

IN THE MATTER OF  
NICOLA M. TAURASO, M.D.

Respondent

License Number: D11324

\* \* \* \* \*

\* BEFORE THE  
\* MARYLAND STATE  
\* BOARD OF PHYSICIANS  
\* Case Numbers: 2010-0329  
\* & 2010-0922  
\* \* \* \* \*

**ORDER FOR SUMMARY SUSPENSION  
OF LICENSE TO PRACTICE MEDICINE**

The Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of Nicola M. Tauraso, M.D., (the "Respondent") (D.O.B. 11/05/1934), license number D11324, to practice medicine in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Govt Code Ann. § 10-226(c)(2009 Repl. Vol.) concluding that the public health, safety or welfare imperatively requires emergency action.

**INVESTIGATIVE FINDINGS**

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:<sup>1</sup>

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was

---

<sup>1</sup> The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

originally licensed to practice medicine on Maryland on September 16, 1966.

2. The Respondent is board-certified in pediatrics. The Respondent practiced as a pediatrician from 1972 to 2007. In 2007, the Respondent went to Panama. Upon his return to Maryland in the late summer of 2009, he commenced the practice of pain management. The Respondent maintains an office for the practice of pain management in a converted barn on his residential property located at 7051 Poole Jones Road in Frederick, Maryland.

- I. **Procedural Background**

3. On or about October 26, 2009, the Board received a written complaint from a pharmacist in which he stated he had "serious concerns" regarding the Respondent's prescribing practices. Specifically, the pharmacist ("Pharmacist A") noted that he recently had been seeing prescriptions written by the Respondent for OxyContin, a Schedule II Controlled Dangerous Substance ("CDS"), in high dosages and quantities. The patients who presented the prescriptions were "from all over including western Maryland." Pharmacist A reported that he had received an inquiry from a pharmacist in Bethesda, Maryland who had similar concerns regarding the Respondent. The Board designated this complaint as Case Number: 2010-0329.
4. On or about June 7, 2010, the Board received a referral from the State Division of Drug Control that supported the allegation that the Respondent

prescribed excessive quantities of narcotics. In the referral, a pharmacist ("Pharmacist B") provided a print-out of all of the prescriptions written by the Respondent since January 2010. Pharmacist B noted that the Respondent's patients lived "some distance" from the pharmacy. The Board designated this complaint as Case Number 2010-0922.

### **INVESTIGATIVE FINDINGS**

#### **I. Board Investigation**

5. In furtherance of its investigation of the Respondent's prescribing practices, the Board obtained pharmacy surveys from several pharmacies and information from the Frederick County Narcotics Task Force ("FCNTF") and the U.S. Drug Enforcement Administration ("DEA") regarding those agencies' investigations of the Respondent. On June 22, 2010, Board staff conducted an unannounced on-site visit of the Respondent's medical office, during which 18 patient records, selected at random from the pharmacy surveys, were obtained. The Respondent certified that the patient records he had provided were complete. On June 28, 2010, Board staff interviewed the Respondent. On July 8, 2010, the Respondent submitted to the Board a "Case Summary" and a supplemental physical examination form for each of the patients, which he stated contained "more detailed physical examination forms which better reflect the original examinations of the patient." The Board thereafter transmitted its investigative material for an expert opinion whether, *inter alia*, the Respondent's prescribing practices raise a substantial likelihood

of risk of serious harm to the public health, safety or welfare of patients in Maryland.

**A. Frederick County Narcotics Task Force ("FCNTF")**

6. In or around November 2009, FCNTF received complaints from several pharmacies regarding the Respondent's prescribing practices. The complaints focused on the excessive number of prescriptions the Respondent wrote for Schedule II CDS, including OxyContin 80 mg<sup>2</sup> and oxycodone. Some of the pharmacists noted that the Respondent rarely wrote a prescription for any other type of drug than Schedule II CDS. The Respondent's prescriptions were often written for hundreds of tablets. In addition, concern was expressed that the vast majority of the Respondent's patients who presented the prescriptions were males in their 20's and early 30's who appeared healthy and did not appear to be terminally ill, and that almost all of them paid for the prescriptions in cash. Many of the local pharmacies had stopped filling prescriptions written by the Respondent because of suspicions regarding his practice.
7. A FCNTF confidential informant reported that upon his/her initial visit, the Respondent conducted a physical examination that consisted of the Respondent taking his/her blood pressure and poking him/her and asking if it hurt. The Respondent did not conduct any examinations after the first visit.

---

<sup>2</sup> OxyContin 80 mg, the second highest unit dosage available, is intended for use only in opioid-tolerant patients. The Physicians' Desk Reference ("PDR") contains the warning that this table strength may cause fatal respiratory distress when administered to patients not previously exposed to opioids. Moreover, it is advised that patients be instructed against use by other individuals as such "inappropriate use may have severe medical consequences, including death."

8. FCNTF made a controlled buy of OxyContin from one of the Respondent's patients. The Respondent had prescribed the OxyContin to the patient. The patient revealed the Respondent writes the same prescription at every visit: 150 oxycodone tablets and 45 OxyContin tablets.
9. Other confidential sources provided FCNTF with the names of other patients of the Respondent who sold/distributed some or all of the Schedule II drugs the Respondent had prescribed to them.

**B. DEA**

10. In late 2009, DEA agents joined FCNTF in an investigation of the Respondent, among others. Information provided to the Board included controlled buys by confidential sources of Schedule II drugs prescribed by the Respondent from various patients to whom he had prescribed the drugs.
11. With regard to the Respondent's prescribing practices, some of the Respondent's patients who were interviewed by FCNTF/DEA reported that after the first visit to the Respondent, the Respondent did not conduct examinations of them; the Respondent would see the patients in his office rather than the examination room. The Respondent would ask the patient how the medication he had previously prescribed was working and often increased the amount he prescribed based on the patient's report.
12. One patient/confidential source reported that after the initial visit with the Respondent, the Respondent offered to increase the patient's prescription for OxyContin.

