

**State of New Hampshire
Board of Medicine
Concord, New Hampshire**

In the Matter of:
Anton Heins, M.D.
License No. 12382
(Adjudicatory Proceedings)

Docket No. 15-07

**ORDER OF EMERGENCY LICENSE SUSPENSION
AND NOTICE OF HEARING TO SHOW CAUSE**

1. RSA 329:18-b; RSA 541-A:30, III, and New Hampshire Board of Medicine Administrative Rule (“Med”) 503.01 authorize the New Hampshire Board of Medicine (“Board”) to suspend a license to practice medicine for no more than one hundred twenty (120) days pending completion of an adjudicatory proceeding, in cases involving imminent danger to life or health. In such cases, the Board must commence a hearing not later than 10 days after the date of the emergency order. If the Board does not commence the hearing within 10 days, the suspension order shall be automatically vacated. *See* RSA 541-A:30, III. The Board may not continue such a hearing without the consent of the licensee to the continuation of the emergency suspension. *See* RSA 329:18-b and Med 503.01. Postponement of the proceeding is prohibited unless the licensee agrees to continue the suspension pending issuance of the Board’s final decision. *See* RSA 329:18-b and Med 503.01.
2. Anton Heins, M.D. (“Dr. Heins” or “Respondent”), holds an active license, No. 12382, originally issued on July 7, 2004, to practice medicine in the State of New Hampshire. In a February 9, 2010 Consent Order, Respondent’s license to practice medicine was suspended for five years. Three years of this suspension could be stayed subject to compliance with certain requirements. (See Attachment 1).
3. The basis for the Board’s action was inadequate care for multiple patients being treated for addiction. Respondent placed numerous patients on Suboxone for treatment of substance use disorders. He did not discuss the risks and benefits of this treatment, and he repeatedly failed to develop treatment plans. Treatment records did not contain physical examinations, including vital signs.

Respondent met patients in public locations and required weekly visits without any documented rationale.

Respondent's care of these patients constituted a pattern of behavior incompatible with the practice of medicine.

4. Following a May 7, 2014 show cause hearing for license reinstatement, the Board issued a Final Decision and Order, in which the following findings were made:

The question, therefore, is one of character and competence, not in the sense of medical knowledge, but more in the ability to successfully care for his patients by complying with law and regulation and the ethics of billing. In reviewing the evidence, *we are not entirely convinced or persuaded that Respondent has either the character or competence to run a successful practice independent of supervision. Consequently, the Board will grant a restricted license on the foregoing basis:*

- *Respondent will continue to abide by the AMI compliance plan and contract with [New Hampshire Professionals Health Program, or NHPHP].*
- *All aspects of the compliance program must be maintained for as long as Respondent continues to practice in New Hampshire. Additionally, Respondent will have Dr. Garhart and/or NHPHP provide input into his hiring of staff, and he shall hire a fulltime, qualified office manager, knowledgeable with Opioid Addiction Treatment.*
- Respondent will have only one commercial office location, where he see patients only at that location. The Policy and Procedure Standards at Exhibit H, reveal that Respondent can come up with a plan of action on this front.
- Follow all practice protocols as provided in the Procedure Manual developed by AMI, and use any new best practice protocols that have been developed after the drafting of the Manual.
- Respondent will be monitored by NHPHP or its equivalent for as long as he continues a New Hampshire practice. He will comply with all recommendations made by the NH PHP. Failure to comply will be considered separate grounds for discipline by the Board.
- Respondent may also provide any other recommendations for solo-practice, which we would need to be approved and adopted by NHPHP.

It is therefore ORDERED, that Respondent be given a Restricted License to practice where he meets the above conditions. (See Attachment 2, emphasis added).

5. The January 9, 2012 AMI compliance plan requires Respondent to comply with numerous conditions, including the development of a practice-specific Compliance Manual and a comprehensive training program for all members of his staff. These requirements should have been completed *sixty days prior to Respondent's return to practice*. On September 2, 2014, Respondent signed a monitoring contract with NHPHP, which included the following term: "I agree that I will not attempt to return to the practice of medicine until my practice and my staff have been approved by the NHPHP."

6. The Board has received information indicating that the continued practice of medicine by Respondent poses an imminent threat to life, safety and/or health, which warrants the temporary suspension of his license to practice medicine pending a hearing on whether permanent and/or temporary disciplinary sanctions should be imposed.

7. In support of this *Order of Emergency License Suspension and Notice of Hearing to Show Cause*, the Board alleges the following facts:

- A. Without complying with the above-mentioned requirements, Respondent opened his own solo practice located at 1650 Elm Street, Manchester, New Hampshire.
- B. Respondent treated four patients at this location and conducted a total of seven visits. He prescribed Suboxone to all four patients on the first visit. Respondent neglected to get records from other treating providers for these patients. He did not sign a release for medical records and was therefore unable to confirm prior or concurrent treatment.
- C. Respondent's justification for prescribing Suboxone for these patients was based solely on a completed questionnaire, the patient's verbal history, and an instant urine drug test cup.
- D. Respondent's treatment plan for these patients was inadequate.
- E. Despite past issues with his billing practices and AMI requirements, Respondent accepted cash from each patient for every visit.

F. Respondent did not inform NHPHP or AMI that he had opened his own practice and was treating patients prior to doing so.

G. Respondent's conduct violated the restrictions placed on his license in the Board's August 18, 2014 Final Decision and Order.

8. Based upon the above information, the Board finds that the case involves imminent danger to life and/or health. Further, the Board believes there is a reasonable basis for both immediately suspending Respondent's license on a temporary basis, and for commencing an expedited show cause hearing against Respondent pursuant to RSA 329:18-b, 541-A:30, III, and Med 503.01.

9. The purpose of this proceeding will be to determine whether Respondent has engaged in professional misconduct contrary to RSA 329:17, VI and RSA 329:18-b, which warrants the continued imposition of a temporary license suspension, the imposition of permanent disciplinary sanctions, or both. The specific issues to be determined in this proceeding are:

- A. Whether Respondent committed professional misconduct by failing to comply with Board imposed restrictions on his license;
- B. Whether Respondent committed professional misconduct by failing to perform adequate patient assessments prior to prescribing Suboxone;
- C. Whether Respondent committed professional misconduct by failing to complete an appropriate treatment plan for these patients;
- D. Whether Respondent's failure to comply with the terms of the AMI compliance plan constitutes unprofessional conduct;
- E. Whether Respondent's failure to comply with the terms of the NHPHP monitoring contract; and
- F. Whether any of the above conduct supports a finding that Respondent's continued practice of medicine presents an imminent danger to life or health; and

G. If any of the above allegations are proven, whether and to what extent, Respondent should be subjected to one or more of the disciplinary sanctions authorized by RSA 329:17, VII.

10. While RSA 329:18-a requires that the Board furnish Respondent at least 15 days' notice of allegations of professional misconduct and the date, time and place of an adjudicatory hearing, RSA 541-A:30, III and Med 503.01 require the Board to commence an adjudicatory hearing within ten (10) days after the date of an immediate, temporary license suspension order.

11. The Board intends to complete this adjudicative proceeding within the one hundred twenty (120) day time period provided by RSA 329:18-b and Med 503.01. Accordingly, neither the date of the initial evidentiary hearing nor the date for concluding this proceeding shall be postponed or extended unless Respondent agrees to continue the suspension period pending issuance of the Board's final decision in this matter. *See* RSA 329:18-b, 541-A:30, III, and Med 503.01.

