, 2006, quantity #90; May 31, 2006, quantity #90;

105. Respondent added Methadone to the medications prescribed to Patient F and prescribed Methadone 5 mg on the following dates: October 24, 2005, quantity #30; November 11, 2005, quantity #30; December 20, 2005, quantity #30; January 20, 2006, quantity #30. Respondent increased the dosage of Methadone and prescribed 10 mg on

the following dates: February 15, 2006, quantity #30; March 14, 2006, quantity #30; April 5, 2006, quantity #60; May 3, 2006, quantity #60; May 31, 2006, quantity #90.

106. On or about May 31, 2006, Respondent conducted a UDS on Patient F. Patient F's UDS tested negative for Methadone and Lortab, despite the patient's documented receipt of current Methadone and Lortab prescriptions issued by Respondent.

107. A "Supplement or Treatment Note" dated June 30, 2006, indicated, "Reviewed drug screen w/ Dr. Kash. Due to discrepancies in screen, patient only to get Methadone as written until it can be discussed with [Dr. Tiwari] when he is back in office. Drug screen reviewed with Dr. Tiwari. OK to give one (1) month supply of Methadone. Patient made aware if it comes back negative for Lortab or Methadone other consequences may happen."

108. On or about August 7, 2006, Patient F was admitted to the Bloomington ER after overdosing on Methadone, Lortab, and Klonopin. Laboratory tests confirmed marijuana usage, and Patient F admitted that he smoked marijuana. Documentation of Patient F's August 7, 2006, Bloomington ER visit was contained in Patient F's patient file at Respondent's office as Respondent received a courtesy copy of the ER admission.

109. Despite his knowledge of Patient F's documented overdose and use of illegal substances Respondent continued to prescribe Patient F the following:

- A. Lortab 10 mg, on the following dates: August 1, 2006, quantity #90 with 2 refills; November 6, 2006, quantity #30; December 8, 2006, quantity 39; December 20, 2006, quantity #90 with 2 refills.

B. Methadone 10 mg, on the following dates: June 30, 2006, quantity #6; July 3, 2006, quantity #90; August 1, 2006, quantity #90; August 29, 2006, quantity #90; September 26, 2006, quantity #90; October 23, 2006, quantity #90; November 22, 2006, quantity #33; December 6, 2006, quantity #45; December 20, 2006, quantity #120; January 12, 2007, quantity #120.

110. On or about February 26, 2007, Respondent conducted a UDS on Patient F which tested positive for Cannabinoids in addition to the medications Patient F was being prescribed by the Respondent. Despite his knowledge of Patient F's continued use of illegal substances Respondent prescribed Patient F the following:

A. Methadone 10 mg on the following dates: February 15, 2007, quantity #120; March 21, 2007, quantity #120; April 16, 2007, quantity #120; May 15, 2007, quantity #16; May 21, 2007, quantity #120; June 13, 2007, quantity #120; July 10, 2007, quantity #120; and,

B. Vicodin 10/650 mg, a Schedule III narcotic, on the following dates: March 21, 2007, quantity #90 with 2 refills; June 13, 2007, quantity #90; July 10, 2007, quantity #90.

111. On or about July 31, 2007, Patient F was voluntarily admitted to Bloomington Hospital Crisis Care Unit due to suicidal thoughts. A UDS conducted at Bloomington Hospital Crisis Care Unit on July 31, 2007, on Patient F tested positive for benzodiazepines and opiates, but not methadone. The treating physician's assessment and plan stated, "Axis I: Polysubstance intoxication; alcohol, benzodiazepines, narcotics and this is what caused him to think unclearly. Question of bipolar disorder, however I

am not sure how one could tell using this variety of chemicals.” Documentation of Patient F’s July 31, 2007 visit at Bloomington Hospital was contained in Patient F’s patient file at Respondent’s office as Respondent received a courtesy copy of the crisis care unit admission.

112. Despite his knowledge of Patient F’s continued abuse of illegal and controlled substances, as well as his knowledge that Patient F tested negative for Methadone despite patient’s documented receipt of current Methadone prescriptions issued by Respondent, the Respondent continued to prescribed the following:

- A. Methodone 10 mg, quantity #120, on the following dates: August 3, 2007; September 14, 2007; September 27, 2007; November 12, 2007;
- B. Vicodin 10/650 mg, quantity #90 on the following dates: August 3, 2007, with 1 refill; September 27, 2007 with 2 refills.

113. No further notations are listed in Respondent’s chart for Patient F.

114. On or about October 9, 2008, Patient F died at age thirty-one (31). According to the ISDH, Patient F’s cause of death was, “respiratory arrest caused by polysubstance abuse.”

