

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **PETER F. LEVINS, M.D.**

4 License No. 27741
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-10-0367B

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

7 Peter F. Levins, M.D. ("Respondent") elects to permanently waive any right to a
8 hearing and appeal with respect to this Order for Letter of Reprimand and Probation;
9 admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of
10 this Order by the Board.

11 **FINDINGS OF FACT**

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

14 2. Respondent is the holder of license number 27741 for the practice of
15 allopathic medicine in the State of Arizona.

16 3. The Board initiated case number MD-10-0367B after receiving a complaint
17 regarding Respondent's care and treatment of a 58 year-old female patient ("MM") alleging
18 inappropriate treatment and prescribing.

19 4. Respondent began treating MM in 2002. At that time, MM was taking
20 Hydrocodone-APAP 7.5/750, with a maximum of #30 tablets per month for back pain from
21 a previous back surgery. Within two months, Respondent switched MM to Percocet 5/325
22 for her pain. Respondent then changed MM to Propoxyphene-APAP N-100 and
23 Propoxyphene alternately or together for back pain, and added Hydrocodone-APAP 5/500
24 when MM started to complain of headaches. By mid-year 2005, Respondent was
25 prescribing very large doses of narcotics. Through February 2008, Respondent provided

1 MM with multiple refills of Propoxyphene and Hydrocodone-APAP of various strengths,
2 tablet numbers and refill numbers, however, there was no documentation regarding the
3 reasoning for the refills. Respondent accelerated MM's medication use by giving her
4 Oxycodone-APAP 7.5/325 #40, followed in 24 hours by a script for Propoxyphene #60,
5 after MM presented with her first episode of abdominal pain, which was later diagnosed as
6 Crohn's disease. On March 19, 2008, MM's medication list included Propoxyphene,
7 Oxycontin and Oxycodone-APAP. At almost every visit, Respondent gave MM narcotics
8 whether for back pain, headache, several falls or abdominal pain.

9 5. On February 12, 2009, MM presented to Respondent. At that time,
10 Respondent had prescribed Hydrocodone-APAP 7.5/500 #120, Hydrocodone-APAP
11 10/500 #150, Hydrocodone-APAP 10/500 #150, Oxycodone-APAP 10/325 #50 and
12 Hydrocodone-APAP 10/325 #180 to MM over the previous month. Respondent was
13 surprised to learn that MM had received Tramadol from another provider and Oxycodone-
14 APAP from another physician over two visits in the same time frame.

15 6. Respondent refused to prescribe more narcotic pain medications to MM and
16 advised MM to enter into rehab, which she did. On March 17, 2009, Respondent saw MM,
17 following her discharge from rehab. Respondent documented that he would no longer
18 prescribe narcotics for MM; however, the note was signed by him on June 10, 2009, after
19 he had already written three prescriptions of Ultram for MM. MM was later taken off the
20 Ultram due to its propensity to cause seizures, even at normal doses.

21 7. On June 23, 2010, after having tried Dolobid and Prednisone, with no
22 success, Respondent prescribed Propoxyphene #60, a known narcotic, for abdominal
23 pain, in spite of a pain contract. He then prescribed Propoxyphene #60 sixteen days later.
24 MM was diagnosed with duodenal ulcer 30 days later. Respondent did not prescribe
25 further Hydrocodone-APAP for MM, but continued prescribing Propoxyphene through 2009

1 and into 2010, very often writing prescriptions for #120 or #180 and then less than ten
2 days later writing another prescription for the same. MM continued to have pain, out of
3 proportion to her abdominal findings, and she continued to receive narcotics, including
4 Hydrocodone-APAP and Oxycodone-APAP from other physicians.

5 8. Respondent did not maintain adequate records for MM as there was no
6 documentation of discussion about the risks and benefits of being back on narcotics, after
7 going through detoxification for addiction. Additionally, the medical record also did not
8 include MM's pain level, prior to prescribing medications. Finally, Respondent's record
9 keeping was incomplete for the number of narcotic prescriptions and the number of
10 medications given.

11 9. The standard of care requires a physician to combine medications only when
12 non-narcotics are combined with a narcotic or along with short and long acting narcotics.

13 10. Respondent deviated from the standard of care by prescribing massive
14 doses of low strength narcotics every month in numerous prescriptions.

15 11. The standard of care requires a physician to avoid prescribing narcotics to a
16 patient with a history of narcotic addiction who just recently had been discharged from
17 rehab after undergoing detoxification.

18 12. Respondent deviated from the standard of care by placing MM back on
19 Propoxyphene, a known narcotic, just three months after she was discharged from rehab.

20 13. The standard of care requires a physician to prescribe narcotics for
21 nociceptive pain, neuropathic pain, and malignant pain, and not for infection or
22 inflammation-related disease.

23 14. Respondent deviated from the standard of care by frequently treating MM's
24 pain without good evidence of what was causing the pain to be worse.