THEREFORE, IT IS ORDERED that Respondent's New Hampshire license to practice medicine is immediately suspended until further order of the Board; and,

IT IS FURTHER ORDERED that an adjudicatory proceeding be commenced for the purpose of resolving the issues articulated above pursuant to RSA 329:17; 329:18-a; 329:18-b; 541-A:30, III; and Med 503.01. To the extent that this order or the Board's rules do not address an issue of procedure, the Board shall apply the New Hampshire Department of Justice Rules, Part 800; and,

IT IS FURTHER ORDERED that Anton Heins, M.D. shall appear before the Board on Thursday, November 12, 2015 at 5:00 p.m., at the Board's office located at 121 South Fruit Street, Concord, N.H., to participate in an adjudicatory hearing and, if deemed appropriate, be subject to sanctions pursuant to RSA 329:17, VII; and,

IT IS FURTHER ORDERED that if Respondent elects to be represented by counsel, at Respondent's own expense, said counsel shall file a notice of appearance at the earliest date possible; and,

IT IS FURTHER ORDERED that Respondent's failure to appear at the time and place specified above may result in the hearing being held *in absentia*, or the imposition of disciplinary sanctions without further notice or an opportunity to be heard, or both; and,

IT IS FURTHER ORDERED that the Administrative Prosecutions Unit, 33 Capitol Street, Concord, N.H., 03301 is appointed to act as Hearing Counsel in this matter with all the authority within the scope of RSA Chapter 329 to represent the public interest. Hearing Counsel shall have the status of a party to this proceeding; and,

IT IS FURTHER ORDERED that Mark Sullivan, PA, President, or any other person whom he may designate, shall act as presiding officer in this proceeding; and,

IT IS FURTHER ORDERED that any proposed exhibits, motions or other documents intended to become part of the record in this proceeding, be filed by the proponent with the Board, in the form of an original and eleven (11) copies, and with an additional copy mailed to any party to the proceeding, and to Assistant Attorney General Lynmarie Cusack, Counsel to the Board, N.H. Department of Justice, 33 Capitol Street, Concord, New Hampshire 03301. All responses or objections to such motions or other documents are to be filed in similar fashion within ten (10) days of receipt of such motion or other document unless otherwise ordered by the Board; and,

IT IS FURTHER ORDERED that a witness and exhibit list and any proposed exhibits, pre-marked for identification only, shall be filed with the Board no later than three (3) days before the date of the hearing. Respondent shall pre-mark her exhibits with capital letters, and Hearing Counsel shall pre-mark her exhibits with Arabic numerals; and,

IT IS FURTHER ORDERED that unless good cause exists, all motions shall be filed at least three (3) days before the date of any hearing, conference, event or deadline which would be affected by the requested relief, except any motion seeking to postpone a hearing or conference, which shall be filed at least ten (10) days before the hearing or conference in question; and,

IT IS FURTHER ORDERED that the entirety of all oral proceedings be recorded verbatim by the Board. Upon the request of any party made at least ten (10) days prior to the proceeding or conference or upon the Board's own initiative, a shorthand court reporter shall be provided at the hearing or conference and such record shall be transcribed by the Board if the requesting party or agency shall pay all reasonable costs for such transcription; and,

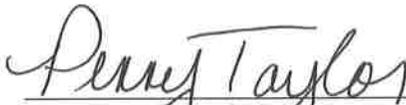
IT IS FURTHER ORDERED that all documents shall be filed with the Board by mailing or delivering them to Penny Taylor, Administrator, N.H. Board of Medicine, 121 South Fruit Street, Concord, New Hampshire 03301; and

IT IS FURTHER ORDERED that routine procedural inquiries may be made by contacting Penny Taylor, Administrator, N.H. Board of Medicine, at (603) 271-1203, but that all other communications with the Board shall be in writing and filed as provided above. *Ex parte* communications are forbidden by statute and the Board's regulations; and,

IT IS FURTHER ORDERED that a copy of this Notice of Hearing to Show Cause shall be served upon Respondent by first class, postage prepaid mail addressed to the address on record with the Board, as well as to Cinde Warmington, Esq. *See* RSA 329:18, VI, Med. 501.02 (c) and RSA 329:16 (f). A copy shall also be delivered to Hearing Counsel.

BY ORDER OF THE BOARD/*

Dated: NOV. 4, 2015


Penny Taylor, Administrator
Authorized Representative of the
New Hampshire Board of Medicine

/* Board members not participating:
Amy Feitelson, MD
Lou Rosenthal, MD

**State of New Hampshire
Board of Medicine
Concord, New Hampshire 03301**

In the Matter of:
Anton A. Heins, III, M.D.
No.: 12382
(Misconduct Allegations)

CONSENT ORDER

In order to avoid the delay and expense of further proceedings and to promote the best interests of the public and the practice of medicine, the New Hampshire Board of Medicine ("Board") and Anton A. Heins, III, M.D. ("Dr. Heins" or "Respondent"), a physician licensed by the Board, do hereby stipulate and agree to resolve certain allegations of professional misconduct now pending before the Board according to the following terms and conditions:

1. Pursuant to RSA 329:17, I; RSA 329:18; RSA 329:18-a; and Medical Administrative Rule ("Med") 206 and 210, the Board has jurisdiction to investigate and adjudicate allegations of professional misconduct committed by physicians. Pursuant to RSA 329:18-a, III, the Board may, at any time, dispose of such allegations by settlement and without commencing a disciplinary hearing.
2. The Board first granted Respondent a license to practice medicine in the State of New Hampshire on July 7, 2004. Respondent holds license number 12382. Respondent is board certified in internal medicine and has practiced addiction medicine in New Hampshire since August of 2004 from his private practice located at 21 Eastman Avenue, Bedford, NH.
3. On or about October 4, 2007, the Board received a consumer complaint from one of Respondent's patients. In March of 2008, the Board received information from the NH

Board of Pharmacy relating to concerns about Respondent's prescribing practice. The Board received consumer complaints from some of Respondent's patients.

4. In response to this information, the Board conducted an investigation and obtained information from various sources relating to Respondent's addiction medicine practice and the management of these patients. In addition, the Board conducted a random review of several patient treatment files to determine the quality of medical records maintained at the practice.
5. On or about November 6, 2009, the Board issued a Notice of Hearing to initiate an adjudicatory proceeding in order to resolve certain allegations of misconduct related to Respondent's conduct while treating patients of his private practice in addiction medicine.
6. Respondent stipulates that if a disciplinary hearing were to take place, Hearing Counsel would introduce the following evidence that Respondent engaged in professional misconduct, in violation of RSA 329:17, VI(c), (d), (i) and (k); Med 501.01(a); Med 501.02(d); Med 501.02(e)(1) and (2); Med 501.02(h); and provisions of the American Medical Association Code of Medical Ethics Standards 2.19, 5.05, and/or 5.059(1), and 8.115 by failing to maintain patient records and informed consent in accordance with the Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction as articulated by the Federation of State Medical Boards as a standard of care, and by failing to engage in the care and/or treatment of each patient in a caring comprehensive approach and address the multiple problems of addicted patients and by such treatment establish a plan to attempt to restore the patient to abstinence, in that:
 - A. On or about August of 2004 Respondent began practicing addiction medicine at a private practice located at 21 Eastman Avenue, Bedford, NH.

- B. On or about November 3, 2004, Respondent began treating patient WW for opioid dependency and chronic pain. Respondent prescribed Suboxone for WW. Respondent's documented assessment was handwritten containing undefined abbreviations and was difficult to interpret without transcription. The handwritten assessment failed to document an individual treatment plan for WW or to document the risks and benefits of Suboxone treatment for WW. Respondent failed to adequately document follow-up treatment notes. Respondent utilized the "S.O.A.P." documentation format but failed to include adequate detail to document WW's condition or progress in treatment. Treatment notes did not document vital signs or reasons for change(s) in WW's Suboxone dosage. Respondent failed to appropriately document prescription(s) for Suboxone in the medical record. Respondent failed to provide patient WW's treatment in a confidential, safe location, in that he met WW for follow-up appointment(s) in a public location on more than one occasion. Respondent failed to document a rationale or plan requiring weekly office visits.
- C. On or about September 1, 2004, Respondent began treating patient AC for opioid dependency. Respondent prescribed Suboxone for AC. Respondent's documented assessment was handwritten containing undefined abbreviations and was difficult to interpret without transcription. The handwritten assessment failed to document an individual treatment plan or to document the risks and benefits of Suboxone treatment for AC. The assessment indicated that at the time, AC was taking Lexapro and Xanax, and was diagnosed with polysubstance abuse, benzodiazepine dependence, THC dependence, and alcohol abuse. The plan was

described only as to induce Suboxone at signs of withdrawal. There was no follow-up documentation of what withdrawal signs were reported. Respondent failed to adequately document follow-up treatment notes. Respondent utilized the "S.O.A.P." documentation format but failed to include adequate detail to document AC's condition or progress in treatment in each note. AC continued to report use of Xanax, benzodiazepines and marijuana, but there was no documentation of a plan to address the possible risks and benefits of Suboxone use in combination with these substances. The record contained no explanation, rationale or plan for change(s) in AC's dosage of Suboxone. Respondent failed to appropriately document prescription(s) for Suboxone in the medical record. No drug screens were ordered or documented. The medical record documented AC's restart of the program on June 22, 2005 but failed to document when or why treatment was ended previously. No subsequent assessment after the 2005 restart was documented. Respondent failed to document a rationale or plan requiring weekly office visits.