Patient G

115. On or about April 23, 2002 prior to Patient G’s initial consultation with Respondent, a Supplemental or Treatment Note states, “[J.J.] (employer) called about [Patient G] – he has had 3 auto accidents resulting in back pain. He is buying narcs off the streets and wants him to be weaned off them.”

116. On or about April 26, 2002, Respondent sent a letter to Patient G’s employer, J.J., stating, “This is a gentleman who started out having minor pain in his

back with auto accidents and later got habituated to medications. Narcotics have covered his pain and at the same time led him to be addicted to those medications.”

117. On or about April 26, 2002, Respondent conducted an initial examination of Patient G due to complaints of back pain. The Initial Consultation note states, “[Patient G] has been treated with Lortab, Vicodin, and Percocet and the dosages have been going up where he has been taking 8 to 10 tablets a day and buying some off the street. . . [H]is problem now is he has gotten used to taking narcotics.” Respondent’s Plan states, “Do facet and SI joint injections, try to wean patient off Norco and OxyContin by putting him on methadone 10 mg PO b.i.d. and Klonopin 0.5 mg PO t.i.d., Bextra 20 mg PO b.i.d., Effexor as he looks very depressed, and Elavil 25 mg PO q.h.s and titrate it upwards.”

118. On or about April 26, 2002, Patient G signed a NA with PMC. The NA provides, “I, [Patient G] agree that I will take narcotics only as prescribed by the Pain Management Center, and that I will not take any narcotics prescribed by any other physician. I will not increase the dose of the narcotic(s) I am taking without the Pain Management Center’s prior consent. If any part of this agreement is violated, the Pain Management Center will no longer prescribe any narcotic(s) for me.”

119. Respondent prescribed Patient G the following:

- A. Methadone 10 mg, quantity #60, on May 6, 2002 and June 3, 2002;
- B. Klonopin 0.5 mg, quantity #90, on May 6, 2002 and June 4, 2002.

120. On or about June 17, 2002, Dr. Enoch Brown, another physician at PMC, conducted a clinic visit with Patient G. The Progress Notes contained in Respondent’s medical record for Patient G state, “[Patient G] states that in spite of his current

methadone dosing, which includes 10 mg b.i.d.; this is not covering his pain adequately. It should be reemphasized that this gentleman has had a problem with narcotic abuse. He admitted to taking large amounts of OxyContin with 'my friends' and needs to be monitored very closely with urine drug screens and very careful titration of his methadone."

121. Despite knowledge that Patient G was addicted to narcotics, Respondent prescribed the following to Patient G:

- A. Methadone 10 mg, quantity #180, on July 12, 2002, August 10, 2002, and September 3, 2002;
- B. Klonopin 0.5 mg, quantity #90, on July 1, 2002, July 23, 2002, August 7, 2002, and September 3, 2002.

122. On or about September 12, 2002, a Supplemental or Treatment Note contained in Respondent's medical record for Patient G states, "[Patient G's] mother called crying concerned about patients drug use. Dr. Tiwari aware of patient going to other MD's and pharmacies."

123. Despite knowledge that Patient G was obtaining prescriptions from other physicians and using more than one pharmacy, in violation of the NA Patient G signed, Respondent prescribed the following to Patient G:

- A. Methadone 10 mg, on September 24, 2002, quantity #180; October 23, 2002, quantity #120; November 18, 2002, quantity #120; December 17, 2002, quantity #120; January 14, 2003, quantity #120; and February 11, 2003, quantity #120;

B. Klonopin 0.5 mg, quantity #90, on October 4, 2002, November 4, 2002, December 30, 2002, and January 28, 2003.

124. On or about February 19, 2003, a Supplemental or Treatment Note contained in Respondent's medical record for Patient G states, "Gus Matthias – director of drug and Alcohol Abuse Clinic called. [Patient G] arrested for driving while under the influence of Rx drugs. He is going to request/recommend that he be sent to Columbus facility to be detoxed."

125. On or about March 6, 2003, a Supplemental or Treatment Note contained in Respondent's medical record for Patient G states, "Dr. Tiwari talked with Dr. Beavers . . . [Patient G] is being taken off of methadone and detoxed. Patient is being taken off his methadone by Dr. Beavers."

126. Despite knowledge that Patient G was arrested due to driving while under the influence of prescription drugs and the notification from Dr. Beavers that Patient G was being detoxed from methadone, Respondent prescribed the following to Patient G:

A. Methadone 10 mg, quantity #90, on April 8, 2003;

B. Klonopin 0.5 mg, quantity #90, on February 26, 2003 and March 24, 2003.

127. On or about April 16, 2003, Respondent received a letter from Patient G's Monroe County Probation Officer stating, "[Patient G] has appeared for his appointments, and for many of those appointments he appears to be heavily medicated. His motor skills appear to be slowed, and his speech seems slurred. . . [I]t should be noted that the results received on his baseline urine drug screen, returned positive for

marijuana as well as oxazepam, and temazepam. . . [D]ue to his substance abuse history, and his behaviors while in this office, I am concerned about his physical well being.”

