Elizabeth G. Schlenoff, M.D.
11-A Kitzbuhel Road
Parkton, Maryland 21120

Date: March 28, 2013

Andrea L. Mathias, M.D., Chair
Maryland State Board of Physicians
4201 Patterson Avenue, 4th Floor
Baltimore, Maryland 21215-2299

RE: Surrender of License to Practice Medicine
License Number: D22557
Case Number: 2011-0590

Dear Dr. Mathias and Members of the Board:

Please be advised that I have decided to **SURRENDER** my license to practice medicine in the State of Maryland, License Number D22557, effective on April 1, 2013. I understand that upon surrender of my license, I may not give medical advice or treatment to any individual, with or without compensation, and cannot prescribe medications or otherwise engage in the practice of medicine in the State of Maryland as it is defined in the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ."), §§ 14-101 *et seq.*, (2009 Repl. Vol.) and other applicable laws. In other words, as of the effective date of this Letter of Surrender, I understand that the surrender of my license means that I am in the same position as an unlicensed individual in the State of Maryland.

I understand that this Letter of Surrender is a **PUBLIC DOCUMENT** and on the Board's acceptance, becomes a **FINAL ORDER** of the Board.

My decision to surrender my license to practice medicine in the State of Maryland arises from an investigation of my license by the Maryland State Board of Physicians (the "Board") and the Office of the Attorney General. The investigation resulted in the issuance of disciplinary charges against me under Board Case Number 2011-0590.

I have decided to surrender my license to practice medicine in the State of Maryland to avoid further prosecution of the disciplinary charges and investigation now pending before the Board, and due to my medical condition and anticipated retirement from the practice of medicine. I acknowledge that the Board initiated an investigation of this matter and voted to issue disciplinary charges against me under Health Occ. § 14-404(a)(22) and § 14-404(a)(40). Specifically, the Board charged me with failing to meet appropriate standards for the delivery of quality medical care with respect to my prescribing of controlled dangerous substances to nine patients. A copy of the Board's

charges dated December 7, 2012, is attached hereto and incorporated herein as Exhibit 1. Additionally, subsequent to the issuance of the charges, the Board conducted further investigation of me based on complaints that I was absent from my practice and failed to provide medical records to my patients on request as a result of protracted surgical recovery.

I wish to make it clear that I have voluntarily, knowingly and freely chosen to submit this Letter of Surrender to avoid prosecution of the aforementioned charges under the Act, the further investigation, as well as because of my medical condition and anticipated retirement from the practice of medicine. I acknowledge that if the case were to proceed to an evidentiary hearing, the Board would submit evidence to support the investigatory findings it made in this case. I acknowledge that for all purposes relevant to medical licensure, those investigative findings will be treated as if proven. I further acknowledge that the Board's charges, if proven, would constitute a violation of Health Occ. § 14-404(a)(22) and (40).

I understand that by executing this Letter of Surrender I am waiving any right to contest the charges in a formal evidentiary hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf and all other substantive and procedural protections provided by law, including the right to appeal.

Should the Board accept this Letter of Surrender, I agree not practice medicine in the State of Maryland unless I am subsequently reinstated by the Board. I affirm that I do not have active privileges at any hospital, outpatient surgical facility, nursing home or other health care facility in the State of Maryland.

I understand that the Board will advise the Federation of State Medical Boards, the National Practitioners' Data Bank, and the Healthcare Integrity and Protection Databank of this Letter of Surrender, and in any response to any inquiry, that I have surrendered my license in lieu of further disciplinary action under the Act. I also understand that in the event I would apply for license in any form in any other state or jurisdiction, that this Letter of Surrender and the underlying investigative documents may be released or published by the Board to the same extent as a final order that would result from disciplinary action, pursuant to Md. Code Ann., State Gov't., § 10-611 *et seq.*, (2009 Repl.), and that this Letter of Surrender is considered a disciplinary action by the Board.

I acknowledge that upon the Board's acceptance of this Letter of Surrender, I shall present to the Board my original Maryland medical license number D22557 and my most recent wallet-sized renewal card; all prescription forms and pads in my possession; all prescription forms or pads on which my name and Drug Enforcement Administration Registration Number are imprinted; and any controlled dangerous substances in my possession, other than those legitimately prescribed by a licensed physician for me. I shall also deliver to the Maryland Division of Drug Control, 4201 Patterson Avenue, 1st Floor, Baltimore, Maryland 21215, my Maryland Controlled

Dangerous Substances Certificate; and my Drug Enforcement Administration Registration Card to Drug Enforcement Administration, 500 K Street, NW, Suite 500, Washington, D.C. 20001.

I further recognize and agree that by submitting this Letter of Surrender, my license in Maryland will remain surrendered for a minimum of three (3) years pursuant to Md. Regs. Code tit. 10, § 36.02.06B(2)(b)(2013) and until such time as I apply for reinstatement and comply with the terms and conditions set forth in this letter and those required under Md. Regs. Code tit. 10, § 36.02.06B(2013).

I acknowledge that I may not rescind this Letter of Surrender in part or in its entirety for any reason whatsoever. Finally, I wish to make clear that I have been given an opportunity to consult with counsel before signing this Letter of Surrender but elected not to do so. I understand both the nature of the Board's actions and this Letter of Surrender fully. I acknowledge that I understand and comprehend the language, meaning and terms and effect of this Letter of Surrender. I make this decision knowingly and voluntarily.

Very truly yours,

Elizabeth G. Schlenoff, M.D.

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Baltimore County

I HEREBY CERTIFY that on this 28 day of March, 2013, before me, a Notary Public of the State and City/County aforesaid, personally appear Elizabeth G. Schlenoff, M.D., and declared and affirmed under the penalties of perjury that signing the foregoing Letter of Surrender was his voluntary act and deed.

AS WITNESS my hand and Notarial seal.