13. Another patient/confidential source reported that all the visits with the Respondent were the same; the patient is in and out without an examination and that the Respondent prescribes whatever the patient asks for.
14. Yet another patient/confidential source reported that he/she had informed the Respondent that he/she was addicted to narcotics, had undergone drug rehabilitation and wanted to be weaned of Schedule II CDS. The Respondent nevertheless increased the number of oxycodone tablets he prescribed over 5 monthly visits from an initial prescription of 180 tablets, to 240 tablets and finally to 360 tablets. The patient reported that when the Respondent prescribed 360 tablets, he told the patient that they would have to last until the following month's visit.
15. DEA/FCNTF interviewed several local pharmacists, all of whom expressed concerns regarding the large quantities of narcotics the Respondent prescribed to young patients who appeared healthy. One pharmacist reported that the Respondent had written some of his prescriptions for 300 to 400 tablets of OxyContin 80 mg. Most of the pharmacists had notified the Respondent that they were no longer filling the prescriptions he wrote. Two of the pharmacists reported that when they complained to the Respondent regarding the excessive quantity of narcotics he prescribed, the Respondent responded that he was working with FCNTF.
16. In January 2010, DEA/FCNTF agents met with the Respondent to discuss the complaints that had been received about the Respondent's practice.

The Respondent told the agents that he had attended medical school, but had never been taught how deceptive patients are in order to obtain drugs. The Respondent stated that patients had tricked him in the past, but now he knew how to check to see if a patient was lying. The Respondent complained that he was upset that pharmacies were not filling his prescriptions, stating the pharmacies had no right to refuse to fill them or to ask for his diagnosis.

17. During the meeting, the DEA/FCNTF agents suggested that the Respondent surrender his registration to write prescriptions. The Respondent refused, stating that to do so would take away his livelihood. The agents then suggested that the Respondent relinquish his registration to write Schedule II CDS. The Respondent again refused, stating that he was helping a lot of people. The Respondent stated that other physicians were not prescribing Schedule II CDS because they were concerned about their liability and the DEA. The Respondent further stated that he was not afraid of the DEA because he was doing nothing wrong.
18. At the conclusion of the meeting, the Respondent was once again asked to consider surrendering his DEA registration. The Respondent again refused stating that it would be very difficult, if not impossible, to get his registration reinstated if he surrendered it. He further stated that if he stopped practicing medicine that his patients would go elsewhere and the problem would not end.

19. Throughout the meeting, the agents noted that the Respondent did not take responsibility for the dosage amounts or quantities of narcotics he prescribed; the Respondent focused the blame on his patients.

**C. Board Staff On-Site Visit**

20. During Board staff's June 22, 2010 unannounced on-site visit, staff observed that the parking lot adjacent to the Respondent's office contained numerous parked cars, some with occupants, and individuals were loitering around the parking lot and the entrance to the office. Most of the individuals observed by Board staff appeared to be in their twenties.
21. The Respondent's staff consisted of 2 males between 20 and 30 years of age who were dressed in jeans and t-shirts and a female who wore scrubs. The Respondent introduced another male, also between 20 and 30 years old, as "security" for the parking lot and the Respondent's "personal bodyguard."
22. Board staff photographed the Respondent's office including, *inter alia*, a sign on the entry door that reads in pertinent part:

Fee Schedule Increase

We are sorry to inform all our patients that due to the increased costs of additional personnel and legal representation coming as a result of harassment by the DEA and local law enforcement we are very reluctantly forced to increase our fees. The following fees will be effective on 9 June 2010.

New patients (effective immediately) \$300.00

Established patients \$200.00

23. During the visit, the Respondent remained seated in his office; he raised his voice to summon various staff to his office. The Respondent was wearing a hospital band on his left wrist; his hands were trembling. He stated that he had had a pacemaker put in on the previous Friday at a local hospital.
24. The Respondent told Board staff that he employs patients while continuing to treat and prescribe to them, but does not give them a discount on their visits. He further stated that he changes staff every week.
25. The Respondent also told Board staff that he had started practicing pain management approximately 1 year ago and had training in that area.
26. The Respondent stated that he requires patients to bring in an MRI, but that some patients falsify the reports.
27. In response to Board subpoenas, the Respondent provided a list of his employees and appointment logs. The Respondent asked for additional time to provide the subpoenaed patient records and Board staff left the office for approximately 1½ hours. Upon their return to the office and inspection of the patient records provided by the Respondent, Board staff observed that many of the records had been altered with white-out, which was still damp and tacky.
28. The Respondent signed a certification that the records he provided to Board staff were complete.
29. On June 27, 2010, prior to the Respondent's interview with Board staff, the Respondent e-mailed to Board staff material including a 3-page

document dated June 23, 2009 entitled, "Open Letter to Local Pharmacists." The document states in pertinent part:

...This letter is directed to local pharmacists, especially to clear the air about misconceptions about me and my practice of Pain Management.

...To set the record straight, our Pain Management Clinic is managed with some of the strictest controls. We accept transfers from other clinics only to drop them when we discover that their back-up documents (MRI's, X-rays, CAT scans) were forged.

...We are collecting a list of pharmacists who persist in telling our patients unfounded rumors...Our lawyers plan to take legal action against these individuals. Although libel may not be the issue, character assassination and damage to my reputation will be the rule. We will also be holding the pharmacies accountable for having such ignorant individuals on their staff. We are serious and will not stop until we get appropriate retribution.

...We physicians have the responsibility to try to make our serious pain management patients more comfortable...The DEA people, and might I add pharmacists, have no such responsibility. More and more physicians cease prescribing Opioids (*sic*) not because their patients do not need them, but because they wish not to deal with the harassing Federal People who, quite frankly, should stay out of the practice of medicine.

...we resent the DEA interfering in our practice of medicine. They do not have the medical degrees I have. They should keep out of the practice of medicine as we will promise to stop arresting criminals on the street! We try our best to improve the lives of individuals suffering from severe intractable pain. Do the DEA people – or the pharmacists for that matter – have any such responsibility? No, they do not. Physicians who know what they are doing should prescribe. Pharmacists should fill scripts, mind their own business, and stop practicing medicine....

**D. The Respondent's Interview**

30. On June 28, 2010, Board staff interviewed the Respondent at the Board's offices. With regard to his practice of pain management, the Respondent advised that "about a year ago I got very much interested in pain.

management, took some courses, and I studied pain management in depth." The Respondent stated that prior to commencing his pain management practice in August or September of 2009, he had no training in this area other than his "general medical knowledge" and took his first formal course, an Audio-digest course, which he described as "quite extensive," in the fall of 2009.