128. Despite knowledge that Patient G tested positive for illegal substances, and the concerns expressed by his probation officer, Respondent prescribed the following to Patient G:

- A. Methadone 10 mg on May 6, 2003, quantity #90; May 27, 2003, quantity #45; June 6, 2003, quantity #90; July 10, 2003, quantity #120; August 6, 2003, quantity #120; September 2, 2003, quantity #120; September 20, 2003, quantity #120; October 27, 2003, quantity #120; November 24, 2003, quantity #120;
- B. Klonopin 0.5 mg, quantity #90, on April 18, 2003, May 10, 2003, June 6, 2003, July 2, 2003, August 4, 2003, November 24, 2003;
- C. Soma 350 mg, quantity #90, on July 10, 2003.

129. On or about November 14, 2003, Patient G signed a MMA with PMC. The MMA provides, “4) I will not use any illegal controlled substances, including marijuana, cocaine, etc. 6) I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Physician. I understand it is against the law to do so. 11) I agree that I will use my medication at a rate no greater than prescribed and that use of my medication at a greater rate will result in my being without medication for a period of time. . . [F]ailure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship.”

130. On or about December 22, 2003, Bloomington Hospital conducted a UDS on Patient G. Patient G tested positive for marijuana and methadone. Patient G tested negative for benzodiazepines, despite being prescribed Klonopin by Respondent.

131. Despite Respondent's knowledge that Patient G tested positive for illegal substances as well as testing negative for the medications prescribed to him by Respondent, the Respondent prescribed the following to Patient G:

- A. Methadone 10 mg on January 19, 2004, quantity #120; February 19, 2004, quantity #120; and March 17, 2004, quantity #72;
- B. Klonopin 0.5 mg, quantity #90, on January 19, 2004 and February 19, 2004.

132. On or about April 8, 2004, Bloomington Hospital conducted another UDS on Patient G. Patient G tested positive for desmethyldiazepam, temazepam, marijuana, methadone, hydrocodone, oxycodone, and oxymorphone.

133. On or about April 22, 2004, Bloomington Hospital conducted another UDS on Patient G. Patient G tested positive for benzodiazepines, marijuana, and methadone.

134. On or about May 12, 2004, a Supplemental or Treatment Note contained in Respondent's medical record for Patient G states, "Received call from Marsh. [Patient G] is getting meds as follows from Dr. Gettlefinger: 4/5/04: Klonopin 1 mg #60, Methadone 10 mg #42, Neurontin #90, Ultram #90 – Per Dr. Tiwari no narcotics are to be given due to drug screen and patient is to follow up with Nancy Niles or be discharged from our practice if he does not follow through with Nancy."

135. On or about June 4, 2004, a Supplemental or Treatment Note contained in Respondent's patient chart for Patient G states, "Per Nancy Niles – 1) wants [Patient G] to have methadone and Klonopin but with weekly supply and holds. 2) Wants random drug screens, patient did smoke marijuana 1 week ago. 3) if marijuana in blood again – discharge patient or if no Klonopin/methadone – discharge patient. All issues discussed with [Dr. Tiwari] and weekly supply of methadone will be given."

136. Respondent prescribed Patient G the following:

A. Methadone 10 mg on June 4, 2004, quantity #28; June 17, 2004, quantity #28; June 22, 2004; June 28, 2004, (x2); July 15, 2004, quantity #30; July 20, 2004, quantity #40.

137. Supplemental or Treatment Notes dated July 20, 2004 and contained in Respondent's patient medical record for Patient G state, "Methadone released early per Dr. Tiwari's orders."

138. Respondent continued to prescribe Patient G the following:

A. Methadone 5 mg on July 29, 2004, quantity #21; August 6, 2004, quantity #120; September 2, 2004, quantity #120; September 3, 2004, quantity #30;

B. Klonopin 1 mg on June 17, 2004, quantity #21; July 8, 2004, quantity #21; July 15, 2004, quantity #90; August 6, 2004, quantity #90; September 3, 2004, quantity #90; September 27, 2004, quantity #90.

C. Soma 350 mg on August 23, 2004, quantity #30; and September 20, 2004, quantity #30.

139. On or about October 18, 2004, a Supplemental or Treatment Note contained in Respondent's medial record for Patient G states, "[Patient G] had been taking methadone QID. Lortab called as written until methadone due." Respondent prescribed Patient G Lortab 10 mg, quantity #15 on October 18, 2004.

