

An Interview With
Thomas P. Lenox

Supervisory Special Agent,
Drug Enforcement Administration

Interview by Roneet Lev, MD



Part 1

DR. LEV: First of all, thank you for agreeing to be in *San Diego Physician* magazine and helping out the medical community. Why don't you first tell us a little bit about yourself?

MR. LENOX: I'm a supervisory special agent with the Drug Enforcement Administration. I've been with them almost 27 years, and I've worked in San Diego for almost 19 years now. I've had prior assignments in El Paso, Texas, and in Mexico.

For the last five years I've been working as part of a pharmaceutical task force — the first year working investigations and the last four years as the supervisor of that unit. We focus on cases that involve controlled substances only. They can range from people selling pills on the street to employees that are stealing them from a pharmacy or a doctor's office, to patients who are doctor-shopping. We will also do cases on physicians who are abusing their registration numbers, and we've had several doctors who were abusing controlled substances themselves.

My unit is a criminal investigation unit, which is very broad and comprehensive. We also have a regulatory and compliance unit that we work very closely with. If we look into a case targeting somebody who has a DEA registration, there may not be criminal violations, but there may be administrative issues. That ranges from a letter of admonition — which is sort of like a letter of reprimand telling you that you're doing something wrong, what the violations are, that you need to fix them, and you need to notify us how you fixed them. In more egregious cases, a physician can potentially lose their registration, and we'll request a hearing before an administrative law judge to revoke a registration. If we do a criminal case on a registrant, we'll typically try and immediately suspend their registration so they can't prescribe.

One of the things that we're trying to do here in San Diego and in our office is to really work with the physicians in advance so that if we come out and see you, it's not going to be something that's in a negative light. We're going to be working with you to resolve the problems and to solve the issues in advance. We may recommend training or provide you with the necessary information so you don't get caught up in a situation where your registration is at risk.



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DR. LEV: Your involvement in the medical community — is it all going after doctors, or do you have positive interactions with physicians and defend them?

MR. LENOX: We’re very lucky in San Diego because we don’t have the situations that a number of other DEA officers are seeing around the country with pill mills. I think San Diego has a very conscientious, compassionate, and passionate medical community. But there’s a handful that we come across who, for a variety of reasons, take the wrong path. So we do a very small percentage of cases against physicians — one or two criminal cases a year. The majority of what we do is administrative action, typically a letter of admonition notifying a doctor that they’ve done something wrong and they need to fix it, and bring their prescribing practice into compliance with DEA regulations.

REPORT SUSPECTED DOCTOR-SHOPPING

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Give the name of the patient, his or her date of birth, the location of the occurrence, and describe the suspicion.

DR. LEV: But since I met you, my interactions with the DEA have all been positive. You’ve been involved in the Prescription Drug Abuse Task Force. You’ve been active in the Medical Task Force. And you’ve educated physicians that when they get a call from DEA, chances are they’re being called as a victim, and not necessarily as the bad guy.

MR. LENOX: One of the things that we’re trying to do is work more with the medical community. Outside my role as a supervisor of the DEA, I also participate in the Prescription Drug Abuse Task Force and now the Prescription Drug Abuse Medical Task Force. In those roles we can partner with the medical community and let them know what the problems are that we’re seeing in law enforcement with prescription drugs, and how, if we work together, we can hopefully greatly diminish the abuse and addiction of prescription drugs by people in San Diego County. The reception I’ve received from the medical community in San Diego has been great. They’ve been very open and interested in learning what the current trends are, and what’s happening in our community.

There are a few instances where some physicians are a little defensive when we’re going out trying to explain to them that their DEA registration number is being abused or that somebody may have stolen some of their pads — they didn’t realize they were stolen, and they get very nervous. There are some physicians or medical groups that believe that because of HIPAA they can’t discuss things with us. However, when we go out to the community, we’re doing criminal cases, and we’re looking at the physician as the victim — the questions that we’re asking really have no relationship to HIPAA issues.

DR. LEV: So let’s divide this discussion: What happens when DEA calls, and what about HIPAA? If you get a call from a DEA

agent as a physician, what should you expect? Should you be thinking, “Oh my gosh, I’m in trouble. What does this guy want from me?”

MR. LENOX: No. Typically, if we’re calling a doctor, they’re not in trouble. When we do a case against a doctor, we do not call – that would be undercover work. So if we’re calling you, 99% of the time we’re calling you because there is a patient who has come in to see the doctor and is committing fraud, such as lying to the doctor to get prescriptions. They’re abusing the doctor’s DEA registration number, and that’s what we’re trying to find out. We want to be able to talk to the doctor and let them understand that there’s a DEA issue with one of their patients, and figure out the best way to resolve it.