31. According to the Respondent, 95% of his patients see him for pain management. He stated that he sees from 20 to 50 patients a day. Review of the Respondent's patient appointment logs confirmed the Respondent's higher estimate; patients were scheduled every 15 minutes, and were frequently double-booked in a 15-minute time slot, and were seen often without a break, from 7:00 a.m. to 5:00 p.m. or later on most days.

32. Prior to the Board interview, the Respondent sent to Board staff a document entitled, "Standard Operating Procedure for the Tauraso Medical Clinic," which states in pertinent part:

The [clinic] schedule does not really reflect when patients arrive. Many come in early or late because they know we are usually open or available – sometimes at late as 7:00 PM in the evening.

We will see approximately anywhere from 40 – 50 patients, sometimes more, depending on days that the Doctor might take off to deal with a recently implanted pacemaker, or necessary sick time, as the Doctor is 75 years old with Diabetes and a heart condition.

During the day, although staff might find time to take a lunch break, Doctor Tauraso does not – he works straight through as he is currently the only Medical Doctor on premises and it is

necessary to make sure that each patient get (*sic*) adequate time and attention from the Doctor to care for their needs.

33. In the "Standard Operating Procedure" document, the Respondent claimed that he "currently follow[s] the CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF OPIOD (*sic*) THERAPY FOR CHRONIC PAIN PUBLISHED BY THE DEPT OF VETERANS AFFAIRS, DEPT OF DEFENSE. (Emphasis in original) The Respondent attached the Department of Veterans Affairs ("VA") Guideline (over 50 pages in length) to his transmission.
34. Among the recommendations in the VA Guideline for the "optimal management" of chronic pain is a "comprehensive assessment leading to an individualized treatment approach using a combination of treatment options." Listed among the elements of a comprehensive assessment are: a history of the present illness including a complete pain assessment, which includes the patient's response to past pain treatment, substance abuse history; review of systems; physical examination; mental status examination; review of diagnostic studies and assessment and urine drug screens. As will be detailed in the Expert Opinion and Patient-Specific Findings of Fact sections below, the Respondent's practice fails to conform with most, if not all, of the recommendations of the VA Guideline.
35. During the Board interview, the Respondent acknowledged that he does not document a patient's diagnosis in the patient's chart and conceded that "maybe I should."

36. The Respondent stated that on a patient's first visit, he performs a physical examination to "see if my physical examination findings jive with what the MRI findings are." When asked whether he conducts examinations during subsequent visits, the Respondent stated, "[not necessarily. I just talk to them and review what they put on their [pain scale] charts. The only time I do a physical is if they have a cold, or if they have some other thing, or if a new pain arose."
37. The Respondent further stated that he does not document the rationale for the medications he prescribes because, "I'm settling on a couple of medications that I know work[,] later specifying that he "usually" uses OxyContin, oxycodone and Percocet.<sup>3</sup>
38. The Respondent acknowledged that he prescribed OxyContin 80 mg to patients at their initial visit if the patients reported that that was their current or prior medication regimen. He stated, "[t]hey came in on oxy 80, and I can't drop those people to oxy 40."
39. The Respondent complained that he recently had been "forced to give up" and had stopped prescribing OxyContin 2 weeks before the interview because, "I'm trying to make a deal with the DEA...They want OxyContin off the street. So I made an offer, I'll stop OxyContin if they leave me alone."<sup>4</sup>

---

<sup>3</sup> Oxycodone is the generic name for OxyContin. Percocet, a combination of oxycodone and acetaminophen, is a Schedule II CDS.

<sup>4</sup> Board staff contacted DEA and FCNTF agents to confirm the Respondent's statement; they were not aware of any such "deal" with the Respondent.

40. The Respondent stated that patients are not necessarily referred to him from other physicians and that he does not refer patients for diagnostic testing, with the exception of MRI's.
41. When reviewing the chart of a specific patient, Patient J, below,<sup>5,6</sup> the Respondent acknowledged he had begun prescribing the patient OxyContin 80 mg, 3 times a day, and oxycodone 30 mg as of Patient J's initial visit in October 2008 based on the patient's report that this was his prior medication regimen.<sup>7</sup> Patient J's chart contained prior medical records dating from January to May, 2002 and an MRI report dated December 20, 2008, the results of which revealed no degenerative changes, possible minimal compression in 1 of the lower thoracic bodies, but otherwise no fracture or subluxation.
42. When Board staff observed that the Respondent had not ordered Patient J to undergo drug screening, the Respondent stated that he does not obtain urine screens from patients unless "I suspect a problem."
43. Board staff reviewed with the Respondent his record of a second patient, Patient K below. The Respondent saw Patient K for the first time on or about October 26, 2009 (the Respondent did not date his note) and documented at that visit, "not convinced of presence of much pain" and

---

<sup>5</sup> Patient names are confidential.

<sup>6</sup> Information received from the DEA/FCNTF revealed that on March 29, 2010, Patient J had an "emergency evaluation." In Patient J's home, police found 3 spoons with white substance crushed on them, multiple syringes, multiple empty prescription pill bottles and a white powdery substance. The pill bottles, all of which had been prescribed to Patient J by physicians including the Respondent, were labeled as either OxyContin or oxycodone.

<sup>7</sup> Patient J's chart indicated that the Respondent initially prescribed OxyContin 40 mg (#120), but increased the dosage to 80 mg on Patient J's third visit without documenting his treatment rationale.

"get MRI thoracic and lumbar spine...if no MRI next month no meds." At Patient K's initial visit, the Respondent prescribed OxyContin 80 mg t.i.d.<sup>8</sup> (quantity unspecified) and Oxycodone 30 mg q.i.d.<sup>9</sup> (#120).