140. On or about November 12, 2004, Patient G and Respondent signed a MMA. The MMA provides, "4) I will not use any illegal controlled substances, including marijuana, cocaine, etc. 6) I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Physician. I understand it is against the law to do so. 11) I agree that I will use my medication at a rate no greater than prescribed and that use of my medication at a greater rate will result in my being without medication for a period of time. . . [F]ailure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship."

141. Despite Patient G's inability to take medications as prescribed and the lack of documented urine drug screens as recommended by Niles, Respondent continued to prescribe the following:

- A. Methadone 5 mg on October 21, 2004, quantity #30; November 12, 2004, quantity #60; December 9, 2004, quantity #60; January 10, 2005, quantity #60; February 4, 2005 – "Methadone Rx for next time is not due till (sic) 3-13-05"; February 11, 2005, quantity #60; March 11, 2005, quantity #60; April 8, 2005, quantity #60; May 6, 2005, quantity #60; June 6, 2005, quantity #60; June 30, 2005, quantity #60.

B. Klonopin 1 mg on November 8, 2004, quantity #90; December 7, 2004, quantity #60; December 30, 2004, quantity 60; January 26, 2005, quantity #27; February 3, 2005, quantity #21; February 7, 2005, quantity #90; February 10, 2005, quantity #90; April 1, 2005, quantity #90; May 9, 2005, quantity #90; June 7, 2005, quantity #90; June 30, 2005, quantity #90.

C. Soma 350 mg on October 21, 2004, quantity #30; November 12, 2004, quantity #30; December 9, 2004, quantity #30; January 18, 2005, quantity #17; February 4, 2005, quantity #6; February 7, 2005, quantity #60; February 10, 2005, quantity #60; April 1, 2005, quantity #60; May 9, 2005, quantity #60; June 7, 2005, quantity #60; June 30, 2005, quantity #60.

D. Respondent added Percocet 5/325 to Patient G's medications on June 17, 2005, quantity #90; June 30, 2005, quantity #90.

142. On or about July 27, 2005, a Supplemental or Treatment Note contained in Respondent's medical record for Patient G states, "Dr. Bales office stated patient was discharged due to the double prescriptions he had been receiving between our two offices. They also stated he was getting Darvocet from someone but did not know who. Dr. Bales office also stated they had only seen patient two times on 11/16/04 and 4/14/05. Patient also failed a UDS. Dr. Bales office stated patient had been on Vicodin, Klonopin, Morphine, Valium, Zoloft, Methadone, phenergan, protonix, and zonegram from their office. They stated patient had been trying to get appointment, but they will no longer

see him. Dr. Tiwari notified of information and stated he will see patient tomorrow in a.m.”

143. Despite knowledge that Patient G had been discharged from Dr. Bales practice due to a failed UDS and again obtaining drugs from multiple doctors, Respondent prescribed the following to Patient G:

- A. Methadone 5 mg on July 28, 2005, quantity #60; August 9, 2005, quantity #90; September 21, 2005, quantity #60; October 19, 2005, quantity #60;
- B. Klonopin 1 mg on July 28, 2005, quantity #90; September 1, 2005, quantity #90; September 29, 2005, quantity #90; November 2, 2005, quantity #90;
- C. Soma 350 mg on July 28, 2005, quantity #60; September 1, 2005, quantity #60;

144. On or about October 31, 2005, Patient G signed a new MMA with PMC. The MMA provided, “4) I will not use any illegal controlled substances, including marijuana, cocaine, etc. 6) I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Physician. I understand it is against the law to do so. 11) I agree that I will use my medication at a rate no greater than prescribed and that use of my medication at a greater rate will result in my being without medication for a period of time. . . [F]ailure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship.”

145. Respondent continued to prescribe the following to Patient G:

A. Methadone 5 mg on November 18, 2005, quantity #90; December 12, 2005, quantity #90; January 16, 2006, quantity #90; February 10, 2006, quantity #90.

B. Klonopin 1 mg on November 29, quantity #90; December 29, 2005, quantity #90; January 20, 2006, quantity #90; February 20, 2006, quantity #90.

C. Soma 350 mg on November 2, 2005, quantity #60; November 29, 2005, quantity #60; December 29, 2005, quantity #60; January 20, 2006, quantity #60; February 20, 2006, quantity #60.

146. Respondent's medical record for Patient G contains no documentation of UDS between November 2005 and February 2006.

147. On or about February 27, 2006, a Supplemental or Treatment Note contained in Respondent's medical record for Patient G states, "Received phone call from Officer Davis at Ellettsville Police Department. [Patient G] is in custody – ran someone off the road this a.m. and caused accident, a short time after he ran into a building. He is in custody and is being taken to jail."

