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| IN THE MATTER OF | * | BEFORE THE |
| PHYLLIS K. BARSON, M. D. | * | MARYLAND STATE |
| Respondent | * | BOARD OF PHYSICIANS |
| License Number: D15687 | * | Case Numbers: 2009-0607 |

* * * * *

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

The Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **Phyllis K. Barson, M.D. (the "Respondent") (D.O.B. 02/25/1942)** License Number D15687, to practice medicine in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Gov't Code Ann. § 10-226(c)(2)(i)(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, but not limited to, the instances described below, the Board has reason to believe that the following facts are true: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

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

medicine on August 16, 1973 under license number D15687. Her license is currently active and will expire on September 30, 2012.

2. The Respondent's specialty is anesthesiology. She is not board-certified. The Respondent also considers herself to be a specialist in algology (pain management), but is not board-certified in pain management.

3. The Respondent practices anesthesiology as an independent contractor at Facility A in Bowie, Maryland. She is the Chair of the Department of Anesthesiology at Facility A.

4. The Respondent also holds hospital privileges at Facility B.

5. On February 9, 2009, the Board received a complaint from an investigator at Travelers Insurance Company ("Travelers") concerning the Respondent's prescribing of controlled dangerous substances ("CDS") to two injured workers who are receiving workers compensation benefits from Travelers. The complaint alleged that the Respondent is not maintaining a legitimate doctor/patient relationship that supports the prescribing of narcotics; that the Respondent is sending prescriptions for CDS through the mail without examining patients; and that the Respondent is receiving payments in the mail to her home address in exchange for CDS prescriptions.

6. The Board subsequently initiated an investigation.

7. A peer review of the Respondent's medical care of 12 patients concluded that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care in all 12 patients; and that the Respondent failed to keep adequate medical records for all 12 patients.

8. After reviewing the Respondent's medical practice, the Board issued this Order for Summary Suspension pursuant to Md. State Gov't Code Ann. § 10-226(c)(2), concluding that the public health, safety or welfare imperatively required emergency action.

9. The Board's investigative findings are set forth, *infra*.

GENERAL INVESTIGATIVE FINDINGS

10. The Respondent prescribed potent opioid medications to patients for extended periods of time in violation of the standards of quality medical care.

11. The Respondent failed to properly assess these patients at their initial appointments before prescribing CDS. The Respondent failed to perform or document performing physical examinations.

12. The Respondent failed to take or document taking appropriate patient histories or update those histories.

13. The Respondent failed to obtain and review pertinent medical records from other providers, including the referring physicians and often primary care physicians, prior to treating these patients.

14. The Respondent failed to appropriately evaluate the etiology of the pain complained of by these patients.

15. The Respondent failed to establish a plan of care for these patients prior to commencing treatment.

16. The Respondent did not attempt a trial of non-narcotic medications or other treatment modalities prior to resorting to long-term use of opioid therapy.

17. The Respondent prescribed opioid medications to these patients without establishing an appropriate medical justification for their initial and continued use.

18. The Respondent failed to undertake periodic monitoring and assessments of her patients' response to opioid therapy.

19. The Respondent regularly prescribed opioid medications for extended periods of time—often years—without an accompanying office visit or physical assessment.

20. When re-filling prescriptions for narcotics, the Respondent relied only on subjective information provided by the patients on pre-printed forms that were mailed to the Respondent's home address with a \$25.00 check.

21. When prescribing narcotic opioids, the Respondent failed to minimize drug abuse and diversion by instituting pill counts, random urine screenings and/or implementing narcotic contracts.

22. The Respondent's medical records are cursory and frequently do not contain essential elements of a medical record, such as a history and physical, plan of care, and the results of imaging studies.

23. Examples of these deficiencies are set forth *infra*.

24. The Respondent was notified of the Board's investigation and given an opportunity to respond to the allegations. In her written response to the Board, the Respondent stated that her patients complete a form and mail it, along with a check or money order for \$25.00. In exchange, the Respondent provides prescriptions, through the mail, for CDS and other medications.

25. The Respondent further stated that she employs a secretary at her residence to receive and process mail order requests for prescriptions.

26. The Respondent admitted that she does not conduct physical examinations or speak to patients over the telephone before mailing the prescriptions.

27. The Respondent prescribes CDS for her patients based solely on the information reported by her patients on a self-reporting form.

28. Based on information provided to the Board by the Respondent, this conduct has been ongoing for more than eight years.

PATIENT-SPECIFIC FINDINGS

Examples of the above investigative findings are set forth in the following patient specific findings. These summaries are not intended as, and do not represent, a complete description of the evidence with respect to the Respondent's conduct in this matter.

