BEFORE THE ARIZONA REGULATORY BOARD
OF PHYSICIAN ASSISTANTS

In the Matter of:

NATHANIEL A. WELLY, PA-C

Holder of License No. 3406
For the Performance of Healthcare Tasks
In the State of Arizona

Case No. PA-20-0094A, PA-21-0012A, PA-21-0047A, PA-21-0074A

ORDER FOR LETTER OF REPRIMAND; AND CONSENT TO SAME

Nathaniel A. Welly, PA-C ("Respondent"), elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Regulatory Board of Physician Assistants ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of physician assistants in the State of Arizona.

2. Respondent is the holder of license number 3406 for the performance of health care tasks in the State of Arizona.

3. Respondent's license is subject to terms and conditions of probation as stated in the Board's Findings of Fact, Conclusions of Law and Order for Decree of Censure and Probation with Practice Restriction issued in Case PA-17-0096A ("Prior Order"). The Prior Order required Respondent to undergo periodic chart reviews by a Board approved Monitoring Company.

PA-20-0094A

4. The Board initiated case number PA-20-0094A after receiving notification that Respondent had received an unfavorable chart review from the Monitoring Company. Based on the Monitoring Company's report, Board staff requested Medical Consultant ("MC") review to further address whether Respondent's treatment of two patients met

generally acceptable standards of practice. The MC identified a deviation from the standard of care regarding Respondent's treatment of SW.

5. SW was a 68 year-old male with a past medical history of hypertension, neck and back pain, Crohn's disease, cervical spine facet arthropathy, and a distant smoking history followed intermittently in the clinic since 2001. Respondent saw SW to address complaints of continued decreased range of motion to the neck despite home exercises. prescribed SW medications including metaxalone 800mg twice daily, Tizanidine 4mg twice daily, and Tramadol 50mg four times daily.

6. The MC opined that Respondent's medical records were 'copy and paste' and did not reflect changes from visit to visit.

7. The standard of care requires a physician assistant to perform urinary drug screens on patients prior to prescribing controlled substances. Respondent deviated from this standard of care by failing to perform urinary drug screens prior to prescribing controlled substances.

8. The standard of care requires a physician assistant to query the controlled substance prescription monitoring program on patients prior to prescribing controlled substances. Respondent deviated from the standard of care by failing to query the controlled substance prescription monitoring program for patient SW prior to prescribing controlled substances.

9. There was potential for patient harm in that SW was at risk for the side effects of opioid medications including addiction and overdose.

PA-21-0012A

10. The Board initiated case MD-21-0012A after receiving notification that Respondent had received an unfavorable chart review from the Monitoring Company. Based on the Monitoring Company's report, Board staff requested Medical Consultant

("MC") review to further address whether Respondent's treatment of three patients ("AC" "RC" and "LM") met generally acceptable standards of practice.

11. AC was a 47 year-old female with a past medical history ("PMH") of morbid obesity, gastroesophageal reflux disease ("GERD"), hypothyroidism, hyperlipidemia, asthma, migraines, tobacco use, and kidney stones with recurrent urinary tract infections ("UTIs") who was an established patient of the clinic. Respondent prescribed AC medications including hydrocodone-acetaminophen 7.5/325mg three times daily, Tizanidine 4mg three times daily, gabapentin 800mg three times daily, Ibuprofen 600mg three times daily, and Ibuprofen 800mg three times daily.

12. Respondent saw AC on August 4, 2020, for follow up before starting pulmonary rehabilitation the next day. AC endorsed shortness of breath but denied difficulty breathing at night or dyspnea on exertion. Respondent noted prescriptions for hydrocodone-acetaminophen and ibuprofen to address flank pain

13. On September 3, 2020, AC saw Respondent with complaints of severe reflux, sharp abdominal pain, nausea and vomiting, and inability to keep anything down including water. Respondent instructed AC to implement a BRAT diet and to try medications for GERD. Respondent ordered an EGD and imaging and documented that there was most likely no internal bleeding.

14. On September 5, 2020, AC was hospitalized and underwent surgery for a pleural empyema due to misplacement of a urinary stent and a GI bleed requiring transfusions.

15. On September 14, 2020, Respondent saw AC and prescribed Tizanidine and escitalopram.

16. On September 18, 2020, AC presented to Respondent for wound care following surgery. Respondent instructed AC to continue to use her oxygen and pain medications.

17. AC continued to see Respondent through December 9, 2020. Records for that visit indicate that Respondent continued to prescribe AC ibuprofen, hydrocodone-acetaminophen and gabapentin.