44. On November 27, 2009, Patient K underwent an MRI of his thoracic spine, the results of which were normal and without evidence of central, lateral recess or neural foraminal stenosis. The MRI report was faxed to the Respondent's office on November 27, 2009. Patient K visited the Respondent on the same date; the Respondent's note, in its entirety reads: "ibid, 1 mos" (*sic*).
45. On December 22, 2009, the Respondent noted, "still believe he is faking it, do an MRI of back and thoracic – if neg will stop meds...will drop as patient." Notwithstanding Patient K's normal MRI, the Respondent continued to prescribe OxyContin 80 mg (#120) and oxycodone 30 mg (#90) at monthly visits through June 2010.
46. When Board staff pointed out that Patient K's MRI was normal, the Respondent replied that, "he should be relieved." He then referred to a 2009 MRI report of Patient K's shoulder which indicated a "small complete tear of the subscapularis tendon." The Respondent stated that type of injury is "very difficult to examine" and that he "usually need[s] the advice of an orthopedic surgeon." The Respondent did not seek such advice in this case.

---

<sup>8</sup> The abbreviation for 3 times daily.

<sup>9</sup> The abbreviation for 4 times daily.

47. When Board staff asked the Respondent why entries in the records had been whited-out prior to providing them to Board staff, the Respondent stated that he had told "the big guy who monitors the parking lot" to white-out the charges for office visits.
48. When reminded that the Board had also subpoenaed billing records and, moreover, that some of the whited-out entries were patient notes, the Respondent stated that he whites out entries "if I want to cross something off."
49. With regard to the patient records reviewed by Board staff, the Respondent commented, "[y]ou've got to remember that when we started, we were a little looser than we are now. We are very, very strict now, we double check everything." The Respondent stated that he had begun urine screening in January 2010 and had begun checking patients for criminal backgrounds in February 2010.
50. The Respondent told Board staff that when he first started practicing pain management, he was "trusting patients to tell me the truth. I don't trust my patients to tell me the truth anymore, that's a hell of a way to practice medicine."
51. The Respondent also told Board staff that, "in retrospect, ...we've corrected what we felt were the deficiencies in our practice, and which are deficiencies in many other people's practice."

**E. Summary of Expert Opinion**

52. Upon review of the patient records, the expert opined:

- there is an "overwhelming lack of appropriate documentation" by the Respondent, including the absence of adequate physical examinations;
- in some instances, the Respondent ordered imaging studies, but failed to follow up with them;
- the Respondent spent a totally inadequate amount of time with each patient as evidenced by his appointment logs;
- MRI's showed little or no pathology;
- the Respondent writes dangerous amounts of potent opioids (usually OxyContin 80 mg, oxycodone 30 mg and Xanax) without regard to the absence of physical findings in the young patient population he was treating;
- the Respondent fails to exhibit any understanding of aberrant drug-seeking behaviors to the point of putting the community's health at risk; and
- the Respondent demonstrates a lack of adequate training in pain management as evidenced by his over-prescribing of opioids, his failure to provide medical necessity and therapeutic rationale for his limited treatment protocols and his lack of appropriate documentation.

#### **F. Patient-Specific Findings of Fact<sup>10</sup>**

##### **Patient A**

---

<sup>10</sup> The Respondent discharged 1 patient after the first visit (in November 2009) because the patient did not have an MRI report when she presented for her second visit. The Respondent had, however, prescribed OxyContin 40 mg (3/day) and Roxycodone 30 mg (3/day) at the first visit. The patient had reported those drugs as her current medications on her patient information sheet.

53. Patient A, a female born in 1969, initially presented to the Respondent on October 7, 2009 complaining of pain in her lower right hip and right leg. The Respondent's entire examination note for Patient A's visit reads: 1998 car accident – lumbar tenderness, esp[ecially] on rt.
54. On her patient information form, Patient A had indicated that her current medications were: Roxycodone<sup>11</sup> 30 mg (5/day) and OxyContin 40 mg (4/day). A person other than Patient A, presumably the Respondent, had added Xanax<sup>12</sup> 2 mg (2/day).
55. There are no diagnostic studies or past medical records in Patient A's chart.
56. On the initial visit, the Respondent prescribed to Patient A: Roxycodone 30 mg (#150); OxyContin 40 mg (#120) and Xanax 2 mg (#60).
57. Patient A returned to the Respondent on October 26, 2009. The Respondent documented only the drugs he prescribed.
58. On December 31, 2009, the Respondent's entire note consist of "ibid, 1 mo."<sup>13</sup> Pharmacy surveys indicate that he prescribed 180 tablets of oxycodone and 90 tablets of OxyContin on that date.
59. On January 7, 2010, the Respondent noted "3 refills Xanax."
60. On January 22, 2010, the Respondent noted that Patient A had "OD' (*sic*) the other day. Out of practice." In Patient A's chart is a "Psychiatric Summary of Hospitalization." She had been admitted to a local hospital from January 15 through January 19 for an overdose of Xanax and

<sup>11</sup> Roxycodone (also spelled Roxicodone) is a Schedule II CDS.

<sup>12</sup> Xanax is a Schedule III CDS.

<sup>13</sup> Ibid. is used to refer to the previous entry.

narcotics; she admitted past drug overdoses and had suicidal ideations and intent. Patient A's diagnoses at discharge included: major depressive disorder, severe, recurrent; opiate dependent, continuous and sedative hypnotic dependence, continuous.

61. The Respondent documented that he had discharged Patient A from the practice on January 22, 2010 because of her overdose. In his case summary, he stated that she was reinstated after "it was discovered and concluded" that she had not been suicidal and the overdose had been accidental.
62. The Respondent continued to prescribed OxyContin and oxycodone to Patient A through June 2010 (the last available records). The notes for those monthly visits consist of a "Follow Up Form" on which Patient A reported her level of pain and how "helpful" the medications had been on a scale from 1 to 10. Patient A also completed her medication list. The Respondent failed to document any examination whatsoever; his notes consist only of a blood pressure and pulse reading and "ibid, 1 mos."

#### **Patient B**

63. Patient B, a male born in 1970, initially presented to the Respondent on January 29, 2009. The Respondent noted that Patient B had "pain in back" that had been treated by another physician, "required refills of OxyContin and oxycodone." Patient B had provided 2 pages from his prior medical record that indicated his medication regimen was OxyContin 80 mg (#40) and Roxicodone 15 mg (#40) and that he had a "pain

management appointment" in February. The Respondent did not order any diagnostic studies nor were there any previous studies in Patient B's chart.