148. On or about March 10, 2006, a Supplemental or Treatment Note contained in Respondent's medical record for Patient G states, "[Patient G] requesting methadone. Per [Dr. Tiwari], no methadone, but patient may have a pump adjustment if needed. Patient stated, "I will go to Gettlefinger." Told patient that was his choice, but [Dr. Tiwari] had made the decision of no further methadone at last appointment.

149. Despite knowledge of Patient G's history of substance abuse, obtaining prescriptions from other physicians and using more than one pharmacy, documented use of illegal substances as well as testing negative for medications prescribed to him by Respondent, Patient G's arrest for driving while intoxicated and Respondent's documented note that he would no longer prescribe Patient G methadone, Respondent prescribed Patient G the following:

- A. Methadone 5 mg on March 29, 2006, quantity #90; April 24, 2006, quantity #90; May 19, 2006, quantity #90; June 14, 2006, quantity #90; July 19, 2006, quantity #90; August 18, 2006, quantity #120; September 15, 2006, quantity #90; October 11, 2006, quantity #120; November 13, 2006, quantity #120; February 19, 2007, quantity #120; and March 20, 2007, quantity #120.
- B. Klonopin 1 mg in quantity of #90 on March 29, 2006; April 27, 2006; May 19, 2006; June 14, 2006; August 21, 2006; October 18, 2006, with 2 refills; February 19, 2007, with 2 refills; and May 11, 2007.
- C. Soma 350 mg, quantity #60, on March 30, 2006; April 24, 2006; May 19, 2006; June 14, 2006; August 21, 2006; September 18, 2006; October 18, 2006, with 2 refills; February 19, 2007; and March 20, 2007, with 2 refills.

150. Respondent's medical record for Patient G contains no documentation of UDS from February 2006 through March 2007.

151. On or about June 13, 2007, a Supplemental or Treatment Note contained in Respondent's medical record for Patient G states, "Talked to Valerie – probation

officer -- [Patient G] has a court order he is not to receive any oral narcotics. He is also going to Midtown Meth. Clinic. She will fax us his court order. [Patient G] was in her office and acting very strangely." A second note dated the same date states, "Valerie (probation officer) called, [Patient G] only has #11 of his methadone Rx left that he filled on 6/12/07 for #120."

152. Respondent continued to provide treatment to Patient G while he was in jail in 2007. Respondent prescribed Elavil 10 mg, quantity #30 on August 13, 2007, Dyazide, quantity #20 on September 4, 2007, and conducted office visits in November 2007. Respondent's patient chart for Patient G contains no treatment notes after November 16, 2007.

Patient H

153. On or about March 3, 2005, Respondent conducted an initial examination of Patient H with a history of lower back pain. Patient H reported being prescribed Carisoprodol (Soma), Lortab and Percocet in the past by another physician, with minimal results. Patient H and Respondent signed a MMA on this date. Respondent prescribed Lortab 10 mg., quantity #60; Baclofen 20 mg, quantity #60; Elavil 10 mg, quantity #30; and Neurontin 300 mg, quantity #60 on this date.

154. Respondent prescribed Patient H the following medications:

- A. Lortab 10 mg, quantity #90, on March 23, 2005;
- B. Percocet 7.5 mg, quantity #90, on April 7, 2005, May 6, 2005, and June 3, 2006;
- C. Soma 350 mg, quantity #60, on May 19, 2005 and June 16, 2005.

155. On or about June 16, 2005, Patient H was admitted to Dunn Memorial Hospital Emergency Room (Dunn ER) in Bedford, IN due to a Soma overdose. Dunn ER's Discharge Summary states, "Diagnoses During Hospitalization: 1. Soma overdose. 2. Respiratory failure due to above. 3. Encephalopathy due to above. 4. Tremors due to above." Dunn ER's History and Physical states, "The patient's girlfriend stated that the patient is 'completely out of control.' He takes any medications he can get and takes them by the handful. Apparently, yesterday the patient received a prescription of 60 Soma from Dr. Tiwari. He started taking these yesterday evening and took a handful around 9 or 10 o'clock, and then continued to take them intermittently all night long until he was found to be unresponsive this morning." Patient H left Dunn hospital against medical advice. Documentation of Patient H's June 16, 2005 Dunn ER visit was contained in Patient H's medical record at Respondent's office as Respondent received a courtesy copy of the Dunn ER discharge summary.

156. Despite the knowledge that Patient H overdosed on Soma and was abusing prescription medications, Respondent prescribed the following to Patient H:

- A. Percocet 7.5/325, quantity #90, on July 5, 2005;
- B. Soma 350 mg, quantity #60, on July 28, 2005, after Patient H called Respondent's office stating he was out of his Soma and would like the prescription to be called in so his wife could pick it up as he would be in North Carolina for two weeks.