18. RC was a 70 year-old male with a PMH of osteoarthritis, hyperlipidemia, migraines, and current tobacco use who was an established patient of the clinic, and being treated by both Respondent and his Supervising Physician. Respondent prescribed RC medications including oxycodone-acetaminophen 5/325mg three times daily and pentazone-naloxone 50-0.5mg three times daily. In November 2020, RC was seen by Respondent for a new pulmonary lesion found on CT for chest pain after a fall and suspected fractured ribs. RC was subsequently diagnosed with Adenocarcinoma of the left lung, stage IV and referred to specialty care.

19. LM was a 63 year-old male with a PMH of degenerative joint disease and diabetes mellitus who had previously established care in the clinic with Respondent in June 2018. Respondent prescribed LM medications including hydrocodone-acetaminophen 10/325mg three times daily, metformin, Lantus, Januvia, and Tradjenta.

20. On October 8, 2020, LM presented for his annual physical and medication refill of hydrocodone. LM had just returned from a Reservation in South Dakota and had not been seen since May 2019. LM had recently undergone surgery on his heel and was on pain medication from the Indian Health Service and "not needing refills" as they had provided a 90 day supply. A CAGE assessment was negative. The CSPMP report shows a prescription for hydrocodone-acetaminophen 10/325mg #15 on this date.

Deviations from the Standard of Care

21. The standard of care requires a physician assistant to recognize the signs and symptoms of emergent medical issues. Respondent deviated from the standard of care by failing to urgently refer AC to a higher level of care when she demonstrated signs and symptoms of a GI bleed.

22. The standard of care requires a physician assistant to address hypoxemia. Respondent deviated from the standard of care by failing to address AC's hypoxemia.

23. The standard of care prohibits a physician assistant from prescribing Ibuprofen above the maximum recommended dosage without a clinical rationale. Respondent deviated from the standard of care by prescribing Ibuprofen to AC above the maximum recommended dosage without a clinical rationale.

24. The standard of care prohibits a physician assistant from prescribing hydrocodone-acetaminophen without clinical justification. Respondent deviated from the standard of care by prescribing hydrocodone-acetaminophen to AC without clinical justification.

25. The standard of care prohibits a physician assistant from prescribing medications with significant drug interactions. Respondent deviated from the standard of care by concurrently prescribing two opioids with significant drug interactions to Patient RC.

26. The standard of care requires a physician assistant to refer a patient for specialty consultation. Respondent deviated from the standard of care by failing to refer Patient RC to a neurologist for complaints of persistent migraines.

27. The standard of care prohibits a physician assistant from prescribing opioids to a patient with a supply of opioids prescribed by another provider. Respondent deviated

from the standard of care by prescribing hydrocodone to LM when the patient already had opioids prescribed by another provider.

28. The standard of care requires a physician assistant to perform urinary drug screens prior to prescribing controlled substances. Respondent deviated from the standard of care by failing to perform urinary drug screens prior to prescribing controlled substances to Patient LM.

29. The standard of care requires a physician assistant to query the controlled substance prescription monitoring program on patients prior to prescribing controlled substances. Respondent deviated from the standard of care by failing to query the controlled substance prescription monitoring program on patients prior to prescribing controlled substances to Patient LM.

30. There was actual patient harm in that AC experienced an acute GI hemorrhage requiring hospitalization and multiple blood transfusions. Patient RC experienced prolonged suffering due to inappropriately treated migraines as well as a fall. There was potential for patient harm in that AC was at risk of death, myocardial infarction, stroke, renal failure, falls, infectious diseases and reaction to transfusion. Patient RC was at risk of physical dependence, addiction, withdrawal, falls, and suppression of the immune and endocrine system. LM was also at risk of overdose.

PA-21-0047A

31. The Board initiated PA-21-0047A after receiving notification that Respondent had received an unfavorable chart review from the Monitoring Company. Based on the Monitoring Company's report, Board staff requested Medical Consultant ("MC") review of Respondent's care and treatment of four patients (PM, KN, NR and BD). The MC found that Respondent met the standard of care, but identified medical recordkeeping deficiencies with regard to all four patients.

32. PM was an established patient of the clinic who was most recently seen for medication management of osteoarthritis and treatment of chronic urinary tract infection symptoms. The MC noted insufficient documentation regarding physical examination findings, as well as incongruent assessment and plan information. Additionally, although Respondent reported that a specialist was managing the patient's UTI symptoms, the MC noted that Respondent did not document that information in the chart.

33. KN was an established patient of the clinic with a past history of supernumerary kidney and back pain, who was most recently seen by Respondent to request an MRI for evaluation of persistent back pain, abdominal bloat and discomfort. The MC noted that Respondent's documentation of his evaluation, plan and thought process was unclear, and lacked a differential diagnosis.