Patient A

29. Patient A, a female born in 1950, began seeing the Respondent in April 1994. The Respondent was treating Patient A for reflex sympathetic dystrophy ("RSD") of the right leg secondary to a 1991 work-related injury. Patient A's medical record lacks sufficient detail to reconstruct her medical history; however, a 1996 consultation report from another physician outlines her disease history.

30. According to Patient A's medical record, the Respondent or other physicians performed epidural injections to treat Patient A's RSD.

31. Patient A's medical record contains a prescription log which indicates that from September 2000 until December 1, 2009 the Respondent prescribed Oxycontin² and Ritalin³ for Patient A. The Respondent never changed the dosages of these

² Schedule II CDS.

³ Schedule II CDS.

medications in more than nine years. The Respondent also prescribed Vicoprofen⁴ and Donnatal⁵ regularly.

32. Based on Patient A's medical record, the Respondent refilled Patient A's prescriptions monthly, upon receipt of a patient-filled Request for Renewal form ("renewal form"), most of which are undated, and a \$25.00 check.

33. The Respondent asserted that she sees Patient A "personally 2-3 time/year [sic] for evaluation and prescription renewal." However, the Respondent failed to document these visits in Patient A's medical record.

34. On one undated renewal form, the Respondent wrote "[Patient A] you are going to have to have your PMD fill these rx as I really do not see you anymore." Patient A responded on the form, "Primary care doctor will not write these prescriptions." The Respondent continued to prescribe CDS for Patient A despite this information.

35. The Respondent made no attempts to re-assess Patient A's continued need for narcotics by instituting drug-free periods or weaning Patient A from narcotics.

Patient B

36. Patient B, a female born in 1948, began seeing the Respondent in October 1997. The Respondent was treating Patient B for RSD of the right leg secondary to a work-related injury. However, the diagnosis could not be confirmed by the peer reviewers because Patient B's medical record lacks a detailed history and physical examination other than a brief 2007 pre-operative evaluation.

37. The majority of the Patient B's medical record consists of handwritten, undated renewal forms and copies of prescriptions written by the Respondent.

⁴ Schedule III CDS.

⁵ Schedule IV CDS.

38. Patient B's medical record contains a detailed prescription log which indicates that from September 28, 2000 through December 29, 2009, the Respondent prescribed medications in various combinations for Patient A, including Oxycontin and Percocet.⁶ The Respondent also prescribed Neurontin,⁷ Skelaxin and Soma regularly.⁸

39. According to the peer reviewers, the Respondent prescribed high doses of these medications. Further, the dosages remained relatively unchanged over a period of several years.

40. Patient B sent in a check for \$25.00 with each renewal form.

41. The Respondent asserted that Patient B was seen at Facility A over 50 times between 1997 and 2004. However, the Respondent failed to document these visits in Patient B's medical record, which was provided by the Respondent in response to a subpoena issued by the Board.⁹ Further, the Respondent asserted that she saw Patient B two to three times per year "for evaluation and writing of her prescriptions." The Respondent failed to document of these visits in Patient B's medical record.

42. The Respondent prescribed long-term opioid therapy for Patient B without regularly re-examining her for a period of more than nine years.

43. The Respondent wrote a note, dated May 13, 2008, on the bottom of an October 3, 2007 operative report, that states "Pt continues on chronic analgesics and muscle relaxant. Pt is having difficulty with W/C in approving her for epid steroids. Pt

⁶ Both are Schedule II CDS.

⁷ Schedule IV CDS.

⁸ Skelaxin and Soma are not controlled substances; however, Soma (generic: Carisoprodol), a skeletal muscle relaxant, has a high abuse potential.

⁹ There is a handwritten note on one page of Patient B's medical record which states, "only two visits in [medical record] others on microfilm 10/3/07 [and] 9/26/07 50 visits on microfilm from 1997 thru [sic] 2004." The Board's subpoena requested "any and all medical and billing records" pertaining to Patient B. (emphasis in original).

now requesting epid block as she is unable to remain in work force because of pain.” It is unclear whether this note is the result of a telephonic communication with Patient B or a patient visit, and the Respondent failed to document a physical examination on this date, or any other date.

44. The Respondent failed to monitor or failed to document monitoring Patient B’s medication compliance using a pain management contract, urine screens or pill counts.

Patient C

45. Patient C, a female born in 1955, began seeing the Respondent in 2004. Patient C was diagnosed with post-laminectomy syndrome (lumbar), lumbar epidural adhesions, lower extremity radicular pain and spinal stenosis. The Respondent listed five different referring physicians, but Patient C’s medical record contains only one history and physical examination, dated May 8, 2009, from one of those physicians.

46. Patient C’s medical record consists primarily of undated renewal forms and copies of prescriptions written by the Respondent. Most of the forms contain handwritten correspondence between the Respondent and Patient C concerning her medication needs.