157. Respondent's patient chart for Patient H contains no other notations after July 28, 2005.

Patient I

158. On or about April 3, 2003, Respondent conducted an initial consultation with Patient I due to complaints of hip pain. Patient I reported taking Vicodin with limited success. Respondent's plan states, "Start him on Vioxx 25 mg q.d., Zanaflex 1 mg q.h.s., Effexor 37.5 mg to be titrated upwards to 75 mg, Lortab 7.5 mg b.i.d. as he has taken that and he claims that does help."

159. On or about April 3, 2003, Patient I and Respondent signed a MMA. The MMA provides, "(8) I agree to use Walmart Pharmacy, located at . . . telephone number. . . for all my pain medication. If I change pharmacy (sic) for any reason, I agree to notify the Physician at the time I receive a prescription, and advise my new pharmacy of my prior pharmacy's address and telephone number. 11) I agree that I will use my medication at a rate no greater than prescribed and that use of my medication at a greater rate will result in my being without medication for a period of time. . . [F]ailure of the Patient to abide by the terms of the Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship."

160. Patient I rescheduled or failed to show for office visits with Respondent on the following dates: April 14, 2003, April 15, 2003, April 28, 2003, May 1, 2003, May 16, 2003.

161. During this time Patient I called Respondent's office requesting refills for Lortab. A Supplemental or Treatment Note dated May 2, 2003, states, "Left message for patient - No meds will be given until patient seen in clinic by physician due to rescheduled and no show appointments."

162. On May 16, 2003, a notes states, "Office Visit – Cancelled – Patient said that he is never coming back."

163. On or about June 2, 2003, Respondent's patient chart for Patient I chart was reactivated due to a referral from Dr. Enoch Brown. Dr. Brown conducted another consultation at this time and treated Patient I with trigger point injections.

164. Respondent's medical record for Patient I contains no documentation of treatment between June 2003 and September 2006.

165. On or about October 25, 2006, a Supplemental or Treatment Note states, "[Patient I] called asking for Xanax because Effexor was not working and wants stronger pain medication because Vicodin isn't strong enough. Spoke to Dr. Tiwari about – he said no to both and that he needed appointment before he would change anything ([Patient I] has only been seen here once).

166. On or about November 3, 2006, Respondent prescribed Patient I Restoril 15 mg, quantity #30, before Patient I's scheduled office visit on November 6, 2006.

167. On or about November 6, 2006, Respondent conducted an office visit with Patient I. At that time Respondent prescribed Patient I Methadone 5 mg, quantity #15, and Xanax XR 2 mg, quantity #30.

168. On or about December 13, 2006, Respondent wrote a prescription to Patient I Lortab 7.5 mg, quantity #90, and Xanax XR 2 mg, quantity #30, that was cancelled on December 18, 2006, when Respondent's office learned that Patient I switched pharmacies in violation of the MMA without notification to Respondent's office.

169. On or about January 3, 2007, a Supplement or Treatment Note in Respondent's medical record for Patient I states, "Patient called stating he was going through withdrawals – called patient back asked why he was going through withdrawals. Patient stated he is addicted to pain killers and he had taken them all; told patient we would speak to [Dr. Tiwari] and call him back." The next Supplemental or Treatment Note in the chart, dated January 8, 2007, states, "Per [Dr. Tiwari], may take Klonopin 0.5 mg PO QHS and Clonidine 0.1 mg PO QD. Meds called in at . . . per [Dr. Tiwari] orders."

170. Despite documented knowledge that Patient I was using multiple pharmacies and admitted being addicted to pain killers, Respondent prescribed Patient I the following:

- A. Klonopin 0.5 mg, quantity #30, on January 8, 2007;
- B. Clonidine 0.1 mg, quantity #30, on January 8, 2007;
- C. Methadone 5 mg, quantity #30 on January 10, 2007.

171. On or about January 19, 2007, a Supplement or Treatment Note in Respondent's medical record for Patient I states, "Patient called claiming he took extra Methadone and now he's out. Patient filled a 15 day supply on 1/10/07 and should not be due until 1/24/07. The reason he was only given a 15 day supply is because he has an admitted drug addiction problem and [Dr. Tiwari] is trying to get him off all pain meds. Informed patient that we would not give him more until he's due and that he needed to make appointment to discuss this issue with [Dr. Tiwari]."

172. On or about January 24, 2007, Respondent prescribed the following to Patient I:

- A. Xanax XR 2 mg, quantity #15;
- B. Klonopin 0.5 mg bid, quantity #30;
- C. Prozac 10 mg po qd, quantity #30;
- D. Methadone 5 mg 1 po bid, quantity #30.

173. On or about February 7, 2007, a Supplement or Treatment Note in Respondent's medical record for Patient I states, "[Dr. Tiwari] made aware of above statement and that patient has a drug problem; Per [Dr. Tiwari], OK to give patient meds on a months worth; also OK per [Dr. Tiwari] to give Klonopin and Xanax together."