34. NR was a female patient who established care with the clinic in 2018. Respondent saw the patient on December 2, 2020, for an annual physical examination. The MC noted that Respondent did not document wellness recommendations in the chart, and recommended that Respondent's documentation be more specific.

35. BD was a male patient who established care with the clinic in January, 2021, and was being treated for left knee pain and anxiety. Respondent saw BD on May 17, 2021, for a refill of his alprazolam. Respondent performed depression and anxiety screening and documented discussions including review of BD's Controlled Substance Prescription Monitoring Profile ("CSPMP"), and referral to a psychiatrist for medication weaning. The MC commented that Respondent's documentation regarding these discussions was substandard and lacked information regarding prior treatments for BD's anxiety and alternatives to alprazolam.

PA-21-0074A

36. The Board initiated PA-21-0074A after receiving notification that Respondent had received an unfavorable chart review from the Monitoring Company. Based on the Monitoring Company's report, Board staff requested MC review of Respondent's care and treatment of two patients (MJ and KT). The MC identified deviations from the standard of care regarding Patient MJ, and identified medical recordkeeping deficiencies regarding both patients.

37. Patient MJ was an established patient of the clinic who Respondent had most recently treated MJ for anxiety disorder, hypertension, alcohol use issues, and COVID. On January 8, 2021, MJ saw Respondent and reported being treated at the hospital for alcohol withdrawal with two subsequent weeks of sobriety. MJ requested labs and medication updates. An afternoon Testosterone level was 275 (reference range 250-840).

38. Respondent saw MJ again on February 1, 2021. Respondent informed MJ that he had low testosterone for which MJ requested treatment. Respondent's assessment included hypogonadism/low testosterone. Respondent ordered Testosterone 200mg IM every two weeks.

39. On April 6, 2021, MJ was seen by a physician at the clinic and reported that he was not feeling well and had started drinking a half gallon of alcohol daily. MJ was diaphoretic and reported vomiting. MJ was directed to go to the ER immediately for proper treatment of alcohol withdrawal.

40. Respondent saw MJ again on June 7, 2021. MJ admitted to smoking marijuana. Respondent addressed MJ's alcohol and tobacco abuse and discussed a weight loss program.

41. MJ was seen by Respondent again on July 27, 2021, and requested labs and abdominal imaging as he had started drinking again and was worried about his liver. An abdominal ultrasound showed a mildly enlarged liver without gallstones or ductal dilation.

42. The standard of care requires a physician assistant to obtain at least two low testosterone levels prior to testosterone treatment to diagnose hypogonadism. Respondent deviated from this standard of care by prescribing testosterone therapy for hypogonadism without documentation of at least two low testosterone levels.

43. There was potential for patient harm in that MJ was at risk of adverse events from the testosterone therapy including increased risk of blood clots, heart attack, and stroke.

44. Patient KT was an established patient of the clinic that Respondent had most recently seen for medication management of depression and anxiety symptoms. The MC opined that Respondent met the standard of care but found that one of Respondent's office visit notes was incomplete.

PA-21-0074A

45. The Board initiated PA-21-0074A after receiving notification that Respondent had received an unfavorable chart review from the Monitoring Company. Based on the Monitoring Company's report, Board staff requested MC review of Respondent's care and treatment of two patients (MJ and KT). The MC identified deviations from the standard of care regarding Patient MJ, and identified medical recordkeeping deficiencies regarding both patients.

46. Patient MJ was an established patient of the clinic who Respondent had most recently treated MJ for anxiety disorder, hypertension, alcohol use issues, and COVID. On January 8, 2021, MJ saw Respondent and reported being treated at the

hospital for alcohol withdrawal with two subsequent weeks of sobriety. MJ requested labs and medication updates. An afternoon Testosterone level was 275 (reference range 250-840).

47. Respondent saw MJ again on February 1, 2021. Respondent informed MJ that he had low testosterone for which MJ requested treatment. Respondent's assessment included hypogonadism/low testosterone. Respondent ordered Testosterone 200mg IM every two weeks.

48. On April 6, 2021, MJ was seen by a physician at the clinic and reported that he was not feeling well and had started drinking a half gallon of alcohol daily. MJ was diaphoretic and reported vomiting. MJ was directed to go to the ER immediately for proper treatment of alcohol withdrawal.

49. Respondent saw MJ again on June 7, 2021. MJ admitted to smoking marijuana. Respondent addressed MJ's alcohol and tobacco abuse and discussed a weight loss program.