- D. On or about June 28, 2006, Respondent began treating patient MA for opioid dependency. Respondent prescribed Suboxone for MA. Respondent's documented assessment of MA was handwritten containing undefined abbreviations, and was difficult to interpret without transcription. The handwritten assessment failed to identify an individual treatment plan or the risks and benefits of Suboxone treatment for MA. Respondent failed to adequately document follow-up treatment notes. Respondent utilized the "S.O.A.P." documentation format but failed to include adequate detail to document MA's condition or progress in

treatment. The medical record did not document MA's vital signs or random urine screens. Respondent failed to appropriately document prescriptions in the medical record. Respondent failed to adequately document discussions of the risks relating to MA's continued use of Xanax in combination with Suboxone. Respondent failed to provide MA's treatment in a confidential, safe location, in that he met patient MA for follow-up appointments in a public location on more than one occasion. Respondent failed to document a rationale or plan requiring weekly office visits.

- E. On or about March 22, 2006, Respondent began treating patient LG for opioid dependency. The documented assessment of LG was handwritten containing undefined abbreviations, and was difficult to interpret without transcription. The assessment indicated that LG suffered from Lyme disease and was treated with Biaxin and Plaqueril for this condition. Respondent prescribed Suboxone for LG. The record did not adequately document whether or not LG continued to take Biaxin and Plaqueril after Respondent commenced treating LG with Suboxone. Respondent failed to adequately document follow-up visits. Respondent utilized the "S.O.A.P." format of documentation, but failed to record sufficient detail to determine LG's condition or progress in treatment. Respondent failed to document any vital signs in the medical record. Respondent failed to document the plan or rationale for change(s) made to LG's dosage of Suboxone. Respondent failed to document Suboxone prescriptions in the medical record. Respondent failed to provide treatment in a safe and confidential environment by

meeting LG in a public location on at least one occasion. Respondent failed to document a plan or rationale requiring weekly visits.

- F. On or about August 2, 2006, Respondent began treating AM for opioid dependency and polysubstance abuse (including a reported history of THC, Benzodiazepine and Cocaine abuse, and alcohol dependency). Respondent documented that he recommended in-patient treatment for AM, which AM refused. Respondent prescribed Suboxone for AM. Respondent failed to document discussions of the risks of using Suboxone in combination with alcohol and other controlled substances. On August 30, 2006 AM admitted to using Xanax while taking Suboxone. On September 13, 2006 Respondent documented "ETOH on breath." No follow-up response or plan was documented for addressing AM's continued alcohol and benzodiazepine consumption. Respondent continued to prescribe Suboxone. Respondent failed to adequately document all follow-up visits. Respondent utilized the "S.O.A.P." format of documentation but failed to include adequate detail to document AM's condition or progress in treatment. Respondent failed to adequately document the prescriptions for Suboxone in the medical record. Respondent failed to document vital signs or the rationale or plan relied upon for changing AM's Suboxone dosage. Respondent failed to provide AM's treatment in a confidential, safe location, in that he met patient AM for follow-up appointment(s) in a public location on more than one occasion. Respondent failed to document a plan or rationale requiring weekly visits.
- G. On or about May 2, 2007, Respondent began treating patient AG for opioid dependency. The assessment documented that AG had a diagnosis of high blood

pressure. The documented assessment of AG was handwritten containing undefined abbreviations, and was difficult to interpret without transcription. The assessment failed to identify an individual treatment plan or the risks and benefits of Suboxone treatment for AG. Respondent prescribed Suboxone for AG. Respondent failed to adequately document follow-up visits. Respondent utilized the "S.O.A.P." format of documentation but failed to include adequate detail to document AG's condition or progress in treatment. Respondent failed to document AG's blood pressure or record other vital signs or the reasons for change(s) in AG's Suboxone dosage. Respondent failed to appropriately document prescriptions in the medical record. Respondent failed to document the plan or rationale requiring weekly visits. Respondent failed to provide AG treatment in a confidential, safe location in that he met AG for follow-up appointment(s) in a public location on at least one occasion.

- H. On or about June 29, 2007, Respondent began treating Patient JS for opioid dependency. The assessment also listed diagnoses of chronic pain, hypothyroidism, THC abuse and polysubstance abuse. The documented assessment of JS was handwritten containing undefined abbreviations, and was difficult to interpret without transcription. The assessment failed to identify an individual treatment plan or the risks and benefits of Suboxone treatment for JS. Respondent prescribed Suboxone for JS. Respondent failed to adequately document follow-up office visits. Respondent utilized the "S.O.A.P." format of documentation, but failed to include adequate detail to determine JS's condition or progress in treatment. No vital signs were documented. Respondent failed to

appropriately document Suboxone prescriptions in the medical record. Respondent failed to document change(s) in JS's Suboxone dosage. Respondent failed to document a plan or rationale requiring weekly visits.

- I. On or about March 21, 2007, Respondent began treating patient PP for opioid dependency. The assessment at that time included a history of polysubstance abuse, benzodiazepine dependency, chronic pain, possible bi-polar disorder and Hepatitis C. The documented assessment of PP was handwritten containing undefined abbreviations, and was difficult to interpret without transcription. The assessment failed to identify an individual treatment plan or the risks and benefits of Suboxone treatment for PP. Respondent prescribed Suboxone for PP. Although Respondent continued to treat PP until April 23, 2008, only one drug screen was obtained during that time. This drug screen tested positive for benzodiazepines. Respondent failed to document discussions with PP of the risks and benefits of Suboxone use in combination with other medications. Respondent utilized the "S.O.A.P." format of documentation but failed to include adequate documentation to determine PP's condition or progress in treatment. Respondent failed to document reasons for change(s) in PP's dosage of Suboxone. Respondent failed to document the rationale requiring weekly visits.
- J. On or about October 11, 2007, Respondent began treating patient JW for opioid dependency. The documented assessment of JW was handwritten containing undefined abbreviations, and was difficult to interpret without transcription. The assessment failed to identify an individual treatment plan or the risks and benefits of Suboxone treatment for JW. Respondent prescribed Suboxone for JW.

Respondent failed to conduct an appropriate assessment of JW, by meeting with JW in a public location where confidentiality and safety of the patient were not controlled and where Respondent was in the company of his wife and children. Respondent failed to adequately document treatment notes. Respondent failed to adequately document follow-up visit(s) and utilized the "S.O.A.P." format of documentation but failed to include adequate detail to document JW's condition or progress in treatment. Respondent failed to adequately document prescription(s) for Suboxone in the medical record. Respondent made changes to JW's dosage of Suboxone without appropriately documenting the reason and clinical consequences of the change. Respondent failed to document discussion with JW of testing results. Respondent failed to document a rationale or plan requiring weekly office visits.

- K. On or about January 30, 2007, Respondent began treating patient MO for opioid dependency. The assessment listed other diagnoses of ADHD, anxiety, polysubstance abuse and alcohol dependence. The assessment also stated that MO agreed to taper her use of Klonopin. The documented assessment of MO was handwritten containing undefined abbreviations, and was difficult to interpret without transcription. The assessment failed to identify an individual treatment plan or the risks and benefits of Suboxone treatment for MO. Respondent prescribed Suboxone for MO. Respondent failed to appropriately document Suboxone prescriptions in the medical record. Respondent failed to adequately document the risks and benefits of Suboxone use in combination with other medications that MO reported taking. The record failed to document any vital

signs or orders for drug testing. Respondent utilized the "S.O.A.P." format of documentation but failed to include sufficient detail to determine MO's condition or progress in treatment. Respondent failed to document a rationale for change(s) in MO's Suboxone dosage. Respondent failed to document a rationale or plan requiring weekly visits.

L. On or about November 2007, Respondent began treating LR for opioid dependency. The documented assessment of LR was handwritten containing undefined abbreviations, and was difficult to interpret without transcription. The assessment failed to identify an individual treatment plan or the risks and benefits of Suboxone treatment for LR. Respondent prescribed Suboxone for LR. Respondent utilized the "S.O.A.P." format of documentation but failed to include adequate detail to determine LR's condition or progress in treatment. Respondent failed to document a rationale or plan for changing LR's dosage of Suboxone. Respondent documented no vital signs. Respondent failed to appropriately document the Suboxone prescriptions in the medical record. Respondent failed to treat LR in a safe and confidential location, meeting her on at least two occasions in a public location. Respondent failed to document a rationale or plan requiring weekly visits.

M. On or about May 19, 2007, Respondent began treating KL for opioid dependency. The assessment listed a diagnosis for KL of polysubstance abuse. The documented assessment of KL was handwritten containing undefined abbreviations, and was difficult to interpret without transcription. The assessment failed to identify an individual treatment plan or the risks and benefits of

Suboxone treatment for KL. Respondent prescribed Suboxone for KL. Respondent utilized the "S.O.A.P." format of documentation but failed to document adequate detail to determine KL's condition or progress in treatment. No vital signs were noted in the medical record, and there was no documentation of discussion with KL regarding the risks and benefits of using Suboxone in conjunction with other substances. There was no documentation of a plan to address KL's reported use of alcohol on November 7, 2007. Respondent failed to adequately document a rationale or plan for change(s) in KL's Suboxone dosage. On October 24, 2007, the number of tablets provided in the P section of the follow-up note indicated, "#7 due to Medicaid issues." The record documented a request for a drug test on December 26, 2007, but there was no follow up recorded and no drug test results documented in the record. Respondent failed to provide treatment in a safe and confidential location, meeting KL on one occasion at a public location. There was no documentation of the rationale or plan requiring weekly visits.