ANNELIESE MAYA LUCIER
Notary Public
Baltimore County
Maryland
My Commission Expires Sept. 15, 2015

Anneliese Maya Lucier
Notary Public

My Commission expires: 9/15/2015

ACCEPTANCE

On this 1st day of April, 2013, I, Andrea L. Mathias, M.D., on behalf of the Maryland State Board of Physicians, accept Elizabeth G. Schlenoff, M.D.'s **PUBLIC SURRENDER** of her license to practice medicine in the State of Maryland.

Andrea Mathias, MD, MPH
Andrea L. Mathias, M.D.
Chair
Maryland State Board of Physicians

w/ permission by ge

IN THE MATTER OF	*	**BEFORE THE**
ELIZABETH G. SCHLENOFF, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D22557	*	**Case Number: 2011-0590**

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

The Maryland State Board of Physicians (the "Board") hereby charges **ELIZABETH G. SCHLENOFF, M.D.** (the "Respondent"), License Number D22557, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2009 Repl. Vol.).

Specifically, the Board charges the Respondent with violating the following provisions of the Act under H.O. § 14-404:

> (a) *In general* – Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; [and]
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

ALLEGATIONS OF FACT[1]

The Board bases its charges on the following facts that the Board has reason to believe are true:

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[1] The allegations set forth in these charges are intended to provide the Respondent with notice of the Board's charges. 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 these charges.

EXHIBIT 1

BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on August 15, 1978, under License Number D22557. The Respondent's license is set to expire on September 30, 2013.

2. The Respondent is board-certified in Family Medicine.

3. From 1998 to 2009, the Respondent maintained an office for the practice of medicine at 16918 York Road, Suite 100, Monkton, Maryland 21111. In August or September 2001, the Respondent relocated her medical office to 214 Mount Carmel Road, Suite 4, Parkton, Maryland 21120. Prior to 1998, the Respondent was involved in a practice with other physicians in Eldersburg, Maryland.

4. The Board initiated an investigation of the Respondent after receiving a complaint from a patient who alleged that the Respondent "casually" prescribed narcotics to her and failed to take appropriate steps to address her withdrawal when she requested that she be weaned off narcotics.

5. In furtherance of the investigation, the Board submitted twelve medical records of patients who received treatment from the Respondent to an independent reviewing entity for peer review. Two peer reviewers, who are board-certified in Family Medicine, reviewed the records and found that the Respondent failed to meet quality medical and documentation standards in nine of the twelve patient records reviewed.

6. The results of the Board's investigation, including the peer review findings, are set forth *infra*.

PRIOR DISCIPLINARY ORDER

7. On December 19, 2007, the Board charged the Respondent in Case Number 2007-0032 with: engaging in unprofessional conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(ii); willfully making or filing a false report or record in the practice of medicine, in violation of H.O. § 14-404(a)(11); and willfully making a false representation when seeking or making application for licensure or any other application related to the practice of medicine, in violation of H.O. § 14-404(a)(36). The Board's charges alleged that the Respondent failed to disclose that she was under Board investigation as required in her reappointment applications to two area hospitals.

8. In a Consent Order, dated April 23, 2008, the Board reprimanded the Respondent and imposed a fine of $1,500. The Board made factual and legal findings that the Respondent violated the Act as charged when she willfully failed to disclose that she was under Board investigation in her reappointment applications to two area hospitals.

GENERAL ALLEGATIONS

9. In addition to specific allegations pertaining to each patient to be fully set forth under the subheading "Patient-Specific Allegations," the Respondent generally failed to meet quality medical and documentation standards for reasons including but not limited to:

a) Failing to perform and/or document proper evaluations of patients;

b) Failing to formulate and/or document proper treatment plans for patients;

c) Failing to conduct and/or document proper periodic review of the patients' course of pain treatment, new etiology of pain, and their state of health;

d) Failing to refer patients for consultation when appropriate; and

e) Failing to keep accurate and complete medical records.

PATIENT-SPECIFIC ALLEGATIONS

PATIENT A[2]

10. Patient A, an adult female, initially presented to the Respondent in early 2005 after her primary care physician retired. Patient A's earliest record with the Respondent was a patient medical history form, dated March 12, 2005, in which she stated that her medical history included back problems, anxiety, depression, and a change in moles. Patient A also wrote that she was hospitalized in 1994 for a bacterial infection and in 2003 for gastric bypass surgery. Patient A listed her current medications to include Wellbutrin[3] 150 mg (three per day), fluoxetine[4] 20 mg (one per day) and Darvocet.[5] Patient A's record does not contain a corresponding progress note from the Respondent for that date.

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[2] To ensure confidentiality, the names of individuals, hospitals and healthcare facilities involved in this case, other than the Respondent, are not disclosed in this document. The Respondent may obtain the identity of the referenced names in this document by contacting the administrative prosecutor.

[3] Wellbutrin, a brand name for bupropion, is a prescription-only antidepressant used to treat major depressive disorder and seasonal affective disorder.

[4] Fluoxetine is a prescription-only antidepressant of the selective seratonin reuptake inhibitor (SSRI) used to treat major depression, obsessive compulsive disorder, some eating disorders, and panic attack.

[5] Davrvocet, a brand name for acetaminophen and propoxyphene, is a Schedule IV controlled substance, and a centrally acting narcotic analgesic agent used to relieve mild to moderate pain.

11. The Respondent's first progress note of Patient A was dated June 14, 2005. During that visit, the Respondent assessed Patient A with obesity, mood disorder, attention deficit disorder ("ADD") and low back pain.

12. According to Patient A's medical record, the Respondent provided primary care to Patient A from approximately early-to-mid 2005 until July 12, 2011, which was the date of the last available progress note. During this time period, the Respondent treated Patient A primarily for conditions including, but not limited to, depression, anxiety, ADD and chronic pain. The Respondent consistently provided Patient A with monthly prescriptions for narcotics and other medications, but the frequency of Patient A's visits with the Respondent varied from several times within a month to as long as six months between visits.