50. MJ was seen by Respondent again on July 27, 2021, and requested labs and abdominal imaging as he had started drinking again and was worried about his liver. An abdominal ultrasound showed a mildly enlarged liver without gallstones or ductal dilation.

51. The standard of care requires a physician assistant to obtain at least two low testosterone levels prior to testosterone treatment to diagnose hypogonadism. Respondent deviated from this standard of care by prescribing testosterone therapy for hypogonadism without documentation of at least two low testosterone levels.

52. There was potential for patient harm in that MJ was at risk of adverse events from the testosterone therapy including increased risk of blood clots, heart attack, and stroke.

53. Patient KT was an established patient of the clinic that Respondent had most recently seen for medication management of depression and anxiety symptoms. The MC opined that Respondent met the standard of care but found that one of Respondent's office visit notes was incomplete.

Additional Facts

54. As identified in the Prior Order, Respondent voluntarily completed the 8 hour DATA waiver training course on July 28, 2018 as well as five hours of online continuing medical education ("CME") in controlled substance prescribing. Additionally, on September, 28-29, 2019, Respondent completed an intensive, in-person controlled substance prescribing course for an additional 21 CME credit hours.

55. On March 12, 2021, Respondent completed an intensive, in-person CME course in medical recordkeeping pursuant to the Board's Order for Continuing Medical Education (Non-Disciplinary) issued in PA-20-0040A, PA-20-0048A and PA-20-0055A.

56. Additionally, Respondent reported implementation of a new electronic medical record program, after which, improvements to Respondent's documentation were noted.

57. The Board initiated case PA-21-0100A after receiving notification that Respondent had received an unfavorable chart review from the Monitoring Company. Based on the Monitoring Company's report, Board staff requested ("MC") review to further address whether Respondent's treatment met the standard of care. The MC reviewed Respondent's care and treatment of two patients and found that Respondent met generally acceptable standards of care. The Board considered the case at its August 24, 2022 meeting and voted to dismiss PA-21-0100A.

58. The Board initiated case PA-22-0042A after receiving notification that Respondent had received an unfavorable chart review from the Monitoring Company.

Based on the Monitoring Company's report, Board staff requested MC review of Respondent's care and treatment of one patient. The MC reviewed the case and determined that Respondent met the standard of care, with minor recommendations regarding documentation of the patient's care plan.

59. At the Board's November 9, 2022 Board meeting, the Board voted to dismiss MD-22-0042A, and terminate the probation in the Prior Order.

CONCLUSIONS OF LAW

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

2. The conduct and circumstances described in PA-20-0094A, PA-21-0012A and PA-21-0074A above constitute unprofessional conduct pursuant to A.R.S. § 32-2501(18)(j) ("Committing any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.").

3. The conduct and circumstances described in PA-20-0094A, PA-21-0012A, PA-21-0047A and PA-21-0074A above constitute unprofessional conduct pursuant to A.R.S. § 32-2501(18)(p) ("Failing or refusing to maintain adequate records on a patient.")

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand;

DATED AND EFFECTIVE this 9th day of November, 2022.

ARIZONA REGULATORY BOARD
OF PHYSICIAN ASSISTANTS

By
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent in this Order are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Notwithstanding any language in this Order, this Order does not preclude in any way any other State agency or officer or political subdivision of this state from instituting proceedings, investigating claims, or taking legal action as may be appropriate now or in the future relating to this matter or other matters concerning Respondent, including but not limited to, violations of Arizona's Consumer Fraud Act. Respondent acknowledges that, other than with respect to the Board, this Order makes no representations, implied or otherwise, about the views or intended actions of any other

state agency or officer or political subdivisions of the State relating to this matter or other matters concerning Respondent.

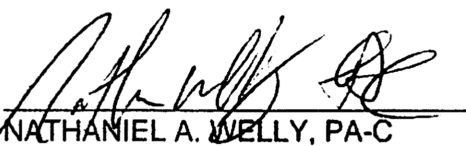
7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

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

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

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

11. ***Respondent has read and understands the terms of this Agreement.***



NATHANIEL A. WELLY, PA-C

DATED: 11-1-2022

1 EXECUTED COPY of the foregoing mailed
this 9th day of November, 2022 to:

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3 Nathaniel A. Welly, PA-C
Address of Record

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Scott Hergenroether, Esq.
5 The Ledbetter Law Firm
1003 North Main Street
6 Cottonwood, Arizona 85326
Attorney for Respondent

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8 ORIGINAL of the foregoing filed
this 9th day of November, 2022 with:

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10 Arizona Regulatory Board
of Physician Assistants
11 1740 West Adams, Suite 4000
Phoenix, Arizona 85007

12 Michelle Robles
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13 Board staff

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