- N. On or about September 8, 2007, Respondent began treating patient JJ for opioid dependency. The assessment also listed diagnoses for JJ of Androgenic Steroid dependence and a \$3,000-a-week Oxycontin habit. Respondent prescribed Suboxone for JJ. The documented assessment of JJ was handwritten containing undefined abbreviations, and was difficult to interpret without transcription. The assessment failed to identify an individual treatment plan or the risks and benefits of Suboxone treatment for JJ. The record did not adequately document whether or not JJ continued to take Androgenic Steroids or Oxycontin after Respondent

began treating JJ with Suboxone. Respondent utilized the "S.O.A.P." format of documentation in follow-up treatment notes, but failed to include adequate detail to document JJ's condition and progress in treatment. Respondent failed to document any vital signs in the record and ordered no drug tests. Respondent failed to appropriately document Suboxone prescriptions in the medical record, and failed to document a rationale or plan for change(s) in JJ's dosage of Suboxone. The record documented on January 30, 2008 that the patient was progressing out of the program. However, Respondent continued to prescribe Suboxone at the same or at a higher dosage until April 14, 2008. There was no termination of care documented, and no change in plan documented. Respondent failed to document a rationale or plan requiring weekly visits.

- O. On or about April 9, 2008 Respondent began treating patient NV for opioid dependency. Respondent prescribed Suboxone for NV. The documented assessment was handwritten containing undefined abbreviations that were difficult to interpret without transcription. The handwritten assessment failed to identify an individual treatment plan, or the risks and benefits of Suboxone treatment for NV. Respondent failed to adequately document follow-up visits and utilized the "S.O.A.P." format without including specific details relating to NV's condition or progress in treatment. Respondent failed to document a rationale or plan requiring weekly office visits. Respondent engaged in five (5) follow-up visits with NV. On May 21, 2008, Respondent documented termination of the physician/patient relationship. Respondent failed to appropriately terminate the

physician/patient relationship and provided inaccurate documentation of the termination.

- P. On or about March 20, 2008, Respondent began treating patient NS for opioid dependency. The documented assessment was handwritten containing undefined abbreviations that were difficult to interpret without transcription. The handwritten assessment failed to identify an individual treatment plan, or the risks and benefits of Suboxone treatment for NS. Respondent prescribed Suboxone for NS. Respondent failed to adequately document follow-up visits. Respondent utilized the "S.O.A.P." form of documentation but failed to include adequate detail to document NS's condition or progress in treatment. Respondent failed to appropriately document the prescription(s) for Suboxone in the medical record. On May 7, 2008, Respondent noted "chronic knee pain" but failed to appropriately document any assessment of the knee pain, and failed to provide diagnostic follow up or referral. Respondent made changes to NS's dosage for Suboxone without documenting the reason or rationale for such changes. Respondent failed to document a plan or rationale requiring weekly office visits.
- Q. On or about January 9, 2008 Respondent began treating patient SO for opioid dependency. The assessment listed other diagnoses of benzodiazepine abuse and polysubstance abuse. The documented assessment was handwritten containing undefined abbreviations that were difficult to interpret without transcription. The handwritten assessment failed to identify an individual treatment plan, or the risks and benefits of Suboxone treatment for SO. Respondent's assessment indicated that SO was taking Lexapro and that she would reduce the Lexapro dose by a half.

Respondent prescribed Suboxone for SO. Respondent failed to adequately document follow up treatment notes. Respondent documented follow-up notes utilizing the "S.O.A.P." format but failed to provide adequate detail of SO's condition and follow up in treatment. No vital signs were documented. No drug screens were documented, even after SO admitted, on February 20, 2008, continuing to take benzodiazepines and Klonopin. The medical record failed to document discussions of the risks of taking these medications in combination with Suboxone. Respondent failed to appropriately document Suboxone prescriptions in SO's record. Respondent failed to document a rationale for change(s) in SO's dosage of Suboxone. Respondent failed to document a plan or rationale requiring weekly visits.

- R. Respondent failed to follow all federal requirements established by the Drug Enforcement Administration (DEA) in that he treated more patients with Suboxone than he had authorization to treat according to the DEA regulations.
 - S. Respondent failed to operate the addiction medicine practice in accordance with the standard of care outlined in the "Clinical Guidelines for Use of Buprenorphine in the Treatment of Opioid Addiction" as adopted by the Federation of State Medical Boards and/or to demonstrate through the patient medical record a treatment plan which established measurable goals to achieve objectives for the patient of: freedom from intoxication; improved physical function and improved psychosocial function.
7. The Board finds that Respondent committed the acts as described above and concludes that, by engaging in such conduct, Respondent displayed a pattern of behavior

incompatible with the basic knowledge and competence expected of persons licensed to practice medicine or any particular aspect or specialty thereof. These acts are in violation of RSA 329:17, VI(c) and (d); and RSA 329:17, VI(i) and (k). In addition, his failure to maintain appropriate documentation are in violation of Med 501.01(a); Med 501.02(d); Med 501.02(e)(1) and Med 501.02(e)(2); Med 501.02(h); and the American Medical Association Code of Medical Ethics Standards 2.19, 5.05, and/or 5.059(1), and 8.115.

8. Respondent acknowledges that this conduct constitutes grounds for the Board to impose disciplinary sanctions against Respondent's license to practice as a physician in the State of New Hampshire.
9. Respondent consents to the Board imposing the following discipline, pursuant to RSA 329:17, VII:
 - A. Respondent's license to practice medicine is suspended for a period of five (5) years commencing forty-five (45) days from the effective date of this Consent Order. Subject, however, to the terms and conditions set forth in ¶'s 9B-9P below, three years of Respondent's suspension may be stayed for the remaining term of said suspension.
 - B. At any time after one year of the effective date of this Consent Order, Respondent may petition the Board to stay the last three years of the suspension imposed herein. Such petition shall include certification that: (1) Respondent has satisfied all pre-stay aspects of the Board approved Plan prior to any stay of suspension; (2) Respondent will conduct his practice in accordance with a Board-approved compliance and monitoring plan (the "Board-approved plan"), as more fully described below; (3) Respondent

remains under contract with Affiliated Monitors Inc., P.O. Box 961791, Boston, MA 02196 ("AMI"), to conduct the training and monitoring activities required by the Board-approved plan; and (4) all necessary training, assessment and any other prerequisites of the Board-approved plan are, or will be, in place or completed prior to the effective date of the stay. Upon such petition and certification, the Board may stay the remaining period of Respondent's suspension. The Board shall not unreasonably refuse to grant the stay, so long as Respondent has demonstrated good faith in compliance with all requirements set forth by the Board and the Compliance Monitor, and in fulfilling his obligations under the Board-approved plan as they exist at the time the Petition is submitted.

- C. Respondent has entered into a contract with AMI for the development, implementation and ongoing monitoring of a Board-approved compliance and monitoring plan. That plan will be designed by AMI, subject to such input from the Board (or its designee) as the Board deems appropriate, to improve and monitor Respondent's practice of medicine, including addiction medicine. A copy of Respondent's contract with AMI is attached to this Consent Order and incorporated herein.
- D. Prior to implementation, such compliance and monitoring plan must be approved by the Board and shall, at a minimum, authorize AMI to (1) review patient treatment and billing records; and (2) monitor Respondent's medical practice including, but not limited to Respondent's patient evaluations, treatment, documentation of treatment and prescriptions, documentation of

follow up care and referral, and Respondent's billing practices. Additionally, the plan shall require AMI to train Respondent's staff and to monitor Respondent's practice of medicine for compliance with the terms of this Consent Order, the Board-approved plan, and all applicable state and federal laws, regulations and administrative rules. AMI's monitoring of Respondent's practice shall remain in effect throughout the period of stayed suspension.