13. From Patient A's initial visit sometime in early-to-mid 2005 until early 2006, the Respondent maintained Patient A on a medication regimen that generally included Adderall[6] 10 to 40 mg, fluoxetine 20 mg and Wellbutrin 200 mg. On or about March 8, 2006, the Respondent replaced Adderall with Ritalin[7] 40 mg, and for about the next two years, the Respondent maintained Patient A on largely the same medication regimen.

14. In an office note dated April 3, 2008, the Respondent stated, "She's been using Ritalin and Adderall... Her Adderall has continued to be helpful, and she's had no side effect from either one." The Respondent's note is inconsistent with Patient A's medication record in that the Respondent had taken Patient A off of Adderall since

[6] Adderall, a brand name for amphetamine and dextroamphetamine, is a Schedule II controlled substance indicated for attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD).

[7] Ritalin, a brand name for methylphenidate, is a Schedule II controlled substance indicated for ADD and ADHD.

February 2006. Five days later, the Respondent added lorezepam[8] 1 mg (#120) to Patient A's medication regimen, without documenting any medical rationale.

15. During a visit on or about September 25, 2008, Patient A complained of an on-going kidney stone problem and the Respondent prescribed Dilaudid[9] 2 mg. The following day, on September 26, 2008, Patient A called the Respondent's practice requesting Percocet 10/325[10] mg (#60), which the Respondent approved, on the condition that Patient A return the Dilaudid prescription.

16. From September 2008 until July 2011, the date of the last available record, the Respondent maintained Patient A on a progressively escalating dosage of Percocet 10/325 mg without obtaining an appropriate history or identifying a specific chronic pain syndrome that Patient A suffered.

17. Initially, in or around September 2008, the Respondent prescribed 60 tablets of Percocet 10/325 mg to Patient A, generally about every two months. About a year later, on or about August 13, 2009, the Respondent increased Patient A's Percocet prescription to 100 tablets without documenting any medical rationale.

18. Three months later, on or about November 19, 2009, the Respondent increased Patient A's Percocet 10/325 mg prescription to 120 tablets without any corresponding progress note or documented medical rationale.

19. From November 2009 to July 2011, Patient A consistently received monthly prescriptions for 120 tablets of Percocet 10/325 mg from the Respondent. One

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[8] Lorezapam is a Schedule IV benzodiazepine used to treat anxiety disorder.

[9] Dilaudid, a brand name for hydromorphone, is a Schedule II opioid pain medication used to treat moderate to severe pain.

[10] Percocet, a brand name for acetaminophen and oxycodone, is a Schedule II opioid pain medication used to treat moderate to severe pain.

exception to the monthly routine occurred on or about March 29, 2011, when the Respondent prescribed 200 tablets of Percocet 10/325 mg to Patient A, even though 12 days earlier on March 17, 2011, Patient A had already received a prescription for 120 tablets of Precocet. The Respondent also failed to keep a corresponding progress note for March 29, 2011, in Patient A's record and failed to document any medical justification for the prescription.

20. During Patient A's more than six years of treatment, the Respondent failed to meet quality medical and documentation standards for reasons including, but not limited to:

a) Diagnosing and treating Patient A for depression, anxiety, ADD and chronic pain without first obtaining and/or documenting an adequate history;

b) Failing to conduct a comprehensive evaluation of Patient A before initiating narcotic therapy;

c) Initiating and maintaining Patient A on long-term narcotic therapy in the absence of identifying a chronic pain syndrome;

d) Increasing Patient A's narcotic dosages without medical justification and/or documentation;

e) Failing to properly monitor Patient A's potential risk for narcotic abuse through the use of periodic urine drug testing or other monitoring methods;

f) Failing to address Patient A's receiving narcotic prescriptions from multiple prescribers;

g) Failing to accurately document Patient A's current medications in a pre-operative assessment, dated December 22, 2009;

h) Documenting in a progress note, dated April 3, 2008, that Adderall was continuing to be helpful to Patient A, when the Respondent had discontinued Patient A on Adderall since February 2006;

i) Failing to document legible notes; and

j) Failing to keep adequate medical records.

PATIENT B

21. Patient B, an adult female, initially saw the Respondent for primary care in the late 1990s, when the Respondent was still at her former practice in Eldersburg, Maryland. According to a summary of care from the Respondent, she provided routine care, such as gynecologic issues, pelvic, neck and back pain, mood issues and a heart murmur, to Patient B at the Eldersburg practice. Towards the end of her treatment there, the Respondent diagnosed Patient B with fibromyalgia in addition to some degenerative issues.

22. While at the Eldersburg practice, the Respondent prescribed narcotics to Patient B for fibromyalgia. In a progress note dated November 5, 1997, the Respondent wrote that Patient B had "Narcotic dependence – [Patient] 'I am aware and in acknowledgment. Both wish to find alternative options.'"

23. Patient B began receiving treatment from the Respondent at her new practice in 1999. Patient B's first progress note at the Respondent's new practice was dated May 17, 1999. In it, under the heading "Subjective," the Respondent noted Patient B "Has become discouraged [with] care. [illegible] Med. Recently told to take ½

of her Oxycontin[11] to make it last till visit (has 80 mg tabs) rather than get her usual PF. Oxycontin use has been 100% stable for a year. 'Wouldn't have a life without it, although remorseful having to take it.'" Despite those findings, the Respondent, in her treatment plan, continued Patient B on Percocet (#200), Oxycontin 80 mg (#60) and Prozac[12] 20 mg (#60).