64. The Respondent failed to conduct and document a physical examination; nonetheless, he diagnosed Patient B with "back pain" and "drug addiction."
65. Patient B returned to the Respondent 2 or 3 times a month through August 2009. The Respondent's notes state merely, "refill prescription."
66. Over a period of 2 months, the Respondent increased the amount of Patient B's OxyContin and oxycodone from 40 to 60 tablets. He failed to document his treatment rationale for this increase.
67. In his Case Summary, the Respondent documented that his physical examination "reveal (*sic*) tenderness in lumbar sacral spine. Notes from previous doctor document illness but no MRIs were available." In fact, the only "illness" documented in the prior notes was clogged ears, congestion and an elevated blood pressure.

#### **Patient C**

68. Patient C, a male born in 1968, initially presented to the Respondent on December 29, 2009. He provided the Respondent with a May 2009 radiograph report that revealed anterior listhesis.<sup>14</sup> The Respondent noted that he ordered an MRI but failed to follow up; there is no MRI report in Patient C's chart.

---

<sup>14</sup> Listhesis is the forward displacement of 1 of the lower lumbar vertebrae over the lower segment.

69. Patient C reported his medication regimen as "Roxy" 30 mg and "Oxy" 80 mg.
70. The Respondent documented "tender lumbar area, sciatica left, numbness and tingling of feet."
71. The Respondent prescribed OxyContin 80 mg (t.i.d. – quantity unspecified) and oxycodone 30 mg (every 4 to 6 hours – quantity unspecified).
72. Patient C returned to the Respondent for monthly visits through May 2010. At each visit, he completed the Patient Comfort Assessment Guide. The Respondent failed to examine Patient C, he typically noted "ibid, 1 mos" on the bottom of the forms which constituted his entire documentation of the visit.

#### **Patient D**

73. Patient D, a male born in 1981, initially presented to the Respondent on November 17, 2009 complaining of back pain after moving furniture. He provided a May 27, 2009 radiograph report that was unremarkable except for mild degenerative changes.
74. The Respondent documented "tender lumbar area, consistent with MRI results"<sup>15</sup> and prescribed OxyContin 40 mg t.i.d. and oxycodone 30 mg q.i.d. The Respondent did not specify the quantity prescribed; however, a pharmacy survey indicates that he prescribed 120 tablets of oxycodone in December 2009, and 180 tablets of oxycodone and 90 tablets of OxyContin in April 2010.

---

<sup>15</sup> There is not an MRI report in Patient D's chart.

75. Patient D returned to the Respondent for monthly visits through June 2010. At each visit, he completed the Patient Comfort Assessment Guide. The Respondent failed to examine Patient D; on 2 of the notes he noted merely "ibid, 1 mo" on the bottom of the forms. The Respondent failed to document why he increased the amount of Patient D's oxycodone.
76. On June 16, 2010, "Bruno" documented in Patient D's chart that Patient D had been observed getting into a car driven by a suspected drug dealer which was also occupied by a patient whom the Respondent had previously "kicked out" of his practice. The Respondent noted, "Consider OUT next time."

#### **Patient E**

77. Patient E, a male born in 1979, initially presented to the Respondent on January 25, 2010.<sup>16</sup> The Respondent noted "car accident 5 mos ago, [blood pressure/pulse], tender lumbar spine, see MRI's."
78. The results of the October 27, 2009 MRI of Patient E's lumbar spine included: small right-sided foraminal protrusion and annular fissure abutting the left L5 nerve roots in the neural foramen. There is no extruded fragment or spinal stenosis. The results of the MRI of Patient E's hip MRI include: findings consistent with right trochanteric bursitis as well as a grade 1 tear<sup>17</sup> of the myotendinous junction of the tensor fascia lata. No evidence of avascular necrosis or osteoarthritis of the right hip.

---

<sup>16</sup> Patient E is Patient N's father.

<sup>17</sup> A grade 1 tear is a microscopic tear; it is likened to a muscle pull.

79. Patient E's chart contains 2 pages of notes from his previous physician, representing 2 visits in October 2009. Patient E's previous physician, "Dr. Z," was the object of concerns regarding excessive CDS prescribing as reported by pharmacists during the FCNTF/DEA investigation of the Respondent. The prior physician had diagnosed Patient E with chronic pain syndrome and had prescribed OxyContin, oxycodone and Xanax.
80. At Patient E's initial visit, the Respondent continued his medication regimen. He prescribed 210 tablets of oxycodone, 90 tablets of OxyContin 80 mg and 90 tablets of Xanax (with 3 refills).
81. Patient E returned on February 25, 2010. He completed a "Follow Up Form" on which he recorded his pain level (9 on a scale of 0 to 10). The Respondent did not examine Patient E; however, he increased the amount of "codone" to 240 tablets. The Respondent failed to document his treatment rationale for the increase.
82. Information received from the DEA revealed that, on May 5, 2010, a confidential source made a controlled buy from Patient E of 10 OxyContin tablets (\$400). The confidential source reported that he/she observed that the Respondent's name appeared on the bottle of OxyContin from which Patient E took the tablets he sold.
83. Patient E saw the Respondent once a month. By June 21, 2010, the Respondent had increased the amount of OxyContin and oxycodone to 280 tablets. On that date, he noted that he would discontinue Patient E's OxyContin and "try doubling oxycodone."

84. The Respondent failed to conduct a physical examination of Patient E at any of his monthly visits after his first. In April, the Respondent noted "urine test;" however, there are not drug screens in Patient E's chart.

#### **Patient F**

85. Patient F, a female born in 1963, initially presented to the Respondent on October 12, 2009 with complaints of neck and back pain.
86. On her patient information form, Patient F recorded that her current medications included blood pressure medications and bronchial dilators, she did not list any CDS; the Respondent noted that she "was taking Vicodin."
87. At the October 12, 2009 visit, the Respondent noted that Patient F had "pain all over, tenderness all over, believe it's not physical will try meds pending x-rays and MRI's." (emphasis in original).
88. The results of the MRI reports of Patient F's cervical spine in 2002 and 2004 were relatively normal. Patient F also underwent an MRI of her knee in February 2010 after falling. The results indicated a bone bruise, a type 1 sprain of the medial collateral ligament and small to moderate joint effusion and moderate to large size popliteal cyst.<sup>18</sup>
89. At Patient F's initial visit, the Respondent prescribed MS Contin<sup>19</sup> 60 mg (#90), oxycodone 30 mg (#120) and amoxicillin (for her bronchitis). An entry, "OxyContin" was whited out of the note, the notation "2 days" was written adjacent to the whited-out entry.