- E. The Board-approved plan shall also provide for AMI to regularly report to the Board as scheduled and described in ¶ 9.H. vii., below. In order to facilitate AMI's development of the Board-approved plan, Respondent shall execute and/or implement any and all necessary releases or procedures, including a "HIPAA compliant business affiliation agreement," to facilitate and authorize unrestricted communications between AMI and the Board with regard to the development, implementation or enforcement of the Board-approved plan and to provide the Board access to all information obtained by the Monitor approved by the Board in accordance with ¶ 9.F., below. Respondent shall provide the Board with these releases at the time of filing any petition to stay the suspension with the Board. Respondent shall have no authority to revoke such releases or business affiliation agreements during their effective dates.
- F. Subject to the Board's review and approval, AMI will select a monitor (the "Monitor") who shall be a physician with expertise in the practice of addiction medicine. The Monitor shall be responsible to oversee the implementation of the Board Approved Plan and shall be responsible for all reports and evaluations required by that Plan. If the Monitor becomes unable to serve or to

fulfill his/her obligations, AMI may nominate a different Monitor who meets the criteria set forth in this paragraph and who is acceptable to the Board. In addition, the Board, in its discretion, may at any time during the period of monitoring request that AMI select a different Monitor.

- G. The Board Approved Plan shall include at least the following five components:
- (1) attend a global competency evaluation to be pre-approved by the Board (which approval the Board will not unreasonably withhold), and provide the Board with the report therefrom that demonstrates competence for the continued practice of medicine and, if deficiencies are noted, includes a plan for their remediation;
 - (2) on-going reviews of patient treatment records and all documentation related to the care of patients and the operation of the medical practice;
 - (3) unannounced visits to observe the operation of the medical practice and to observe and assess Respondent's evaluation and care of patients;
 - (4) meetings between the Monitor and Respondent in which the Monitor will provide Respondent with feedback and evaluation of his practice; and
 - (5) quarterly reports to the Board of the Monitor's observations and assessments.
- Respondent shall cooperate fully in all of his contacts with AMI and the Monitor and shall comply with any and all requests made by AMI, the Monitor or the Board for records, documentation, inspection and training of staff. Training of the staff and Respondent shall commence at least sixty days prior to lifting of stay and/or return to practice. Failure to do so shall constitute a violation of this Consent Order and may result in the stay being vacated and the imposition of the remaining period of license suspension.

H. Upon the Board's approval of both the compliance and monitoring plan and Respondent's Petition to stay the remaining period of suspension, the Monitor shall perform the following services which will continue, as described, throughout the remainder of the period of stayed suspension:

- i. The Monitor shall conduct monthly visits to all offices at which Respondent practices medicine in the State of New Hampshire and, during the first twelve months of monitoring, shall review a total of ten (10) randomly selected patient charts per month, including copies of prescriptions maintained by Respondent, for patients who are then currently treated by Respondent and/or patients who were last seen or treated by Respondent within the twelve (12) months prior to the effective date of the suspension. The purpose of that review shall be to ensure that records, if not complete, are, on a going forward basis, completed and that such records comply with all applicable federal and state laws, rules and regulations. During the Monitor's first review, the Monitor will identify to Respondent any records found not to be in compliance with federal and state laws, including the nature of the deficiencies found. Such records shall be the subject of the Monitor's report but shall not be grounds for further disciplinary action by the Board. As regards this and any subsequent record reviews, the Monitor shall make reasonable efforts to ensure that Respondent has no notice of which charts will be selected for review.

- ii. After twelve (12) months of monitoring, the Monitor shall, at his or her discretion, review no fewer than five (5) and nor more than ten (10) patient charts per month. The chart review shall include all documentation that the Monitor deems necessary and appropriate to the patients' treatment, including but not limited to documentation of: a HIPAA compliant business affiliation agreement that authorizes the Monitor and the Board to observe and review Respondent's care and treatment of that patient in his practice; necessary informed consents; medical records of patients' prior treatment, as appropriate; narcotic prescribing management agreements; reports of follow-up testing and drug screens; and appropriate referrals to specialists and follow-up care.
- iii. In addition to a review of randomly selected patient treatment records as provided above, the Monitor shall visit Respondent's practice to observe Respondent's practice, including but not limited to the number of patients scheduled for treatment by Respondent during office hours per day; the number of patients treated by Respondent as walk-in patients; and the average time of each visit. The Monitor shall make these visits to Respondent's practice on an "unannounced" basis. The Monitor shall conduct these unannounced visits on no fewer than four (4) and no more than six (6) occasions during a twelve-month calendar year beginning from the effective date of the Board-approved Plan. After twelve months, the Monitor shall continue the unannounced visits as determined appropriate by the Monitor and approved by the Board.

- iv. The Monitor shall also attend, on an "unannounced" basis, no fewer than four (4) and no more than six (6) patient evaluations conducted by Respondent during a twelve-month calendar year beginning from the effective date of the Compliance Plan and/or the date on which Respondent returns to practice. After twelve months, the Monitor shall recommend to the Board continuation of the unannounced visits as often as determined appropriate by the Monitor and approved by the Board. In the Monitor's sole discretion, the Monitor's attendance at such patient evaluations may occur on the same date as the "unannounced" office reviews identified in ¶ 9.H.iii., above.
- v. On a monthly basis, the Monitor shall meet and discuss with Respondent the cases of the patients whose charts were reviewed and/or whose evaluations were observed. The Monitor shall also discuss with Respondent any practice issues noted in the course of the unannounced office visit.
- vi. Each month, following review of the patient records and discussion with Respondent, the Monitor shall review Respondent's practice for compliance with any remaining terms of the Board-approved plan. Such review may include, but will not be limited to: inspection of computer drives and records, facsimile records, interviews with practice partners, staff, pharmacies, and any other parties necessary to ensure Respondent's compliance with the Board-approved plan as well as with generally accepted standards of medical practice.

vii. The Monitor shall submit quarterly written reports to the Board, which shall at a minimum contain: a description of each of the records reviewed; and the Monitor's opinion whether Respondent is practicing medicine in accordance with both generally accepted standards of medical practice and applicable laws, rules and regulations. Each report shall specifically address Respondent's prescribing practices; documentation; compliance with confidentiality and informed consent standards; billing procedures; and an assessment of both Respondent's participation in and adherence to the Board-approved plan, and his overall practice of medicine.

I. The terms and provisions of the Board-approved plan shall be incorporated into this Consent Order by reference. A copy of the Board-approved plan shall be attached to the Consent Order and its terms incorporated herein by separate order of the Board prior to the stay of Respondent's license suspension.

Furthermore:

- i. Respondent shall comply with all AMI recommendations and instructions during the monitoring period.
- ii. Respondent's failure to comply with the Compliance Plan and with any AMI Contract terms and recommendations shall constitute a violation of the terms of this Consent Order.
- iii. It is the responsibility of the Respondent to provide information to AMI in a timely and complete manner and to assure that all written reports setting forth the findings of the Monitor are timely transmitted to the Board on a quarterly basis.

- J. If at any time AMI believes Respondent is not in compliance with this Consent Order and/or any provision of the Compliance Plan and/or is unable to practice with skill and safety to patients, or has otherwise committed unprofessional conduct as set forth in RSA 329; Med 500 and/or the American Medical Association Code of Medical Ethics, AMI shall immediately inform the Board. The Board shall thereafter be authorized, in its sole discretion, to immediately vacate the stay and impose the remainder of the suspension, if it deems such action to be warranted. Should the stay be vacated at any time after the stay has been ordered, Respondent shall be entitled to a hearing only to contest the existence of the non-compliance or risk of patient harm. Respondent shall not contest the imposition of the remainder of the suspension.
- K. Unannounced visits of Respondent's practice by the Board's investigator or designee may be conducted at any time during the monitoring period and after completion of the term of the Compliance Plan during normal operating hours in an unobtrusive manner so as not to interfere with Respondent's ordinary practice. During the visits, the Board's investigator or designee will be authorized to examine, inspect and to obtain copies of scheduling documentation, treatment records, billing records and to review and request copies of any other documentation of Respondent's medical practice that the investigator deems appropriate to complete the inspection.
- L. Respondent is assessed an ADMINISTRATIVE FINE in the amount of \$10,000. Respondent shall pay this fine in no more than five (5) installments of \$2,000.00 each. The first payment shall be due within thirty (30) days of the

effective date of this agreement. Each remaining payment shall be due on the first day of the month for the four following months. All payments shall be made in the form of a money order or bank check made payable to "Treasurer, State of New Hampshire" and delivered to the Board's office at 2 Industrial Park Drive, Suite 8, Concord, New Hampshire.

- M. Respondent shall bear all costs of the assessment, supervision, reporting and the monitoring services of AMI as required by this Consent Order, but shall be permitted to share such costs with third parties.
- N. The Board may consider Respondent's compliance with the terms and conditions of the Compliance Plan and the terms of this Consent Order in any subsequent proceeding before the Board regarding Respondent's license.
- O. Within ten (10) days of the effective date of this agreement, as defined further below, Respondent shall furnish a copy of the Consent Order to any current employer for whom Respondent performs services as a physician or performs work which requires a medical degree and/or medical license and/or directly or indirectly involves patient care; and to any agency or authority which licenses, certifies or credentials physicians, with which Respondent is presently affiliated.
- P. Commencing upon the effective date of this Consent Order and continuing throughout the period of suspension and stayed suspension, Respondent shall furnish a copy of this Consent Order to any employer to which Respondent may apply for work as a physician and/or for work in any capacity which requires a medical degree and/or medical license, or which directly or

indirectly involves patient care; and to any agency or authority that licenses, certifies or credentials physicians, to which Respondent may apply for any such professional privileges or recognition.