24. According to Patient B's medical record, the Respondent provided routine care to Patient B at her new practice from mid-1999 until July 26, 2011, which was the date of the last available progress note. During this time period, the Respondent treated Patient B primarily for conditions including but not limited to fibromyalgia, depression, chronic back pain and diabetes mellitus. Patient B generally visited the Respondent once every one-to-two months but consistently received prescriptions for narcotics and other medications every three-to-four weeks. Between mid-2004 and early 2008, the Respondent did not appear to have treated Patient B as there were no progress notes or medication records for that time period.

25. Beginning mid-1999 until October 2001, the Respondent maintained Patient B on the following medications: Oxycontin 80 mg (#60), Percocet 5/325 mg (#100 to #200) and Prozac. The Respondent added Phentermine[13] 15 mg (#30) to Patient B's regimen in December 2010.

26. On or about October 17, 2001, the Respondent noted that Patient B continued to be depressed, tearful, socially isolated and despondent. She then added

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[11] Oxycontin, a brand name for oxycodone, is a Schedule II opioid pain medication used to treat moderate to severe pain for an extended period of time.

[12] Prozac is a brand name for fluoxetine.

[13] Phentermine is a Schedule IV stimulant and an appetite suppressant used with diet and exercise to treat obesity.

Oxycontin 20 mg (#120) to Patient B's existing narcotic regimen of Oxycontin 80 mg (#60) and Percocet 5/325 mg (#100) without any documented medical rationale.

27. In late 2002, Patient B weaned herself off of Oxycontin by taking 10 tablets of Percocet per day. In April 2003, Patient B separated from her husband and moved to West Virginia. Her visits to the Respondent became infrequent, with only three times in 2003. During a visit on or about October 8, 2003, the Respondent noted that Patient B was no longer on any type of prescription medication. In 2004, Patient B saw the Respondent only once for removal of an Inter-Uterine Device. For three and one-half years, from June 2004 to January 2008, Patient B did not appear to have seen the Respondent.

28. On or about June 22, 2008, Patient B returned to the Respondent's practice, stating that she could not find a doctor in West Virginia who could treat her problems. Patient B also reported that she had a motor vehicle accident two years prior that exacerbated her pain. During that visit, the Respondent placed Patient B on Percocet 10/325 mg (#240).

29. From the June 2008 visit onward, the Respondent consistently wrote Patient B prescriptions for 240 tablets of Percocet 10/325 mg every month until about August 1, 2008, when the Respondent prescribed 360 tablets to her. The Respondent, however, failed to document her reasoning for increasing the quantity of Percocet tablets. Seventeen days later, on or about August 18, 2008, the Respondent prescribed an additional 100 tablets of Percocet to Patient B without documenting any explanation for doing so.

30. In or around September 2008, the Respondent changed Patient B's medication regimen to Oxycodone[14] 30 mg (#160 - #180) and Duragesic Patch[15] 100 mcg/h (#15) without documenting the reason for the change.[16] By February 24, 2009, the Respondent had added Percocet 10/325 mg (#180) and Clonazepam[17] (#90) to Patient B's regimen of Oxycodone 30 mg (#180) and Duragesic Patch 100 mcg/h (#15) without documenting her rationale for doing so.

31. In or around July and October 2009, the Respondent added Oxy IR[18] 15 mg (#180) and Oxycontin 80 mg (#60) to Patient B's existing narcotic regimen. By then, Patient B was receiving an average of 490 mg of Oxycodone per day.

32. From October 2009 to February 2011, the Respondent maintained Patient B on OxyIR 15 mg (#180), Oxy IR 30 mg (#180), Oxycontin 80 mg (#30 - #60), Percocoet 10/325 mg (#180 - #300), and Fentanyl Patch[19] (#15 - #30). The Respondent increased Patient B's Percocet dosage from 180 tablets to 300 tablets per month on or about June 18, 2010, but failed to document her medical rationale for doing so.

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[14] Oxycodone is a Schedule II opioid pain medication used to treat moderate to severe pain.

[15] Duragesic is a brand name for fentanyl transdermal patches and a Schedule II opioid pain medication used to treat moderate to severe pain.

[16] The Respondent wrote in Patient B's progress note, dated September 9, 2008, that she prescribed Oxycodone 15 mg. Patient B's medication record, however, indicated that on that day, the Respondent prescribed Oxycodone 30 mg (#160).

[17] Clonazepam is a Schedule IV benzodiazepine used to treat seizure disorders and panic disorders.

[18] Oxy IR, a brand name for oxycodone, is a Schedule II opioid pain medication used to treat moderate to severe pain.

[19] Fentanyl is a Schedule II opioid pain medication used to treat breakthrough cancer pain that is not controlled by other medicines.

33. From February to July 2011, the Respondent changed Patient B's medication regimen to Percocet 10/325 mg (#300) and Oxy IR 30 mg (#300 - #540) but failed to document her reasoning. By July 26, 2011, the date of the last available progress note, the Respondent was prescribing an average of 640 mg of Oxycodone per day for Patient B.

34. During Patient B's eight and one-half years of treatment, the Respondent failed to meet quality medical and documentation standards for reasons including, but not limited to:

a) Diagnosing and treating Patient B for fibromyalgia, depression and low back pain without first obtaining and/or documenting an adequate history;

b) Failing to perform or document performing finger point assessments with respect to Patient B's fibromyalgia;

c) Prescribing large amounts of narcotics for treatment of fibromyalgia, which is not medically indicated;

d) Inappropriately prescribing high-dose narcotics to Patient B without obtaining and/or documenting adequate history and physical examination;

e) Failing to formulate a clear treatment plan for the use of narcotics, including conducting periodic review and assessment of the effectiveness of Patient B's narcotic therapy;

f) Increasing Patient B's narcotic dosages without adequate medical justification and/or documentation;

g) Failing to properly monitor Patient B's potential risk for narcotic abuse through the use of periodic urine drug testing or other monitoring methods;

h) Prescribing excessive amounts of narcotics without adequate medical justification and/or documentation;

i) Failing to document legible notes; and

j) Failing to keep adequate medical records.