<sup>18</sup> Commonly referred to as a Baker's cyst; it is a small, usually painless lump that forms on the back of the knee.

<sup>19</sup> MS Contin (morphine) is a Schedule II CDS.

90. On October 19, 2009, the Respondent discontinued OxyContin and began Percocet (#90). He failed to document the reason for the change.
91. On January 28, 2010, the Respondent increased the amount of Patient F's oxycodone from 120 tablets per month to 180 tablets based on her report of pain but in the absence of any documentation his treatment rationale or physical examination.
92. The Respondent maintained Patient F's monthly regimen of oxycodone (#180), Percocet (#120) and Xanax (#90) through June 2010 (the last available record).

#### **Patient G**

93. Patient G, a male born in 1978, initially presented to the Respondent on October 22, 2009 with complaints of a "back injury;" the Respondent documented "tender spine lumbar rt., sciatica L[eft] numbness of foot." Patient G's chart contains prior medical records from 2004 through 2007 that mostly address an ankle injury; the patient's complaint of back pain is mentioned only once. None of the prior notes indicate that Patient G was prescribed narcotics.
94. On Patient G's patient information sheet, OxyContin 80 mg q.i.d. and RoxyContin 30 mg q.i.d. are listed as his current medications.
95. At Patient G's initial visit, the Respondent prescribed OxyContin 80 mg (#120) and Roxycodone 30 mg (#120).
96. The Respondent maintained Patient G's monthly regimen through May 2010 (the last available record); the Respondent failed to document his

findings at any of the visits. On May 5, 2010, the Respondent noted "reinjured self, ↑ oxycodone to 6/day for 1 mo only." The Respondent failed to document the location or extent of Patient G's re-injury.

#### **Patient H**

97. Patient H, a male born in 1982, initially presented to the Respondent on September 13, 2009 complaining of a painful left testicle, the result of a varicocele.<sup>20</sup>
98. Patient H noted on his patient information sheet that his current medication regimen was OxyContin 80 mg (4/day) and oxycodone 30 mg (3/day). There are no prior medical records in his chart.
99. In his initial note, the Respondent documented that both of Patient H's testicles had been operated on and that his left testicle was "v. painful and shrinking." The Respondent noted that he planned to refer Patient H to a urologist; however, he failed to follow up on that referral. The Respondent failed to document an appropriate physical examination of Patient H at his first visit. The Respondent prescribed Oxycodone 30 mg (#120); a notation for OxyContin 40 mg (#100) had been whited out.
100. The Respondent initially prescribed OxyContin 40 mg (#120) to Patient H, but then increased the dosage to 80 mg after Patient H's first monthly visit. He failed to document the reason for the dosage increase. The Respondent's notes in later visits typically consisted only of the list of the drugs he prescribed.

---

<sup>20</sup> The abnormal enlargement of the vein in the scrotum draining the testicles.

101. Unlike other patients whose care was reviewed, Patient H's chart did not contain the Follow-up Sheets or Patient Comfort Assessment upon which a patient reported his level of pain.
102. On October 30, 2009, 10 days after his last visit, the Respondent noted that Patient H's medications had been stolen and prescribed 20 days worth of OxyContin and oxycodone to him.
103. On November 17, the Respondent added Adderall<sup>21</sup> to Patient H's regimen; on December 17, 2009, he added Klonopin;<sup>22</sup> the Respondent failed to document his treatment rationale for starting either drug.
104. In the Respondent's case summary, he noted that he saw Patient H for 7 months; the Respondent supplied notes only through January 2010, a total of 4 months. He further noted, "[w]e received numerous anonymous telephone calls implicating this patient as a drug dealer. We eventually discharged him from the practice." On January 28, 2010, the Respondent noted: "[Patient H] is bad news. Sends patients here & later threatens them with gun to sell him their meds."
105. Information obtained from the DEA indicated that Patient H was arrested in or around February 2010 by Frederick County police for selling OxyContin pills. Patient H told police that he obtained the pills from the Respondent.

---

<sup>21</sup> Adderall, an amphetamine product, is a Schedule II CDS.

<sup>22</sup> Klonopin, a benzodiazepine, is a Schedule IV CDS.

## Patient I

106. Patient I, a male born in 1979, first presented to the Respondent on November 23, 2009 after having undergone a replacement of his right hip in August 2008 following an accident on an all terrain vehicle.
107. Patient I had been discharged on November 20, 2009 from the practice of Dr. Z. In his case summary, the Respondent noted that Patient I transferred to his care because he "could no longer afford the previous doctor."
108. On Patient I's initial visit the Respondent did not conduct a physical examination. He continued the medications Patient I had reported on his patient information were his current medications: OxyContin 80 mg (3/day); oxycodone 30 mg (4 – 6/day) and Xanax (3/day).
109. Patient I saw the Respondent on a monthly basis. The Respondent failed to conduct a physical examination of him; his notes of each visit consist of the notation "1 mos" or "ibid." at the bottom of Patient I's Patient Comfort Assessment Guide.
110. On April 12, 2010, the Respondent conducted a criminal background check on Patient I which revealed that Patient I had been arrested on June 14, 2008 for possession of CDS (not marijuana) and paraphernalia.
111. The Respondent continued to prescribe OxyContin, oxycodone and Xanax to Patient I through June 2010 (the last available record).

