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 docu­
mented 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.

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 or 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.
FOR RESPONDENT

Date: 2-1-10

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

Date: 2-21-10

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

(Pen name)

(Pen name)

AUTHORIZED REPRESENTATIVE OF THE
NEW HAMPSHIRE BOARD OF MEDICINE

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