174. Respondent continued to prescribed Patient I the following:

- A. Methadone 5 mg, quantity #90, on February 7, 2007 and March 7, 2007;
- B. Klonopin 0.5 mg, on February 7, 2007, quantity #60; and March 7, 2007, quantity #90;
- C. Xanax XR 2 mg, quantity #30 on March 7, 2007.

175. On or about April 9, 2007, Respondent conducted a UDS on Patient I that was positive for alcohol, benzodiazepines, opiates and hydromorphone. Respondent prescribed the following to Patient I on April 9, 2007: Klonopin 0.5 mg, quantity #90; and Methadone 5 mg, quantity #120.

176. Again, despite documented knowledge that Patient I was using multiple pharmacies and admitted being addicted to pain killers, Respondent continued to prescribe the following to Patient I:

- A. Methadone 5 mg on the following dates: June 8, 2007, quantity #120; July 9, 2007, quantity #120; August 7, 2007, quantity #120; September

5, 2007, quantity #120; October 3, 2007, quantity #120; November 2, 2007, quantity #90; November 30, 2007, quantity #90.

B. Klonopin 0.5 mg on the following dates: June 8, 2007, quantity #90;

C. Soma 350 mg on the following dates: July 9, 2007, quantity #60; August 7, 2007, quantity #60; November 30, 2007, quantity #60.

177. On or about December 8, 2007, Patient I was admitted to the Greene County Hospital Emergency Room (Greene ER). The Greene ER patient chart states, "Patient family walked in and found patient having a seizure. Called ambulance. While in ambulance had 10 mg Valium. Patient still tremoring upon arrival to ER. Nonverbal. Moving all extremities. Family states patient has history of drug use." Documentation of Patient I's admittance to Greene ER was contained in Respondent's patient chart for Patient I as he received a courtesy copy.

178. No further notations are listed in Respondent's records for Patient I.

Patient J

179. On or about September 13, 2005, Janis Stevenson RN, NP, in Respondent's office, PMC, conducted an initial evaluation of Patient J due to head and low back pain resulting from a car accident in 1978. Patient J reported having used Lortab, Demerol, Oxycontin, Morphine and Tylenol for her pain in the past. The initial evaluation states, "The patient is not living with her husband. She states that he is drinking and smoking and it is too great a temptation for her to be around him because of her history of alcohol abuse. She states that she drank alcohol excessively for approximately 10-15 years to control her pain." Nurse Stevenson also stated in Patient J's initial evaluation, "I am concerned about her history of substance abuse." Patient J

was scheduled for an appointment with the Respondent. Nurse Stevenson prescribed one dose of Methadone 5 mg at bedtime until Patient J could be evaluated by Respondent.

180. On or about September 13, 2005, Nurse Stevenson conducted a UDS on Patient J. Patient J tested negative for all medications.

181. Respondent prescribed Methadone 5 mg to Patient J on the following dates: October 10, 2005, quantity #30; November 11, 2005, quantity #30; December 13, 2005, quantity #15; December 29, 2005, quantity #60; January 18, 2006, quantity #60; February 27, 2006, quantity #60; March 17, 2006, quantity #90; April 26, 2006, quantity #90; and May 31, 2006, quantity #90.

182. On or about May 31, 2006, Respondent conducted a UDS on Patient J. Patient J tested negative for all medications, despite being prescribed Methadone by Respondent.

183. Despite knowledge that Patient J tested negative for all medications, Respondent continued to prescribe Methadone 5 mg to Patient I on the following dates: June 27, 2006, quantity #90; July 26, 2006, quantity #90; August 29, 2006, quantity #45; September 25, 2006, quantity #90; and October 24, 2006, quantity #90.

184. On or about November 10, 2006, Respondent conducted a UDS on Patient J. Patient J tested negative for all medications, despite being prescribed Methadone by Respondent. A Follow-up Note in Respondent's medical record for Patient J dated the same day states, "Are you taking your medications as prescribed? – No. – Has been taking extra methadone. No more methadone – ask [Dr. Tiwari] when due."

185. Despite knowledge that Patient J tested negative for all medications, Respondent continued to prescribe Methadone at an increased dosage of 10 mg, quantity #90, to Patient J on the following dates: November 21, 2006, December 20, 2006.

186. On or about February 12, 2007, Respondent conducted a UDS on Patient J. Patient J tested negative for all medications, despite being prescribed Methadone 10 mg by Respondent.