DR. LEV: I’ve actually had that experience. I received a call from a DEA agent asking to meet me, and it was kind of scary. Why is a DEA agent coming to see me in the middle of my shift? Did I do something wrong? However, the agent was very professional, and it took less than five minutes. One time I was shown mug shots and asked if I recognized anyone. Sure enough, I identified a patient I recently saw and prescribed Vicodin. Another time I was asked if I had known my patient had already received prescriptions from five other providers, would I still have written another pain prescription. I simply answered.

MR. LENOX: Yeah, it’s a very simple process. Unfortunately, because of our schedules and the physicians’ schedules, it’s not something where we can always make an appointment in advance, so a lot of times they’re random visits by the agents. Some of the agents will try to call in advance because they know that the physicians are very busy.

We typically will not tell anyone other than the physician why we’re calling. We’re not trying to be disrespectful of the office staff; we’re trying to protect the patient’s privacy. Sometimes we’re referred to a receptionist, a clinic director, or a compliance officer, and we don’t tell them why we’re calling. We’re conducting an investigation and aren’t sure how it’s all going to pan out. So really, other than the investigator and the doctor, there’s no need for us to give information on a patient to

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anybody else. We may never arrest or file charges, and simply close the case. So we don’t want that patient to have a stigma with other people in the office. The patient should still be able to come into their doctor’s office without everybody standing around whispering, “Oh, that’s the one the DEA’s looking at.”

We want to have that respect to both the patient and the physician. But again, we’ll come in, talk to the doctor, ask a half-dozen questions, and then we’re gone. So, five to 10 minutes and that’s about all it takes.

DR. LEV: I would encourage physicians that if they get a phone call from the DEA, don’t be alarmed, just talk to them. It’s a very simple process, and, if anything, it’s interesting to see what is being investigated.

So what should a physician do if called by the DEA about potential prescription drug abuse?

MR. LENOX: DEA agents have the legal right to ask for any information about a prescription and the narcotic being prescribed. A typical initial encounter with a DEA agent is to verify a CURES report – essentially, the agent will work with the physician to validate the prescription. Typical questions include: “Was your DEA registration used?” “Did you write this prescription?” “Was the prescription for this amount?” “Was the prescription for this patient?” “Did you use CURES?” It would be as though the DEA agent handed



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the doctor the CURES report and asked the physician to ensure it was correct. We do not require any HIPAA-related medical information for the CURES conversation. We don't look through a patient's chart. We're just doing an interview of a doctor who's the victim of fraud or theft.

DR. LEV: If a physician suspects doctor-shopping, if they run a CURES report and see that a patient is getting prescriptions at multiple different addresses and different physicians, do you encourage them to report to DEA?

MR. LENOX: First of all, I really encourage all physicians to get access to CURES. It's a very important tool for the physicians because it gives a history of the controlled substances that a patient has been taking.

When physicians have access to CURES and find a pattern of doctor-shopping, there's a couple of things they can do. I'm not opposed to physicians trying to work with the patients and getting them into programs to treat their addiction. Not all patients are ready to go into an addiction program, and some may go in and come out and relapse. We've found that in a number of instances the only way to have patients enter a treatment program is hav-

ing that hammer of the justice system over their head. So they're sort of forced into a program by the justice system, and that's where we step in.

If a physician feels they can't manage the addiction, they absolutely can refer the patient to us. Let us know the situation. It's your patient; you ran CURES; they lied to you; they're not willing to work with you. We will open up a case, and typically what happens is they'll get into the judicial system and end up with court-mandated treatment.

DR. LEV: Is it a HIPAA violation or breaking patient-doctor confidentiality to report a potential prescription drug abuse situation to you?

MR. LENOX: No. All the doctor is saying is, I ran a CURES on this person, here's who the patient is, here's their name and date of birth, and I suspect them to be involved in doctor-shopping, which is criminal activity. It would be as though you saw somebody across the street breaking into a house; you would call the police and say, "I just saw this person, and they look like they were wandering around the house, and they were breaking in." It's suspicious activity, and that's what they're reporting:

suspicious activity to us. There's no HIPAA violation if the only thing being reported is suspicious criminal activity.

DR. LEV: When do HIPAA considerations arise?

MR. LENOX: The operational reality is that if the DEA agent wants additional information from a patient chart, above and beyond the CURES report, they will bring a subpoena or a search warrant – in which case the doctor is compelled to provide the information legally requested without a requirement for a record/account of personal health information (PHI) disclosure.