PATIENT C

35. Patient C, an adult female, initially presented to the Respondent on or about April 6, 2000, with a history of severe temporal mandibular joint disorder ("TMJ") secondary to mandibular trauma. The Respondent referred Patient C for oral surgical consultation and prescribed Soma (#60). Patient C later met with an oral-maxillofacial surgeon on or about June 5, 2000, who diagnosed her with bilateral temporomandibular disc derangements and recommended an occlusal splint and surgical lysis and lavage, which Patient C declined to undergo.

36. Patient C returned to the Respondent on or about September 15, 2000, with complaints of severe left hip/back spasm after a "slip" that morning. The Respondent prescribed Percocet (#50) and Valium[20] 10 mg (#30), and later referred her for an orthopedic consultation. Patient C's medication record showed that the Respondent prescribed Percocet "5-10" mg on September 15, 2000, but Valium was not listed. Reports from a consultation with an orthopedic surgeon in Patient C's chart indicated that she had moderate disc degeneration and herniation at L5-S1 and

[20] Valium, a brand name for diazepam, is a Schedule IV benzodiazepine used to treat anxiety disorders, alcohol withdrawal symptoms, and muscle spasms.

significant degeneration at L4-5. Patient C underwent discectomy in June 2001, which resulted in significant scarring around the disc herniation.

37. The Respondent provided pain management to Patient C for approximately eleven years and three months, from April 6, 2000, to July 27, 2011. Initially, from October 2000 to November 2001, the Respondent prescribed Patient C Percocet "5 to 10 mg" (#100) on average every two months. Beginning December 19, 2001, the Respondent increased Patient C's Percocet "5 mg" dosage to 100 tablets every month but failed to document an entry in Patient C's chart for that day.

38. From December 2001 to April 2003, the Respondent consistently wrote monthly prescriptions for Percocet 5/325 mg (#100) for Patient C and saw her generally once every six months.

39. On or about May 13, 2003, the Respondent switched Patient C from Percocet to Oxy IR (#100). The Respondent wrote in the progress note for that day, "[refill] Percocet – due for [follow-up]! Will [change] to oxy IR."

40. For the next approximately five years and eight months, from May 2003 to January 2009, the Respondent kept Patient C on monthly prescriptions of OxyIR or oxycodone 5 mg (#100) and saw her generally once every six months. The Respondent added phentermine to Patient C's medication regimen on or about April 5, 2007.

41. Patient C's medication record showed that the Respondent increased her oxycodone 5 mg dosage to 200 tablets per month on February 23, 2009, but failed to document her rationale or even a patient visit for that day, as there was no corresponding entry for that day in Patient C's office chart. The Respondent kept

Patient C on monthly prescriptions of oxycodone or Oxy IR 5 mg (#200) and phentermine (#30) from February 2008 to January 2010 but only saw her every six months.

42. On or about February 17, 2010, the Respondent increased Patient C's Oxy IR 5 mg dosage from 200 to 400 tablets per month. Patient C's medication record contained a note, "see [patient's] note this date," but there was no corresponding entry for that day in Patient C's office chart. The Respondent continued to write prescriptions for Patient C for 400 tablets of Oxy IR 5 mg per month until September 2010. The Respondent apparently did not see Patient C from March 11, 2010, to March 21, 2011, as there were no progress notes between those two dates.

43. On or about October 12, 2010, the Respondent changed Patient C's narcotic regimen to oxycodone 15 mg (#200) and Embeda[21] (#60) without any documented reasoning, as there was no corresponding progress note for that date in Patient C's office chart. The Respondent again increased Patient C's oxycodone dosage from 200 to 240 tablets in June 2011 and to 300 tablets in July 2011. On both occasions, the Respondent failed to document any medical justification, as there were no corresponding progress notes in Patient C's chart for those dates.

44. During the approximately eleven years and three months the Respondent provided pain management to Patient C, she failed to meet quality medical and documentation standards for reasons including, but not limited to:

a) Prescribing narcotics for lengthy period of time without seeing or documenting seeing Patient C;

[21] Embeda, a brand name for morphine and naltrexone, is a Schedule II opioid pain medication used to treat moderate to severe pain.

b) Prescribing excessive amount of narcotics to Patient C without adequate medical justification and/or documentation;

c) Increasing Patient C's narcotic doses without medical justification and/or documentation;

d) Failing to document Patient C's narcotic doses accurately;

e) Failing to document legible notes; and

f) Failing to keep adequate medical records.

PATIENT D

45. Patient D, an adult female, transferred to the Respondent's practice for pain management on or about November 5, 2007, from a rehabilitation facility in Pennsylvania. In a medical history questionnaire, Patient D reported a history of hepatitis C, arthritis, anxiety, depression, muscle/joint/bone problem, swollen ankle and a prior motor vehicle accident in 2001, after which she was hospitalized at Shock Trauma. Patient D listed her medications to include Actiq[22] 800 mcg, Percocet PRN, Kadian,[23] Avinza,[24] Zonegran[25] and Forteo.[26] During this initial visit, a physician assistant ("Physician Assistant A") at the Respondent's practice assessed Patient D

[22] Actiq, a brand name for fentanyl citrate, is a Schedule II opioid pain medication used to treat breakthrough cancer pain that is not controlled by other medicines.

[23] Kadian, a brand name for morphine sulfate extended-release capsules, is a Schedule II opioid pain medication used to treat moderate to severe pain.

[24] Avinza, is a brand name for morphine sulfate, is a Schedule II opioid pain medication used to treat moderate to severe pain.

[25] Zonegran, a brand name for zonisamide, is a prescription-only sulfa drug used together with other anti-convulsant medications to treat partial seizures in adults with epilepsy.