10. Respondent's breach of any terms or conditions of this Consent Order or breach of the Compliance Plan shall constitute unprofessional conduct pursuant to RSA 329:17, VI (d), and a separate and sufficient basis for further disciplinary action by the Board.
11. Except as provided herein, this Consent Order shall bar the commencement of further disciplinary action by the Board based upon the misconduct described above. However, the Board may consider this misconduct as evidence of a pattern of conduct in the event that similar misconduct is proven against Respondent in the future. Additionally, the Board may consider the fact that discipline was imposed by this Order as a factor in determining appropriate discipline should any further misconduct be proven against Respondent in the future.
12. This Consent Order shall become a permanent part of Respondent's file, which is maintained by the Board as a public document.
13. Respondent voluntarily enters into and signs this Consent Order and states that no promises or representations have been made to him other than those terms and conditions expressly stated herein.
14. The Board agrees that in return for Respondent executing this Consent Order, the Board will not proceed with the formal adjudicatory process based upon the facts described herein.
15. Respondent understands that his action in entering into this Consent Order is a final act and not subject to reconsideration or judicial review or appeal.

16. Respondent has had the opportunity to seek and obtain the advice of his attorney Paul R. Cirel, Esq. in connection with his decision to enter into this agreement.
17. Respondent understands that the Board must review and accept the terms of this Consent Order. If the Board rejects any portion, the entire Consent Order shall be null and void. Respondent specifically waives any claims that any disclosures made to the Board during its review of this Consent Order have prejudiced his right to a fair and impartial hearing in the future if this Consent Order is not accepted by the Board.
18. Respondent is not under the influence of any drugs or alcohol at the time he signs this Consent Order.
19. Respondent certifies that he has read this Consent Order. Respondent understands that he has the right to a formal adjudicatory hearing concerning this matter and that at said hearing he would possess the rights to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on his own behalf, to contest the allegations, to present oral argument, and to appeal to the courts. Further, Respondent fully understands the nature, qualities and dimensions of these rights. Respondent understands that by signing this Consent Order, he waives these rights as they pertain to the misconduct described herein.
20. This Consent Order shall take effect as an Order of the Board on the date it is signed by an authorized representative of the Board.

N.H. Board of Medicine and Anton A. Heins, III, M.D
Consent Order
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FOR RESPONDENT

Date: 2-1-10


Anton A. Heins, III, M.D., Respondent

Date: 2/2/10


Counsel for Dr. Heins,
Paul R. Cirel, Esq.

FOR THE BOARD/*

This proceeding is hereby terminated in accordance with the binding terms and conditions set forth above.

Date: 2/9/2010


(Signature)

PENNY TAYLOR
(Print or Type Name)
Authorized Representative of the
New Hampshire Board of Medicine

/* Amy Feitelson, MD, Board member, recused.

Before the
New Hampshire Board of Medicine
Concord, New Hampshire

In the Matter of:

Docket #: 13-04

ANTON HEINS, III, M.D.
License No.: 12382
(Show Cause Proceeding)

FINAL DECISION AND ORDER

Before the New Hampshire Board of Medicine ("Board") is a show cause proceeding in the matter of Anton Heins, III M.D. ("Respondent" or "Dr. Heins") for license reinstatement. The issue before the Board is whether Respondent possesses the appropriate character and competency to possess a New Hampshire license. After a hearing on May 7, 2014, held at the Board of Medicine on Fruit Street in Concord, the Board finds and states the following:

I. Background Information and Procedural History

Respondent first obtained his license to practice medicine in New Hampshire in July 2004. In October 2007, following receipt of a complaint of professional misconduct, the Board began an investigation which ultimately led to additional complaints and a New Hampshire license suspension for a five year period, by consent agreement ("Agreement" or "Consent Order") dated February 9, 2010.

On August 25, 2009, prior to the New Hampshire suspension, Dr. Heins pled guilty to a misdemeanor level unsworn falsification charge in Merrimack County Superior Court for submitting a false claim to the State's Medicaid program. He likewise settled with the State, agreeing to pay \$43,536.60 on allegations that he improperly billed the Medicaid program and that he improperly collected cash payments from Medicaid beneficiaries.

The February, 2010 Agreement allowed Respondent to petition for a stay of the last three years of suspension, after one year from the effective date of the Agreement. Additionally, the Agreement required Respondent to certify that he would conduct his practice in accordance with

Board-approved compliance and monitoring, as well as contract with a compliance monitor. *See* Consent Order, pp. 15-26. The Consent Order additionally imposed a \$10,000 administrative fine against Dr. Heins, based on evidence related to his care of patients and his record keeping practices. The Consent Order, by its terms, did not address, settle or resolve Dr. Heins' conduct related to billing under the Medicaid program and of Medicaid beneficiaries.

In February 2010 Respondent, moreover, voluntarily surrendered his license to practice medicine in Massachusetts in lieu of going through a disciplinary proceeding there. He likewise surrendered his American Board of Internal Medicine Certification.

Respondent's New Hampshire medical license lapsed on June 30, 2010, during the suspension period. On July 6, 2010, the Board sent Dr. Heins a letter reminding him that his license had lapsed, and that he had until September 28, 2010 to renew it. The letter made clear that if his license was not renewed by the date specified, he would need to file for reinstatement pursuant to N.H. Admin. Rule Med 301.04. Respondent did not attempt to renew his license by the deadline.

At the end of December 2010, Dr. Heins entered into a Settlement Agreement with the Massachusetts Executive Office of Health and Human Services in which he agreed to pay \$40,000 for allegedly improperly billing under laws governing the MassHealth program. In April 2011, Dr. Heins next surrendered his license to practice medicine in New York rather than face disciplinary proceedings. The next year, on March 26, 2012, Dr. Heins surrendered his DEA license/registration.

After serving two (2) years of his suspension, Respondent applied for a stay of his suspension. The Board reviewed his request on September 5, 2012 at its monthly meeting and in an Order dated September 11, 2012, granted the stay, thereby lifting the suspension. *See* Board

Order in Docket 09-01, dated September 11, 2012. Respondent's license, however, had lapsed at that time.

The Board received an application for reinstatement of license to practice medicine from Dr. Heins on January 2, 2013. The Board initially considered the application but noted that the application was incomplete as it failed to include a letter from the New Hampshire Medical Review Society stating that Respondent had met the Continuing Medical Education ("CME") criteria. The Board received verification from the Medical Review Society on March 1, 2013.

As such, the application was deemed complete on that day and in its next regularly scheduled meeting, on March 6, 2013, the Board reviewed the application and agreed that an investigation was necessary under Board rules and laws to determine whether Respondent had the necessary character and competency requirements for license reinstatement pursuant to RSA 329:14. Based upon the information provided in the Respondent's application (including a four page Addendum attached to it which admitted that Respondent's prescribing practices and recording keeping had been previously poor) and obtained during the investigation, the Board voted on July 3, 2013 to issue a Notice of Hearing to Show Cause pursuant to Medical Administrative Rule ("Med") 301.04(e). *See* Show Cause Notice dated July 23, 2013.

The Notice scheduled a hearing for Wednesday, August 7, 2013, at 3:00 pm. for Respondent to show that he possesses the necessary character and competency under RSA 329:14 and Med 301.04(e) to reinstate his license. Respondent was reminded that he had the burden of proof in the matter.

Respondent, along with Hearing Counsel, asked for a continuance on July 26, 2013 until on or after October 2, 2013. The assented to motion was submitted by Brendan Mitchell, Esq., Respondent's former counsel. The Board issued an Order on July 31, 2013, granting the continuance and rescheduling the hearing to December 4, 2013 at 1 pm. A prehearing conference was scheduled for November 18, 2013. Additional continuances were sought and granted for

hearings scheduled in December and March. *See* Orders dated Nov. 25, 2013 and Feb. 13, 2014.

Due to this history, Respondent has not had an active NH license for four and a half years – just six months shy of the maximum five year suspension.

During the pre-hearing phase, the Parties engaged in discovery and filed Motions to Compel Production of Documents and a Further Motion to Compel Production of Documents. The hearing took place on May 7, 2014. Prior to the hearing, the attorneys from the Administrative Prosecution Unit submitted a prehearing Memorandum of Law, dated April 30, 2014. Respondent's counsel also filed a Memorandum of Law, dated May 2, 2014.