## Patient J

112. Patient J, a male born in 1984, initially presented to the Respondent on October 27, 2009. The Respondent did not conduct an examination of Patient J, he merely noted that Patient J's right knee and ankle had "pins," that he complained of lumbar pain with sciatica, and that he had sustained an "accident" 3 months ago in which he "injured hand, knees, ankle & back.
113. Prior medical records in Patient J's chart indicate that he had broken his right leg in January 2002 while skiing, which had been repaired with intramedullary rodding of the tibia. The last orthopedic note, dated April 8, 2002, indicated that overall alignment was satisfactory.
114. An x-ray report of Patient J's thoracic spine dated December 20, 2008 was essentially normal with no degenerative changes seen.
115. Patient J noted on his patient information sheet that he was currently taking OxyContin 80 mg, oxycodone 30 mg and Xanax 2 mg.
116. The Respondent continued Patient J's reported regimen at his first visit and at monthly visits thereafter, typically prescribing between 90 – 190 tablets of oxycodone and 60 – 90 tablets of OxyContin. The Respondent did not conduct an examination of Patient J at his first visit, and as he later acknowledged in his interview with Board staff, he did not do so at later visits.

### **Patient K**

117. Patient K, a male born in 1983, initially presented to the Respondent on October 26, 2009 with complaints of neck and back pain. In addition to the comments regarding Patient K's care and the Respondent's stated skepticism regarding the legitimacy of his complaints of pain, ¶¶ 43 – 46 above, review of Patient K's chart indicates that the Respondent failed to conduct an adequate examination of Patient K during his course of treatment, relying instead upon his self-reports of pain.

### **Patient L**

118. Patient L, a male born in 1971, initially presented to the Respondent on December 28, 2009; the Respondent noted "tender thoracic and lumbar spine" and "left sciatica." Patient L had undergone an MRI of his lumbar spine in March 2008, the results of which indicated some disk space narrowing and desiccation, with neither disk extrusion nor protrusion.
119. At Patient L's initial visit, the Respondent continued the regimen Patient L had reported on his patient information sheet: OxyContin 80 mg (3/day); oxycodone 30 mg (6/day), Lyrica (1/day) and a prednisone inhaler. The Respondent prescribed the latter medication presumably based on Patient L's report of "breathing problems;" the Respondent failed to document any further information regarding this issue.
120. Patient L returned on January 9, 2010. The Respondent noted only that he prescribed a proventil inhaler and Soma 350. He failed to document on

the office note why he prescribed Soma, although in his case summary he that it was prescribed for "muscle relaxation."

121. On Patient L's January 21, 2009 Follow Up Form, the Respondent whited out Patient L's assessment that his level of pain was 2 out of 10 and replaced it with a 6. When interviewed by Board staff, the Respondent acknowledged he had made the change because the patient "meant" to enter "5."
122. The Respondent continued to prescribe to Patient L 90 tablets of OxyContin 80 mg and 120 tablets of oxycodone on a monthly basis through June 2010 (the last available record). In February 2010, a person other than the Respondent documented that Patient L has come in "way too early" and that he "must bring in meds...or be kicked out;" in March 2010, the Respondent documented that Patient L had "misplaced meds last week." The Respondent failed to address Patient L's conduct; rather, he continued to prescribe the same regimen to Patient L on a monthly basis through June 2010.

#### **Patient M**

123. Patient M, a female born in 1976, presented to the Respondent on September 27, 2009, after having been discharged from Dr.Z's practice the previous month. The Respondent noted that Patient M had endometriosis. A July 2007 procedure note in Patient M's chart indicates that she had undergone laparoscopy with cauterization of endometriosis.

124. On Patient M's information sheet, she reported that her current medication regimen was OxyContin 80 mg b.i.d and oxycodone 30 mg q.i.d.
125. At Patient M's first visit, the Respondent continued her reported regimen and prescribed 30 tablets of OxyContin 80 mg and 120 tablets of oxycodone 30 mg. The Respondent also prescribed 30 tablets of amoxicillin, noting "mod. Bronchitis." The Respondent failed to conduct a physical examination of Patient M at her first visit or thereafter.
126. Patient M returned to the Respondent on October 26, 2009; his note in its entirety reads: "ibid."
127. On December 29, 2009, the Respondent increased Patient M's oxycodone from 120 to 180 tablets in the absence of any documentation whatsoever.
128. On January 5, 2010, he prescribed furosemide, a diuretic, in the absence of any documentation.
129. The Respondent's notes for April and May, 2010 read: "ibid."
130. On May 21, 2010, the Respondent documented: "weaned herself from all meds, did not do well, needed no ancillary meds. No opiates required. Rehired as [Respondent's] office manager."

#### **Patient N**

131. Patient N, a male born in 1989, first saw the Respondent on October 6, 2009, with complaints of knee pain due to arthritis. On his patient information sheet, Patient N reported that his current medication regimen was OxyContin 80 mg (3 times/day) and oxycodone 30 mg (4 times/day).

132. On Patient N's first monthly visit, the Respondent continued his reported regimen. In October, the Respondent increased Patient N's oxycodone from 4 tablets a day to 6 tablets a day and increased the number he prescribed to 180 tablets. The Respondent failed to conduct an examination of Patient N at his initial visit or thereafter.
133. On January 20, 2010, the Respondent added Xanax t.i.d.; he failed to document his treatment rationale. At the bottom of the January 20 Follow Up Form, the Respondent noted: 2/22: [Patient N] gave pills to a friend of [Person A]'s sister. Gave OxyContin 80 & young girl almost OD."
134. At Patient N's next visit, on March 12, 2010, the Respondent did not address his earlier note; he prescribed OxyContin and oxycodone as usual. The Respondent did note, however, "assaulted with gun [Person B]."
135. On April 9, 2010, the Respondent prescribed Patient N OxyContin 80 mg (#90), oxycodone 30 mg (#180) and Xanax (quantity unspecified, 4 refills). At the bottom of the Patient Comfort Assessment Guide, the Respondent noted "OUT OF PRACTICE, assoc[iates] with [Person A]." (Emphasis in original).
136. Despite Patient N's apparent discharge from the practice, the Respondent continued to prescribe the same monthly regimen through June 2010 (last available record). When Board staff asked the Respondent to explain why he continued to prescribe to Patient N, the Respondent stated that Patient N "went and got a lawyer and I re-evaluated his case. ...[h]e said, 'It really

isn't right for you to kick me out because of my association with [Person B]." The Respondent stated that he then reinstated Patient N to the practice.