[26] Forteo, a brand name for teriparatide, is a prescription-only man-made hormone used to treat osteoporosis.

with multiple injuries secondary to a motor vehicle accident and prescribed Actiq, Kadian,Forteo and Percocet 10/325 mg.

46. Patient D's medical record indicates that the Respondent provided primarily pain management to her from November 2007 to July 2011. During this time period, the Respondent saw Patient D generally about once every one to three months, but consistently wrote prescriptions for narcotics and other medications to her once every three to four weeks.

47. In an office note, dated March 26, 2008, the Respondent assessed Patient D with "1) Chronic pain secondary to recurrent automobile accidents, and surgeries, with permanent damage. 2) Opioid tolerance. 3) Dissatisfied with current regimen possibly because of flares, secondary to using a motorcycle for transportation." The Respondent's initial treatment plan consisted of prescribing Avinza 120 mg (#30) and Actiq 1600 (#180), but she later switched Patient D to MS Contin[27] 200 mg (#60) and Oxy IR 30 mg, because Patient D's insurance company refused the earlier prescriptions.

48. On or about June 16, 2008, the Respondent switched Patient C to Oxy IR 15 mg (#360). The following month, on or about July 9, 2008, the Respondent discontinued MS Contin, because Patient D reportedly could not afford it, at which point the Respondent continued her on Oxy IR 15 mg (#360).

49. The Respondent maintained Patient D on Oxy IR 15 mg (#360) until February 27, 2009. Thereafter, the Respondent tried a combination of Oxy IR 15 mg (#480) and Kadian 100 mg (#120) in May, but by June 2009, for of insurance reasons, the Respondent switched Patient D back to Oxy IR 15 mg, at 540 tablets per month.

[27] MS Contin, a brand name for morphine sulfate extended-release tablet, is a Schedule II opioid pain medication used to treat moderate to severe pain.

50. From June 2009 to May 2011, the Respondent maintained Patient D on monthly prescriptions of Oxy IR 15 mg (#540) and Zonegram (#180). On or about April 22, 2011, Patient D requested a stronger dose of Oxy IR, and the Respondent increased her dosage to 30 mg at 450 tablets per month for an average of 450 mg per day. Patient D's last available progress note was dated April 22, 2011, but her medication record indicated that the Respondent continued to prescribe Oxycodone 30 mg (#450) to her every month until July 2011.

51. During Patient D's nearly three years and nine months of treatment, the Respondent failed to meet quality medical standards for reasons including, but not limited to:

a) Prescribing excessive amounts of narcotics to Patient D without adequate medical justification and/or documentation; and

b) Failing to properly monitor Patient D's potential risk for narcotic abuse through the use periodic urine drug testing or other monitoring methods.

PATIENT E

52. Patient E was an adult female patient of the Respondent's, whose medication record dated back to 1999, though the Respondent was only able to provide Patient E's progress notes starting late 2006. In a partial progress note, dated November 30, 2006, the Respondent assessed Patient E with non-insulin dependent diabetes mellitus, obesity, hypertension, hyperlipidemia, and non-compliance with activities of daily living to include dieting and exercising. Although the Respondent had placed Patient E on various combinations and dosages of narcotics and other

medications for the six-to-seven years prior to the date of the first progress note, in late 2006, her narcotic regimen included Oxy IR 5 mg (#180) and Oxycontin 80 mg (#120).

53. Patient E's medical record indicates that the Respondent provided primary care to her for conditions including, but not limited to: chronic pain, diabetes, depression and bipolar disorder, from late 2006 to June 2011. During this time period, Patient E saw the Respondent about once every one-to-two months but consistently received prescriptions for narcotics and other medications from the Respondent about once every three-to-four weeks. Patient E's record showed a brief hiatus between February 19, 2010, and October 25, 2010, as there were no progress notes or medication entries showing that she visited the Respondent.

54. For over four and one-half years, from late 2006 to June 2011, the Respondent maintained Patient E on a combination of Oxy IR 5 mg (#180) and Oxycontin 80 mg (#120), for a dosage averaging 350 mg per day. During this time period, the Respondent failed to meet quality medical and documentation standards for reasons including, but not limited to:

a) Inappropriately prescribing high-dose narcotics to Patient E for a chronic pain syndrome without obtaining and/or documenting adequate history or physical examinations;

b) Failing to properly monitor Patient E's potential risk for narcotic abuse through the use of periodic urine drug testing or other monitoring methods;

c) Prescribing excessive amounts of narcotics to Patient E without adequate medical justification and/or documentation;

d) Failing to document legible notes; and

e) Failing to keep adequate medical records.

PATIENT F

55. Patient F, an adult female, was initially treated by another physician and Physician Assistant A at the Respondent's practice from August 2006 to September 2008. Beginning on or about September 5, 2008, the Respondent took over Patient F's care. During this initial visit, Patient F reported recent visits to the emergency room for abdominal pain of unknown etiology. The Respondent conducted a pelvic examination and prescribed various medications for a bacterial infection, as well as continuing Patient F on alprazolam[28] (#60).

56. Patient F's medical record indicates that the Respondent treated her from September 2008 to April 2010 for conditions including, but not limited to, gastrointestinal, respiratory and pain issues. During this time period, the Respondent saw Patient F about once every one-to-three months but prescribed narcotics and other drugs to her about once every three-to-four weeks.

57. During a visit on or about January 9, 2009, Patient F reported recent visits to a hospital emergency room for a "collapsed lung." Her discharge instructions from the hospital indicated that she was prescribed Lortab.[29] The Respondent's handwritten progress note for that date, though mostly illegible, stated that she prescribed Dilaudid 4

[28] Alprazolam is a Schedule IV benzodiazepine used to treat anxiety disorders, panic disorders, and anxiety caused by depression.