Following the hearing, Respondent presented the Board with a letter dated June 3, 2014 advising that the NH Professionals Health Program (NHPHP) could monitor his practice and report on such practice as required by the Board.

II. May 7, 2013 Hearing

The hearing was held with the following Board Members in attendance:

Mark Sullivan, P.A., President of the Board
John H. Wheeler, D.O., Vice President of the Board
Robert M. Vidaver, M.D., DHHS Commissioner's Designee
Robert J. Andelman, M.D.
Michael Barr, M.D.
Emily R. Baker, M.D.
Gail Barba, Public Member
Daniel Morrissey, O.P., Public Member
Edmund J. Waters, Jr., Esq., Public Member¹

Respondent was represented by Cinde Warmington, Esq. of Shaheen & Gordon, P.A.

Hearing Counsel from the Office of the Attorney General were Attorney Michelle Heaton and Senior Assistant Attorney General Jeffrey Cahill.

The Parties agreed to the introduction of all exhibits found on their respective lists of witnesses and exhibits. Hearing Counsel submitted the following exhibits:

¹ Mr. Waters served as the presiding officer of the hearing.

1. Complaints received by the New Hampshire Board of Medicine regarding Dr. Anton Heins; including complaints from Mary Anne Agostino dated September 20, 2007; Joan Moquin dated May 15, 2008; Natalie Vuletich dated May 28, 2008; Judith Ward dated June 6, 2008; William L. Wescott received June 30, 2008; and an e-mail from Grafton County Department of Corrections dated May 29, 2008.
2. DEA Reports of Investigation including March 13, 2008 "Anonymous call to the Boston Diversion Office regarding Dr. Anton Heins III;" May 6, 2008 "On-Site Inspection and meeting; and May 12, 2008 "Patient files returned to Anton A. Heins III,"
3. Report of an interview with Dr. Kenneth Slater regarding reports from former patients of Anton Heins, III, M.D., conducted May 27, 2008
4. Report from Dr. Michael McGee regarding review of records of patients of Anton Heins, III, M.D., received June 2, 2008
5. Letter to David A. Garfunkel, Esq. from Philip B. Bradley, Assistant Attorney General dated May 20, 2009 with twenty-seven witness interview reports
6. Unsworn Falsification conviction, August 25, 2009; as well as Press Release from the Attorney General regarding State v. Dr. Anton A. Heins, III dated August 26, 2009; Return From Superior Court in Merrimack County dated August 25, 2009 with information; signed Acknowledgment and Waiver of Rights by Anton Heins dated August 25, 2009; Settlement Agreement with the New Hampshire Attorney General signed by Anton Heins dated September 11, 2009
7. Consent Order with the New Hampshire Board of Medicine dated February 9, 2010
8. Resignation of License to Practice Medicine in Massachusetts signed by Dr. Anton Heins dated February 18, 2010
9. Letter from Board to Dr. Heins dated July 6, 2010
10. Settlement Agreement with the Massachusetts Attorney General and the Massachusetts Executive Office of Health and Human Services signed by Anton Heins on December 1, 2010
11. Anton Heins' Addendum to Application for Reinstatement of Medical License received January 2, 2013

Respondent submitted the following exhibits:

- A. Reinstatement Application dated December 12, 2013
- B. February 9, 2010 Consent Order

- C. Compliance Contract with Affiliated Monitors, Inc. (“AMI”), dated October 12, 2009
- D. Second Amendment to Monitoring Contract – Education Plan, dated March 31, 2012
- E. Correspondence between AMI and Board, dated January 9, 2012
- F. Correspondence between Board and AMI, regarding approval of Compliance Plan
- G. CPEP Assessment, dated August 9-10, 2010
- H. Office Policies and Procedures prepared by AMI
- I. Correspondence from Debbie Waugh of AMI to Board, dated May 25, 2012
- J. The Applied Education Program – Clinical Knowledge, AMI
- K. Spreadsheet of Addiction Medicine Resources
- L. Correspondence from James Anliot of AMI to Board, dated August 21, 2012 re compliance with consent order.
- M. Board Order dated September 11, 2012
- N. CME credits for Dr. Heins
- O. Forensic Professional Fitness to Practice Evaluation, dated April 23, 2104 by Acumen Assessments, LLC.
- P. MRSC Report of Investigation, Complaint #2007-281.
- Q. Addendum to ROI, dated August 25, 2009, September 2009.
- R. MRSC Report of Investigation, Complaint #2013-50

Respondent additionally presented the testimony of Sally Garhart, M.D., Medical Director, NH Professionals Health Program (“NH PHP”) and James Anliot of AMI. He also provided testimony on his own behalf. Hearing Counsel presented the testimony of Dori Lefebvre, Investigator to the Board and Philip B. Bradley, Esq., Assistant Attorney General.

The Board found Dr. Garhart, Ms. Lefebvre and Attorney Bradley to be credible and convincing in their testimony. While Ms. Lefebvre and Mr. Bradley presented facts about Respondent’s past behavior and problems, Dr. Garhart focused more on her recent meeting with

Respondent which occurred in approximately March of 2014. She indicated that while she believed Dr. Heins was incredibly naive, she was struck by his articulate and poised responses in his interview with her and believed that with appropriate monitoring and safeguards Dr. Heins could service a population of patients that would not otherwise receive treatment.

Dr. Garhart testified that she recommended Respondent engage in a forensic evaluation at Acumen Assessments, LLC ("Acumen") for an assessment of his fitness and character to practice. She testified that Acumen was her "provider of choice" and that she prefers to use them to get an accurate sense of the medical professional she is working with. Respondent agreed to the evaluation which occurred during the week of April 7-10, 2014. The evaluation was presented as Respondent's Exhibit O. Dr. Garhart acknowledged that she agreed with the assessment and that she believed it was crucial that appropriate measures be implemented to control Respondent's practice.

Considerable attention during the hearing was focused on Exhibit O and in particular the Acumen recommendations for Dr. Heins' successful practice and best care for his patients. In fact, Exhibit O concludes that in the opinion of the Acumen evaluators, Respondent is "fit to practice medicine," "as long, as he adheres to ... very stringent recommendations. ... Dr. Heins appeared to do well in the past when structure was in place and in order to successfully practice in the future, structure and accountability will be paramount." *See Ex. O, p.14.*

Mr. Anliot of AMI also provided factual testimony about the compliance and monitoring of Respondent and the Office Policies and Procedure Manual found at Exhibit H. Dr. Heins entered into a Compliance Contract with AMI in October of 2009, prior to the imposition of discipline by the Board. Mr. Anliot indicated that he had been working with Dr. Heins for approximately four and one half years and they had established appropriate standards of procedure to be used in the medical office.

In particular, Exhibit H, the Office Policies and Procedures Manual was produced as a guide to promote compliance with applicable state and federal law, as well as to improve the quality of patient care. Additionally, Dr. Heins submitted evidence that the following improvements had been implemented prior to his suspension:

1. Expanded physician notes including a functional assessment at each patient visit including the taking of blood pressure at each visit (Ex S, p. 1-2);
2. Maintaining a record of any prescription written by Dr. Heins including a photocopy of the prescription (Ex S, p. 1-2);
3. The implementation of additional office hours (Ex S, tab B);
4. The implementation of a physician intake; physical exam form (Ex S, tab E);
5. Patient meetings were conducted only on-site (Ex S, p. 1); and
6. Random drug screens were implemented.

Dr. Heins testified about his character and fitness to once again practice and be licensed in New Hampshire. He indicated he graduated from medical school in 1977 and practiced successfully for many years in the area of internal and addiction medicine. Dr. Heins completed his residency in Internal Medicine in 1980. He practiced and served as Medical Director for various addiction treatment programs and had an otherwise essentially unblemished career until he opened a private practice here in New Hampshire in 2004, when complaints started to appear in 2007. Respondent had previously worked in New Hampshire in the mid-1990's without any issue.

Testimony and exhibits presented by Respondent and Mr. Anliot demonstrated that Respondent worked to satisfy the components of the 2010 Consent Order and also underwent a global competency evaluation at the Center for Personalized Education for Physicians. Testimony was presented to also demonstrate that Respondent attempted to fill in any competency gaps.

Ms. Lefebvre and Mr. Bradley provided testimony regarding Respondent's conduct related to his criminal misdemeanor conviction, the allegations that he exchanged prescriptions for money,

his conduct relating to patients he was treating in Massachusetts, prescribing a controlled substance in Massachusetts without a license to do so, and his civil settlement with the New Hampshire Medicaid Fraud Unit. Hearing Counsel's position was that these items, where they had never been part of the basis for the Consent Order, should be taken into consideration when analyzing character and fitness for license reinstatement. *See* Hearing Counsel's Pre-Hearing Memorandum of Law.