#### **Patient O**

137. Patient O is a female born in 1970, who is described by both the Respondent and Frederick Memorial Hospital records as homeless, first saw the Respondent on May 27, 2009. Prior medical records in her chart reveal that Patient O had "long-standing issues with depression, anxiety with panic symptoms, idiosyncratic thoughts and attention problems."
138. On her patient information sheet, Patient O reported that she was in "severe pain" and that her past illnesses included: fibromyalgia, trigeminal neuralgia, myofascial syndrome, endocarditis, hepatitis C, ADHD and chronic fatigue syndrome. She also reported that her current medications were Klonopin, Ambien and Adderall.
139. On Patient O's first visit, the Respondent prescribed: Klonopin, Ritalin and Fentanyl 75 mcg patches (for fibromyalgia). The Respondent did not examine Patient O at her initial visit or thereafter.
140. On June 11, 2002, the Respondent discontinued Fentanyl patches and started hydrocodone, noting "Fentanyl patches → death."
141. In July 2009, the Respondent resumed Patient O's Fentanyl without explanation.
142. The Respondent continued to prescribe Patient O Fentanyl patches, Ritalin (#120) and hydromorphone (#100) through October 2009, despite

comments that she was a "psychological mess" and that he did not understand "90% of what she says." In his case summary, the Respondent claimed to have tried "to seek a place where she might be committed to no avail. We continued to treat her over a five-month period after which we lost track of her."

### **Patient P**

143. Patient P, a male born in 1958, initially presented to the Respondent on October 27, 2009 with a history of back pain and diabetes. The Respondent noted, "get MRI results," but did not conduct an examination of Patient P. At the initial visit, the Respondent prescribed OxyContin 80 mg t.i.d., Roxycodone 30 mg q.i.d. and albuterol.<sup>23</sup>
144. Patient P returned to the Respondent on December 22, 2009. The Respondent noted that he had received the patient's MRI results. A review of the March 2008 MRI report indicates findings consistent with osteoarthritis of both knees. The Respondent increased Patient P's Roxycodone from 4 tablets a day to 4 to 6 tablets a day.
145. Patient P saw the Respondent on a monthly basis through June 2010 (last available record). The Respondent failed to examine the Respondent at any of the visits; on most notes the Respondent simply wrote "ibid" at the bottom of the Patient Comfort Assessment Guide upon which the patient had written his current medications (OxyContin 80 mg and Roxycodone).

---

<sup>23</sup> Unlike most of the other patients whose care was reviewed, Patient P's chart did not include a listing of his current medications.

146. On June 16, 2010, the Respondent noted that he was discontinuing Patient P's OxyContin and replacing it with Dilaudid<sup>24</sup> 8 mg and Roxycodone.

#### **Patient Q**

147. Patient Q, a male born in 1971, first saw the Respondent on September 12, 2009 with complaints of low back pain. Patient Q presented to the Respondent his Frederick County Adult Detention Center inmate identification card to verify his identity.

148. Patient Q noted on his patient information sheet that he was currently taking OxyContin (#90/month) and Roxycodone 30 mg (#120/month).

149. At Patient Q's first visit, the Respondent noted "pain left lumbar area, sacroiliac joint" and prescribed OxyContin 40 mg and Oxycodone 30 mg (1 every 6 hours). The Respondent's entry regarding the amount of OxyContin he prescribed had been whited out; however, the entry appeared to be "t.i.d." A copy of the prescription for OxyContin written by the Respondent on September 12, 2009 indicated that he had prescribed 120 tablets of OxyContin on that date.

150. Patient Q returned to the Respondent twice in October and once in November. The Respondent did not examine him at any of those visits; his notes reflect his prescriptions for OxyContin and oxycodone (120 tablets of each in November) or simply "ibid."

151. At the bottom of the Respondent's notes, a person other than the Respondent wrote, "was checking on MRI, Patient left w/ scripts, *FAKE*."

---

<sup>24</sup> Dilaudid, the trade name for hydromorphone hydrochloride, is a Schedule II CDS.

In his case summary, the Respondent stated that it was discovered that Patient Q had presented a fake MRI and was discharged from the practice in November 2009.

### CONCLUSION OF LAW

Based on the foregoing facts, the Board concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226 (c) (2) (i) (2009 Repl. Vol.).

### ORDER

Based on the foregoing, it is this 12<sup>th</sup> day of August, 2010, by a majority of the quorum of the Board:

**ORDERED** that pursuant to the authority vested by Md. State Gov't Code Ann., § 10-226(c)(2), the Respondent's license to practice medicine in the State of Maryland be and is hereby **SUMMARILY SUSPENDED**; and be it further

**ORDERED** that a post-deprivation hearing in accordance with Code Md. Regs. tit. 10, § 32.02.05.B (7) and E on the Summary Suspension has been scheduled for **August 25, 2010**, at **10:30 a.m.**, at the Maryland Board of Physicians, Room 108-109, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and be it further

**ORDERED** that at the conclusion of the **SUMMARY SUSPENSION** hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be held within thirty (30) days of the request, before an Administrative

Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and be it further

**ORDERED** that on presentation of this Order, the Respondent **SHALL SURRENDER** to the Board's Compliance Analyst, the following items:

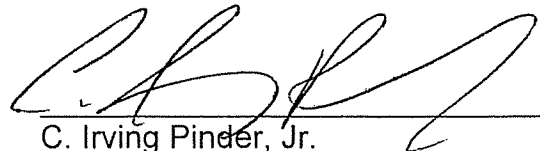
- (1) the Respondent's original Maryland License D11324;
- (2) the Respondent's current renewal certificate;
- (3) the Respondent's Maryland Controlled Dangerous Substance Registration;
- (4) all controlled dangerous substances in the Respondent's possession and/or practice;
- (5) all Medical Assistance prescription forms;
- (6) all prescription forms and pads in her possession and/or practice; and
- (7) Any and all prescription pads on which his name and DEA number are imprinted; and be it further

**ORDERED** that a copy of this Order of Summary Suspension shall be filed with the Board in accordance with Md. Health Occ. Code Ann. § 14-407 (2009 Repl. Vol.); and be it further

**ORDERED** that this is a Final Order of the Board and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.*

August 12, 2010

\_\_\_\_\_  
Date



\_\_\_\_\_  
C. Irving Pinder, Jr.  
Executive Director  
Maryland State Board of Physicians