[29] Lortab, a brand name for acetaminophen and hydrocodone, is a Schedule III opioid pain medication used to treat moderate to severe pain.

mg (#360) to Patient F. The Respondent failed to document her rationale for prescribing Dilaudid to Patient F.

58. From January 2009 to March 2010, the Respondent maintained Patient F on monthly prescriptions for Dilaudid 4 to 8 mg (#180 to #360) and alprazolam 1 mg. In November 2009, the Respondent documented that Patient F was Dilaudid-dependent and initiated her on Suboxone.[30] By December 2009, Patient F weaned herself off of Suboxone and the Respondent placed her back on Dilaudid 8 mg (#160).

59. On or about April 13, 2010, the date of Patient F's last visit, the Respondent discharged Patient F and referred her to a pain management practice after she tested positive for narcotics that the Respondent had not prescribed to her.

60. During Patient F's approximately nineteen-month treatment period, the Respondent failed to meet quality medical and documentation standards for reasons including, but not limited to:

a) Failing to document her medical rationale for initiating Patient F on Dilaudid;

b) Failing to obtain and/or document obtaining adequate history and physical examination before initiating Patient F on narcotic treatment;

c) Initiating and maintaining Patient F on a long-term narcotic therapy without adequate attempts to determine the etiology of Patient F's pain;

[30] Suboxone, a brand name for buprenorphine and naloxone, is a Schedule III controlled substance used to treat opiate addiction.

d) Prescribing excessive amounts of narcotics to Patient F without adequate medical justification and/or documentation;

e) Failing to explore alternative treatment modalities and continuing to prescribe Dilaudid to Patient F despite having assessed Patient F with Dilaudid dependency;

f) Prescribing Suboxone to Patient F without proper induction and close follow-up;

g) Failing to document legible notes; and

h) Failing to keep adequate medical records.

PATIENT G

61. Patient G, an adult female, transferred her care to the Respondent from another physician on or about March 1, 2004. Some of her medical history on presentment included hepatitis C, irritable bowel syndrome, Raynaud's Syndrome, connective tissue disease, hand stiffness, carpal tunnel syndrome, non-specific colitis and status-post orthopedic and gynecologic surgeries. The Respondent assessed Patient G with "numerous medical problems" and wrote a plan of care that was illegible.

62. According to Patient G's medical record, the Respondent provided care to Patient G from March 2004 to August 11, 2011, the date of the last available progress note, for conditions including, but not limited to fibromyalgia, migraine headaches, thyroid disease, cervical degenerative disk disease, tobacco abuse, ongoing joint pains and depression. During this time period, the Respondent maintained Patient G on monthly prescriptions for narcotic and benzodiazepine medications. At times, the

Respondent provided Patient G with prescriptions for up to three months' supply of narcotics.

63. Patient G's medication record indicates that the Respondent initiated her on Oxy IR 5 mg (#100) on or about April 12, 2004, for "severe pain." Subsequently, the Respondent prescribed Oxy IR to Patient G on occasional basis until March 16, 2005, when she began writing them on monthly basis. The Respondent maintained Patient G monthly dosages of 100 tablets of Oxy IR 5 to 10 mg and other prescription medications from March 2005 to May 2007.

64. On or about May 31, 2007, the Respondent increased Patient G's Oxy IR 5 mg from 100 to 180 tablets per month without a documented explanation in her chart. Less than three months later, on or about September 21, 2007, the Respondent again increased Patient G's Oxy IR 5 mg dose from 180 tablets to 200 tablets without documenting her reasoning. A week later, on or about September 28, 2007, the Respondent wrote Patient G a prescription for 600 tablets of Oxy IR 5 mg at Patient G's request. The Respondent wrote Patient G another prescription for 600 tablets of Oxy IR 5 mg to Patient G on or about November 26, 2007. The Respondent maintained Patient G on Oxy IR 5 mg from September 2007 to September 2008.

65. Beginning on or about September 5, 2008, the Respondent changed Patient G's medications to Kadian 100 mg (#30) and Oxy IR 5 mg (#100) without documenting her reasoning in Patient G's chart. The Respondent increased Patient G's Kadian dosage to 50 mg (#90) on or about December 5, 2008. By April 9, 2009, the Respondent had Patient G on Kadian 50 mg (#90) and Oxy IR 5 mg (#200). The

Respondent failed to document her rationale for increasing Patient G's Kadian and Oxy IR doses in her chart.

66. On or about December 1, 2009, the Respondent replaced Kadian 50 mg (#90) with Morphine Sulfate ER[31] 200 mg (#60). Patient G's medication record indicated that Patient G's insurance would no longer cover Kadian. The Respondent kept Patient G on morphine sulfate ER (#60) and Oxy IR 5 mg (#200) per month from December 1, 2009, to August 11, 2011.

67. During the six and one-half years that the Respondent provided care to Patient G, she failed to meet quality medical and documentation standards for reasons including, but not limited to:

a) Inappropriately prescribing high-dose narcotics to Patient G without obtaining and/or documenting adequate history or physical examinations;

b) Prescribing excessive amounts of narcotics to Patient G without adequate medical justification and/or documentation;

c) Failing to establish and/or document a continuity between the her assessment and plan of care;

d) Increasing Patient G's narcotic dosages without adequate medical justification and/or documentation;

e) Failing to refer Patient G to pain management specialist;

f) Failing to document legible notes; and

g) Failing to keep adequate medical records.

[31] Morphine Sulfate is a Schedule II opioid pain medication used to treat moderate to severe pain.

PATIENT H

68. Patient H, an adult male, initially presented to the Respondent's practice in or around November 2005 for management of chronic back pain. Patient H complained of a recurrence of radicular pain despite having undergone a microdiscectomy by an orthopedist in York, Pennsylvania in February 2005. From November 2005 to February 2008, Patient H was treated by Physician Assistant A at the Respondent's practice, who kept him on a combination of OxyContin and oxycodone.