However, if the doctor *voluntarily* provides information above and beyond the CURES report, then, as in all PHI disclosures, the doctor is required to maintain a record/account of the disclosure. The patient does not have to be notified, but, if requested by the patient, the doctor must provide the patient with an accounting of all PHI disclosures.

DR. LEV: Is it a crime if a patient lies to their physician about opiate use? For example, if they say they haven't received a prescription for Vicodin in the past month, but they have?

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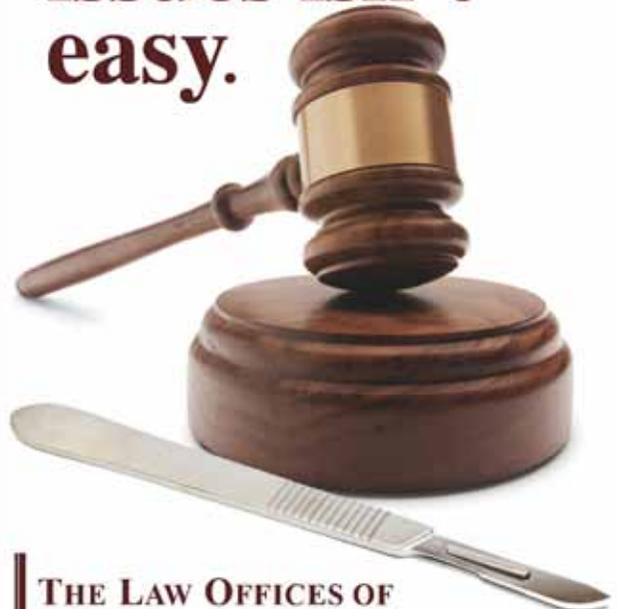


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MR. LENOX: Yes. It's fraud if people lie for the specific purpose of getting drugs that they're addicted to. They're not seeing you to be treated for an injury. They're at the doctor's office to get drugs for addiction, abuse, or diversion. Their purpose for being at the doctor's office isn't true healthcare.

DR. LEV: What should physicians document in their medical records to make such investigations easier? For example, one of the things that I've learned from you is that part of my medication history is to document who gave the patient the medication and when they last received it.

MR. LENOX: Yes, and that helps down the line. The immediate crime is when a patient comes in and you ask them, "Are you taking any pain medication?" and they say no. The personal history is very important for the physician to get. Have you ever been prescribed opiates in the past? Are you seeing any other doctors? We will not ask for a copy of your records, but if a patient is going to commit fraud, and they're going to lie to you, the more detailed their medical history is, the more likely they're going to be lying to you. That's why that's important. The crime we investigate

is prescription fraud – in other words, obtaining drugs from the physician not for the purpose of an injury, but for the purpose of addiction or abuse.

DR. LEV: Is it a crime for someone to take someone else's Vicodin not prescribed to them? Patients often admit, yeah, I've taken a Vicodin, it was my husband's.

MR. LENOX: Yes, they would be illegally in possession of the drug because that person has no right to actually have the drug or to take that drug. This is where it gets a little interesting because if your husband has a pill bottle in the house, it's his pill bottle, and they're in the house. You have access to them, but you're not taking them – they belong to your husband. That is legal. If you now open your husband's pill bottle and start to take them, you are illegally in possession of those pills. They're not yours. You have no right to them, and once you take them, you are illegally in possession of a controlled substance.

DR. LEV: Even if your husband gave them to you?

MR. LENOX: Yes. Well, now you have another problem because the husband is now

distributing drugs illegally. The medication was for his use, and if he gives them to you, then he's committing a crime by giving you drugs, and you're committing a crime for illegal possession. The husband's crime is a bit more serious because distributing drugs is a greater offense than possession of drugs.

DR. LEV: I don't think the public realizes that sharing medications is not just medically unwise, but also a crime.

MR. LENOX: For DEA's purposes we're just looking at the controlled substances, the schedule II through Vs. The truly abused drugs are the IIs and IIIs, a couple of IVs and Vs, but the majority fall within schedule II and III.

Be sure to read Part 2 of this interview in the May issue of San Diego Physician. SDP

Dr. Lev, SDCMS-CMA member since 1996, is the current director of operations for the Scripps Mercy Hospital Emergency Department, current chair of the SDCMS Emergency Medicine Oversight Commission (EMOC), and past president of the California chapter of the American College of Emergency Physicians (CAL/ACEP).



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