187. On or about February 21, 2007, Respondent prescribed Methadone 10 mg, quantity #90, to Patient J.

188. On or about February 26, 2007, Respondent received an anonymous letter stating, "To Home (sic) It May Concern: I would like to advice (sic) you that [Patient J] is selling her pills for money." On February 28, 2007, a Supplemental or Treatment Note in Respondent's chart for Patient J states, "Received a letter from anonymous person that [Patient J] is selling meds and [Patient J's] drug screen was negative. [Dr. Tiwari] made aware – [Patient J] to have another appt. before more meds given." Patient J had an office visit with Respondent on April 30, 2007, prior to receiving more medication.

189. Despite knowledge that Patient J consistently tested negative for medications being prescribed by the Respondent and the knowledge that Patient J may be selling her medications, Respondent continued to prescribe Methadone 5 mg to Patient J on the following dates: May 1, 2007, quantity #60; May 22, 2007, quantity #60. Respondent increased the dosage to Methadone 10 mg on June 26, 2007, quantity #60; July 18, 2007, quantity #90; August 14, 2007, quantity #90; and September 14, 2007, quantity #90.

190. On or about September 11, 2007, Respondent signed a MMA with PCM. The MMA provides, “5) I will not share, sell, or trade my medication for money, goods or services. . . [F]ailure of the Patient to abide by the terms of the Agreement may result in the withdrawal of all prescribed medication by the Physician and the termination of the Physician/Patient relationship.”

191. On or about October 10, 2007, a Supplemental or Treatment Note contained in Respondent’s medical record for Patient J states, “[Patient J] called and requested refill on Lortab – there is no record of patient getting that Rx from our office. I spoke with Eric who said Lortab 7.5/500 #10 was called in on 9/11/07 by “Heather.” (9/11/07 was a Thursday – Heather was in Terre Haute) Heather confirmed calling in Rx.” A second note for the same date states, “Lortab called in as written per [Dr. Tiwari’s] orders to CVS.”

192. Despite knowledge that Patient J consistently tested negative for medications being prescribed by Respondent and the knowledge that Patient J may be selling her medications, Respondent continued to prescribe Patient J the following:

A. Methadone 10 mg, quantity #90, on October 9, 2007, October 29, 2007;

B. Lortab 7.5 mg, quantity #60, on October 30, 2008 with one (1) refill.

193. Respondent’s chart for Patient J contains no notations indicating treatment after December 4, 2007.

194. On or around February 2004 through May 2006, Respondent provided anesthesia services to approximately 1,880 patients at the Bloomington Surgery Center.

During this time, Respondent used the outdated practice of using the same multi-dose syringe among several patients undergoing surgery.

195. Respondent's use of this outdated practice placed the patients he treated at risk for bloodborne infections.

196. The practice of using the same multi-dose syringe among several patients, even if the needle on the syringe is changed, has been an antiquated practice since as early as 1994 due to the possibility that IV administration tubing can become contaminated with blood and infectious bloodborne pathogens if backflow occurs.

COUNTS 1 through 9

Respondent is in violation of Ind. Code § 25-1-9-4(a)(9) in that Respondent knowingly prescribed, sold, or administered any drug classified as a narcotic, addicting, or dangerous drug to a habitue or addict, as evidenced by Respondent's treatment of Patients A, B, C, D, E, F, G, H, and I.

COUNTS 10 through 19

Respondent is in violation of Ind. Code § 25-1-9-4(a)(4)(B) in that Respondent continued to practice although the practitioner has become unfit to practice due to his failure to keep abreast of current professional theory or practice, to wit: 844 IAC 5-2-5 as evidenced by Respondent's failure to exercise reasonable care and diligence in his treatment of Patients A, B, C, D, E, F, G, H, I, and J.

COUNT 20

Respondent is in violation of Ind. Code § 25-1-9-4(a)(4)(B) in that Respondent continued to practice although the practitioner has become unfit to practice due to his failure to keep abreast of current professional theory or practice, as evidenced by

Respondent's use of the outdated practice of using the same syringe among several patients between February 2004 and May 2006.

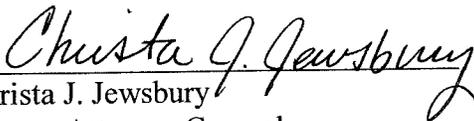
WHEREFORE, Petitioner demands an order against the Respondent, that:

1. Imposes the appropriate disciplinary sanction;
2. Directs Respondent to immediately pay all the costs incurred in the prosecution of this case;
3. Provides any other relief the Board deems just and proper.

Respectfully submitted,

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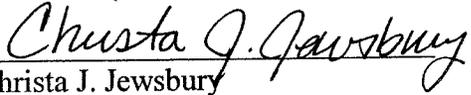
CERTIFICATE OF SERVICE

I certify that a copy of the foregoing "Complaint" has been served upon the Respondent listed below, via hand delivery, on this 30th day of April, 2010.

Kamal Tiwari
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Bloomington, N 47401

By counsel:

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