47. On a monthly basis, beginning in March 2004 through December 22, 2009, the Respondent prescribed the following CDS in various combinations: Percocet, Methadone, Duragesic, Avinza, Oxycontin, and MS Contin.¹⁰ The Respondent also prescribed Lyrica,¹¹ Embeda,¹² Valium¹³ and Soma.

¹⁰ All are Schedule II CDS.

¹¹ Schedule V CDS.

¹² Embeda contains morphine, a schedule II CDS.

¹³ Valium is a Schedule IV CDS.

48. According to the peer reviewers, the Respondent prescribed high dosages of CDS to Patient C.

49. On a monthly basis, Patient C mailed a check for \$25.00 with her prescription renewal form; although for a period of time the Respondent waived the fee due to Patient C's financial difficulties.

50. The Respondent asserted that she saw Patient C monthly; however, the Respondent failed to document these visits in Patient C's medical record.

51. Based upon Patient C's medical records, the Respondent failed to conduct or document conducting an initial history and physical examination, failed to conduct or document conducting a review of previous medical records and imaging studies, and failed to establish or document establishing a plan of care prior to prescribing chronic opiate therapy for Patient C.

52. Based upon the medical records provided by the Respondent, the Respondent prescribed long-term opioid therapy for Patient C without regular re-evaluations for a period of more than five years.

53. The Respondent failed to monitor or failed to document monitoring Patient C's medication compliance using a pain management contract, urine screens or pill counts.

Patient D

54. Patient D, a female born in 1951, was referred to the Respondent in 1997 for pain management procedures to treat a 1979 work-related back injury. The Respondent asserted that Patient D's diagnoses are Anxiety, Degenerative Disc Disease, Spondylosis, Epidural Adhesions, Hyperalgesia, and Chronic Pain

Syndrome. Patient D's medical record also indicates that she has fibromyalgia. However, the medical record lacks relevant history, prior medical records, and imaging studies to support or refute these diagnoses.

55. Patient D's medical record contains one March 16, 2009 history and physical that was performed by another physician.

56. Patient D's medical record, which was provided by the Respondent in response to a subpoena issued by the Board, is primarily comprised of prescription renewal forms.

57. According to the detailed prescription log and check ledger contained in Patient D's medical record, on a monthly basis from September 2000 through January 2010 Patient D mailed the Respondent a renewal form along with a \$25.00 check. In return, the Respondent mailed Patient D her monthly prescriptions. Most of Patient D's renewal forms are undated.

58. With the exception of one hand-written note on Patient D's June 2001 prescription renewal form, the Respondent failed to document in Patient D's medical record any physical examinations of Patient D at any time during this ten-year period.¹⁴

59. From September 2000 through January 2010, the Respondent prescribed the following Schedule II CDS in various combinations: Oxycontin, Duragesic, Percocet, and Opana. The Respondent most often prescribed Percocet, Oxycontin and/or

¹⁴ The hand-written notes stated, "Seen doing well on this routine." The note is unsigned. There is no documentation of a history or physical examination done on this date.

Duragesic. The Respondent also prescribed Ambien¹⁵, Vicodin¹⁶, Flexeril, Lidoderm, Lyrica and Propanolol.¹⁷

60. According to the Respondent, Patient D had been seen at Facility A 54 times since 1997 for invasive block therapy. Further, the Respondent asserted that she has “personally evaluated the patient and [has] written her prescriptions for pain management.”

61. The Respondent failed to document in Patient D’s medical record that she saw Patient D for physical examinations or medication management follow-up appointments in the ten-year period during which the Respondent was prescribing chronic opioid therapy and other medications.¹⁸

62. Patient D’s medical record from Facility A contains records pertaining to pain management procedures performed on seven occasions between February 2008 and November 2009. The Respondent failed to conduct or failed to document conducting a history and physical examination on any of those occasions.

63. Based upon the medical records provided by the Respondent, the Respondent prescribed long-term opioid therapy for Patient D without regularly re-evaluating her for a period of more than ten years.

64. The Respondent failed to document in Patient D’s medical record any narcotic monitoring such as a pain management contract, urine screens or pill counts to minimize the potential for narcotic abuse and/or diversion.

¹⁵ Schedule IV CDS.

¹⁶ Schedule III CDS.

¹⁷ Flexeril, Lidoderm and Propanolol are not controlled substances.

¹⁸ Patient D’s medical record contains a computer print-out of dates and diagnosis codes, as well as other data. There is a handwritten note on the print-out that states, “7 visits 2108 [sic] thru 11/09 45 1/97 thru 7/07.” There is no documentation in Patient D’s medical record of these visits.

65. The Respondent received information that two other physicians were prescribing narcotics to Patient D. The Respondent failed to address or failed to document addressing this issue with Patient D. The Respondent continued to prescribe narcotics to Patient D.