69. The Respondent took over Patient H's care on or about February 1, 2008. In a typed progress note for that day, the Respondent wrote that Patient H had an "injury related L5-S1 herniated disc eventually requiring microdiscectomy with post-surgical fibrosis creating a new pain syndrome involving his low back." The Respondent continued Patient H on Oxycontin and oxycodone, and ordered a repeat Magnetic Resonance Imaging ("MRI").

70. From February to July 2008, the Respondent kept Patient H on a regimen that included Oxycontin 20 mg (#60 to #90) and OxyIR 5 mg (#150 to #200). Beginning August 12, 2008, the Respondent changed Patient H's narcotic regimen to MS Contin 200 mg (#60) and oxycodone 5 mg (#200).

71. On or about December 30, 2008, Patient H complained of increased pain and requested a temporary increase in his OxyIR dosage, to which Respondent complied by increasing the quantity from 200 to 250 tablets per month. From December 2008 to July 2009, the Respondent maintained Patient H on MS Contin 200 mg (#60) and oxycodone 5 mg (#250).

72. On or about July 3, 2009, Patient H complained of left elbow pain and the Respondent increased Patient H's oxycodone to 350 tablets per month. From July 3, 2009, to July 29, 2011, the Respondent continued to write monthly prescriptions for Patient H for MS Contin 200 mg (#60) and oxycodone 5 mg (#300 to #350).

73. In or around January 2010, the Respondent diagnosed Patient H with diabetes, hypogonadism and hyperlipidemia. Prior to making these diagnoses, the Respondent failed to obtain Patient H's HgbA1C level.

74. During Patient H's approximately three and one-half year treatment period, the Respondent failed to meet quality medical and documentation standards for reasons including, but not limited to:

a) Failing to perform and/or document appropriate physical examinations;

b) Prescribing excessive amounts of narcotics to Patient H without adequate medical justification and/or documentation;

c) Diagnosing Patient H with diabetes without first obtaining and/or documenting Patient H's HgbA1C level;

d) Treating Patient H for diabetes without periodic monitoring of Patient H's HgbA1C levels;

e) Failing to document legible notes; and

f) Failing to keep adequate medical records.

PATIENT I

75. Patient I, an adult female, initially presented to the Respondent's practice in or around August 2005, with a history of mood disorder/anxiety, urological disorders,

chronic obstructive pulmonary disease and chronic back pain subsequent to a failed laminectomy for stenosis and radicular pain. From August 2005 to January 2008, Patient I was treated by Physician Assistant A, who kept her on a changing regimen of psychotropic medications, narcotic analgesics and antibiotics.

76. The Respondent took over Patient I's care on or about February 13, 2008. The Respondent's progress note for that day, although largely illegible, noted that Patient I had no changes in status or personal assessment, and that she needed 1000 pills of hydromorphone. During that visit, the Respondent continued Patient I on Oxycontin 80 mg (#120), Dilaudid 8 mg (#1200)[32] and diazepam[33] 10 mg (#18). From February to December 2008, the Respondent provided Patient I with monthly prescriptions for Oxycontin 80 mg (#120), Dilaudid 8 mg (#1200 to #1300) and diazepam 10 mg (#120 to #180). In or around May 2008, the Respondent added Adderall 30 mg (#60).

77. Beginning on January 12, 2009, the Respondent increased Patient I's Dilaudid 8 mg dose to 1300 tablets per month, decreased her diazepam 10 mg to 90 tablets per month, and added alprazolam (#120), all without any documentation as to her rationale in Patient I's chart. On or about July 28, 2009, the Respondent discontinued alprazolam but added Percocet 10/325 mg (#50).

78. For the next approximately two years, from July 28, 2009, to July 18, 2011, the Respondent maintained Patient I on a regimen that included Oxycontin 80 mg

[32] In Patient I's medication record, the 1200 tablets of Dilaudid is listed as "1000 - 100X2."

[33] Diazepam is a Schedule IV benzodiazepine used to treat anxiety disorders, alcohol withdrawal symptoms, and muscle spasms.

(#120), Dilauded 8 mg (#1200 to #1300), diazepam 10 mg (#120), Adderall 30 mg (#60) and Percocet/Endocet 10/325 mg (#50 to #100) per month.

79. During Patient I's approximately three and one-half year treatment period, the Respondent failed to meet quality medical and documentation standards for reasons including, but not limited to:

a) Diagnosing and treating Patient I for ADD without first obtaining and/or documenting an adequate history;

b) Initiating and maintaining Patient I on a long-term drug therapy without conducting and/or documenting adequate evaluations to include routine musculoskeletal examinations and the use of pain scales;

c) Failing to properly monitor Patient I's potential risk for narcotic abuse or drug diversion through the use of pill counts, periodic urine drug testing, or other monitoring methods;

d) Prescribing excessive amount of narcotics and benzodiazepines to Patient I without adequate medical justification and/or documentation;

e) Increasing Patient I's narcotic doses without adequate medical justification and/or documentation;

f) Failing to refer Patient I to a pain management specialist;

g) Failing to document legible notes; and

h) Failing to keep adequate medical records.

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, the Board finds that there are grounds for action under H.O. § 14-404(a)(22) and/or (40), the Board may impose disciplinary sanctions against the Respondent's license, including revocation, suspension, or reprimand, and may place the Respondent on probation, and/or may impose a monetary penalty.

NOTICE OF CASE RESOLUTION CONFERENCE

A Case Resolution Conference in this matter is scheduled for **Wednesday, March 6, 2013, at 10:00 a.m.**, at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the Case Resolution Conference is described in the attached letter to the Respondent.

DOUGLAS F. GANSLER
ATTORNEY GENERAL

12/7/12
Date

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