25

1 15. The standard of care prior to continuing to refill medication requires a
2 physician to ensure that what he is treating is not a side effect of medication

3 16. Respondent deviated from the standard of care by continuing to treat
4 multiple episodes of nausea and vomiting with anti-nausea medications along with the
5 narcotics instead of attempting to wean MM off of the medicine in the consideration that
6 the nausea and vomiting were a side effect of high or inappropriate narcotic doses.

7 17. MM developed an uncontrolled seizure disorder, possibly as the result of
8 overuse of medication and engaged in drug seeking as a result of Respondent's improper
9 prescribing. MM suffered multiple episodes of nausea and vomiting and numerous falls
10 that were likely a result of drug toxicity. Respondent's behavior also may have contributed
11 to MM's addiction to narcotics after she underwent detoxification. MM was at high risk of
12 liver toxicity and death from the overdoses of medications she was receiving.

13 18. A physician is required to maintain adequate legible medical records
14 containing, at a minimum, sufficient information to identify the patient, support the
15 diagnosis, justify the treatment, accurately document the results, indicate advice and
16 cautionary warnings provided to the patient and provide sufficient information for another
17 practitioner to assume continuity of the patient's care at any point in the course of
18 treatment. A.R.S. §32-1401(2). Respondent's medical records were inadequate as he did
19 not document discussion with MM of the risks and benefits of being back on narcotics after
20 going through detoxification, he did not include MM's pain level prior to prescribing
21 medications and he did not document the complete number of narcotic prescriptions and
22 medications given in the medical record.

23 19. According to Respondent, as a result of this case, Respondent has worked
24 to improve his skills, and approach in dealing with patients with chronic pain and multiple
25 medical problems. Also according to Respondent, he has attended over twenty hours of

1 continuing medical education (CME) in pain management and related topics and has
2 instituted systems to help better diagnose sources of patient pain and to facilitate referrals.

3
4 **CONCLUSIONS OF LAW**

5 1. The Board possesses jurisdiction over the subject matter hereof and over
6 Respondent.

7 a. The conduct and circumstances described above constitute unprofessional
8 conduct pursuant to A.R.S. § 32-1401 (27)(e) (“[f]ailing or refusing to maintain adequate
9 records on a patient”); and A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or
10 might be harmful or dangerous to the health of the patient or the public”).

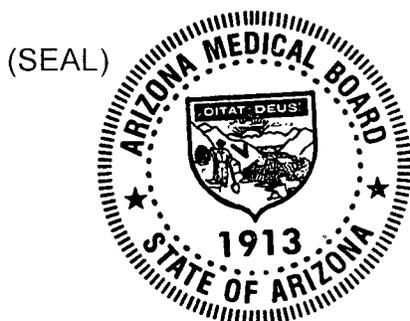
11 **ORDER**

12 IT IS HEREBY ORDERED THAT:

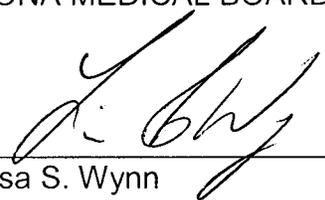
13 1. Respondent is issued a Letter of Reprimand; and
14 2. Respondent is placed on probation for **one year** with the following terms and
15 conditions:

16 a. Within **six months** of the effective date of this Order, Respondent
17 shall complete the PACE prescribing course. The course hours shall be in addition to the
18 CME hours required for the biennial renewal of medical licensure. The Probation shall
19 terminate upon completion of the course work.

20
21 DATED AND EFFECTIVE this 8TH day of DECEMBER, 2010.



ARIZONA MEDICAL BOARD

By 

Lisa S. Wynn
Executive Director

1 modifications to this original document are ineffective and void unless mutually approved
2 by the parties.

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

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

8 9. If the Board does not adopt this Order, Respondent will not assert as a
9 defense that the Board's consideration of the Order constitutes bias, prejudice,
10 prejudgment or other similar defense.

11 10. Any violation of this Order constitutes unprofessional conduct and may result
12 in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation,
13 consent agreement or stipulation issued or entered into by the board or its executive
14 director under this chapter") and 32-1451.

15 11. Respondent acknowledges that, pursuant to A.R.S. § 32-2533(E), he cannot
16 act as a supervising physician for a physician assistant while his license is under
17 probation.

18 12. ***Respondent has read and understands the conditions of probation.***

19

20 Peter F. Levins M.D.

DATED: 11/5/10

21 PETER F. LEVINS, M.D.

22 EXECUTED COPY of the foregoing mailed
23 this 5th day of November 2010 to:

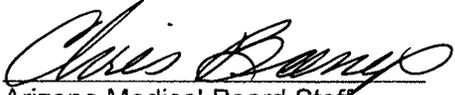
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1 Robert Milligan
4647 North 32nd Street Suite 185
2 Phoenix AZ 85018
3 ATTORNEY FOR RESPONDENT

4 ORIGINAL of the foregoing filed
this 9th day of December 2010 with:

5 Arizona Medical Board
6 9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

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9 Arizona Medical Board Staff

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