Testimony, here, focused on Respondent's failure to properly establish a true physician-patient relationship with most of his patients. Evidence was presented that Dr. Heins' medical records showed little evidence of obtaining a medical history, making a diagnosis, documenting a treatment plan, or documenting the prescribing of drugs. In some cases, Respondent only met with patients, in public places, briefly before prescribing a controlled substance. The testimony also established that Respondent was treating far more patients than appropriate under his DEA license, and that those he did treat, he did not take vital signs, request toxicology screenings, or request medical records from a patient's primary care physician. Hearing Counsel attempted to show that evidence from the New Hampshire Medicaid Fraud Unit's investigation also suggested that Respondent was still attempting to treat patients for pain management, after he was forced to reduce the number of patients he treated for opioid addictions.

The Acumen Report, at Exhibit O, addressed some of these issues, citing particular concern of an "unsettling" nature, to include allegations that he exchanged Suboxone prescriptions for money; that he saw upwards of 70 patients a day; and had no formal treatment process for Suboxone patients. Ex. O, pp. 1-2. Acumen requested that Dr. Heins submit to a polygraph examination regarding these issues and he agreed. *Id.*, p. 13. Essentially, Respondent denied all of the following allegations: 1) seeing upwards to 70 patients per day in New Hampshire; 2) agreeing to provide controlled substances for money without a formal treatment process; and 3) meeting patients in a park and charging them \$2500. The so-called forensic polygraph results

indicated Respondent had “no indication of trying to deploy deception” in responding to these questions. The Acumen Report did, however, suggest that Respondent had an “overly-relaxed appreciation of rules and regulations.” *Id.* It also suggested that because of his particular personality traits that he pursue an employed position, rather than self-employed practice. *Id.*, at p. 14.

At the hearing, Respondent persisted in his denial of seeing upwards of 70 patients in a single day and testified that the DEA Report was inaccurate. He suggested that he treated half of his opioid patients less than weekly. Regardless of the testimony and the Acumen recommendation, Dr. Garhart opined, however, that because of his situation Respondent would likely be able to obtain work only as a solo-practitioner.

III. Analysis and Rulings of Law

The question before the Board is whether Respondent possesses the necessary education, character and other professional qualifications to practice medicine and whether any circumstances exist which would be grounds for disciplinary action. *See* RSA 329:14. In making this determination, the Board is free “to consider a broad range of factors bearing on professional competence, including allegations of dishonesty and unprofessional and negligent conduct.” *Appeal of Dell*, 140 N.H. 484, 491 (N.H. 1995). Because RSA 329 was enacted “to protect the public from persons unfit to practice medicine,” the Board, in its discretion, may consider past allegations of negligence and misconduct when determining a physician’s professional competence. *Id.* at 491, 497.

It first must be noted that we are at this stage because the Respondent allowed his license to lapse while he was under suspension in docket 2007-281. Pursuant to RSA 329:16-e, failure to renew a license within the statutory period of time results in the automatic lapse of the license. *See* RSA 329:16-e. Once the license has lapsed, it can only be reinstated upon payment of the reinstatement fee and a showing by the applicant “of such evidence of professional competence as

the board may require.” *Id.* It is Respondent who carries the burden to prove by a preponderance of the evidence that the basis for the original disciplinary action has been satisfactorily remediated, that no additional charges of misconduct are pending, and that he meets all the character and competency requirements of an applicant for initial licensure. N.H. Admin. R. Med 031.04 (e).

Stripped to its core, this case is one where Hearing Counsel contends that Respondent does not possess the necessary character to be reinstated to the practice of medicine given the patient care concerns (particularly patients on Suboxone), inadequate record keeping, inappropriate billing, and limited office appointments. Respondent, on the other hand, contends that while he had a slipshod documentation practice and failed to appropriately bill he has met every requirement the Board imposed through the Consent Order. Respondent further asserts that he has the competence to practice as determined by CPEP and affirmed by the monitor, as well as being found fit to practice by Acumen. He additionally contends that the Board has already acknowledged that he satisfactorily remediated his past practice and actions when it stayed the suspension of his license.

In evaluating character and competence, we evaluate an applicant’s honesty and professionalism. In this instance we reject the notion put forward by Respondent that because he “passed” a polygraph he must be telling the truth. We need not, however, resolve the issue of whether Dr. Heins exchanged prescriptions for cash. Those issues were part of the previous conduct, which while we take into consideration; we do not place all the evidentiary weight. We also reject Respondent’s claims that his memory may be faulty given the passage of time, as well as the claim that he has taken full responsibility for his past conduct. Dr. Heins still contends he simply was over accommodating to his patients’ needs; rather than lazy, excessively casual and unprofessional in the past. That said, his poor judgment and his failure to appreciate regulatory requirements or dismissive attitude towards rules certainly give us pause.

We look nonetheless at his actions in moving forward with monitoring and evaluations as ordered and his willingness to remain under a monitoring program with the NHPHP. While Dr.

Heins' past actions are very troubling, he has been vouched for by Dr. Garhart, for whom we have the utmost respect. Dr. Garhart has expressed her opinion that with appropriate safeguards, Dr. Heins has the ability to successfully provide for his patients. So too, the Acumen Report reflects that when employed in a setting where others have administrative oversight Respondent was able to function well. Acumen opines with direct guidance Respondent is capable of insight and will be able, with oversight, to manage his practice appropriately.

The evidence suggests that Respondent meets the educational and training requirements under New Hampshire law. He previously held a license in New Hampshire, as well as Massachusetts and New York. CPEP has opined that Respondent demonstrated competency in the area of addiction medicine, with a few gaps. A plan of remediation was put in place and with the assistance of AMI, educational objectives were accomplished. The basis for the original discipline has been successfully remediated, based on the information as supplied by AMI. We, likewise, know of no other disciplinary charges currently pending against the Respondent

The question, therefore, is one of character and competence, not in the sense of medical knowledge, but more in the ability to successfully care for his patients by complying with law and regulation and the ethics of billing. In reviewing the evidence, we are not entirely convinced or persuaded that Respondent has either the character or competence to run a successful practice independent of supervision. Consequently, the Board will grant a restricted license on the foregoing basis:

- Respondent will continue to abide by the AMI compliance plan and contract with NPHP.
- All aspects of the compliance program must be maintained for as long as Respondent continues to practice in New Hampshire. Additionally, Respondent will have Dr. Garhart and/or NPHP provide input into his hiring of staff, and he shall hire a fulltime, qualified office manager, knowledgeable with Opioid Addiction Treatment.
- Respondent will have only one commercial office location, where he see patients only at that location. The Policy and Procedure Standards at Exhibit H, reveal that Respondent can come up with a plan of action on this front.

- Follow all practice protocols as provided in the Procedure Manual developed by AMI, and use any new best practice protocols that have been developed after the drafting of the Manual.
- Respondent will be monitored by NHPHP or its equivalent for as long as he continues a New Hampshire practice. He will comply with all recommendations made by the NH PHP. Failure to comply will be considered separate grounds for discipline by the Board.
- Respondent may also provide any other recommendations for solo-practice, which we would need to be approved and adopted by NHPHP.

It is therefore ORDERED, that Respondent be given a Restricted License to practice where he meets the above conditions.

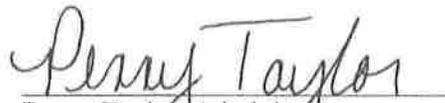
Should Respondent become affiliated with an established medical practice, he will be monitored for one year of that practice, but once no longer employed in a practice with others, monitoring must resume.

IT IS FURTHER ORDERED that the Respondent meaningfully participate in 15 hours of continuing medical education in the areas of (a) medical ethics (including an understanding of what and how one defines a patient-physician relationship under NH law and practice); (b) boundary training and proper prescribing training. These hours shall be in addition to the hours required by the Board for renewal of licensure and shall be completed within one year of the effective date of this Order. If Respondent has already completed coursework in the areas within the last year as described above, Respondent may submit proof of completion of said courses as soon as possible and no later than three months from effective date of this Order. The Board will review the course outlines, and proof of Respondent's attendance at said courses if Respondent has completed any course work prior to issuance of this Order.

IT IS FURTHER ORDERED that this final Decision and Order shall become a permanent part of the Respondent's file, which is maintained by the Board as a public document.

DATED: 8/18/2014

BY ORDER OF THE BOARD*


Penny Taylor, Administrator
Authorized Representative of the
New Hampshire Board of Medicine

*Board Members, Louis Rosenthal, M.D. and Amy Feitelson, M.D., recused.

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