66. Many of the documents in Patient D's medical record are undated and unsigned.

Patient E

67. Patient E, a male born in 1944, began seeing the Respondent for treatment of chronic pain syndrome. According to the Respondent, Patient E also had the following diagnoses: peripheral neuropathy of the lower extremities, spinal stenosis, and degenerative arthritis bilateral knees with post status bilateral total knee replacement. It is not clear when Patient E initially began seeing the Respondent, as the medical record is incomplete.¹⁹

68. The Respondent failed to conduct or failed to document conducting an initial history and physical examination prior to the Respondent prescribing chronic opioid therapy in September 2000.

69. A June 25, 2009 progress note in Patient E's medical records lists Patient E's diagnoses and a plan "to continue all present meds." However, the medications are not listed, there is no physical evaluation documented, and the note is unsigned. A November 15, 2009 note on the same page states "Being seen by VA;" however, there are no treatment records from other providers in Patient E's medical record. A January 14, 2010 note on the same page states "Will [lower] Fentanyl to 12.5mg".

¹⁹ Patient E's medical record contains a computer print-out of dates and diagnosis codes, as well as other data. There is a handwritten note on the print-out that states, "6 visits from 2001 thru 2006 – copied 2 visits on microfilm." There is no documentation in Patient E's medical record of these visits.

The Respondent failed to document a rationale for this change in Patient E's medication dosage. The November 15, 2009 and January 14, 2010 notes are initialed, but the initials are illegible.

70. Patient E's medical record contains results of two MRI imaging studies that do not support the Respondent's diagnosis of severe spinal stenosis.

71. The Respondent failed to document a continued need for narcotics.

72. Patient E's medical record contains an incomplete prescription log indicating that from September 2000 through February 2010, the Respondent prescribed the following medications in various combinations: Kadian,²⁰ Oxycontin, Duragesic, Avinza, Valium, Ritalin, Lyrica and Sonata.²¹ The Respondent also prescribed Xenicol, Propranolol, Metrocream, Celebrex, and Botox.²²

73. Patient E did not utilize the patient-filled prescription renewal request form and there is no documentation of payment rendered in exchange for the prescriptions. It is unclear how Patient E received his prescriptions from the Respondent.

74. The Respondent refilled Patient E's prescriptions without evaluating Patient E's current medical status or his continuing need for narcotics and other medication.

Patient F

75. Patient F, a female born in 1965, began seeing the Respondent in 1992 for treatment of RSD of her right leg secondary to a December 1991 work-related injury.

76. According to Patient F's medical record, the Respondent treated Patient F with various pain management procedures including an epidural catheter and a morphine

²⁰ Schedule II CDS.

²¹ Schedule IV CDS.

²² These medications are not controlled substances.

pump. Ultimately, the Respondent began treating Patient F with opioids and other CDS.

77. The Respondent failed to conduct or failed to document conducting an initial history and physical examination prior to prescribing narcotics to treat Patient F's pain.

78. The Respondent failed to establish or failed to document establishing a plan of care in the nearly 20 years during which the Respondent treated Patient F.

79. There are multiple instances in Patient F's medical record, including two separate notes written by the Respondent, where it is documented that the Respondent had not physically examined Patient F since February 2002 because it would not be covered by Workers' Compensation. However, the Respondent continued to prescribe high doses of narcotics to Patient F.

80. Patient F's medical record contains a March 21, 2006 letter from The Hartford Southeast Workers' Compensation Claim Center ("HSWCCC") to the Respondent authorizing an office visit for examination and treatment and requesting a complete copy of detailed treatment notes and test results. The Respondent failed to document whether this visit took place and failed to document her response to HSWCCC's request for information.

81. Patient F's medical record contains a detailed prescription log indicating that from September 2000 through at least January 2010 the Respondent prescribed the following medications in various combinations for Patient F: Duragesic, Percocet,

Oxycodone, Neurontin, Valium, Flexeril, Ultram,²³ and Elavil.²⁴ The Respondent also prescribed an ultrasound in October 2001 “for determination of gestation”.²⁵

82. According to the peer reviewers, the Respondent prescribed high dosages of the medications, especially Duragesic.²⁶

83. Patient F’s medical records indicate that she submitted a renewal request form each month, with a check for \$25.00, in exchange for her prescriptions. Most of the renewal forms are undated.

84. Often, Patient F would communicate with the Respondent by writing lengthy questions or concerns about her medication on her monthly renewal forms. On at least two occasions, Patient F indicated on her renewal form that she attempted to contact the Respondent with issues concerning her medications, but did not receive a return call.

85. Often, the Respondent would communicate with Patient F in writing on her monthly renewal forms.

86. The Respondent failed to monitor or failed to document monitoring Patient F’s medication compliance using a pain management contract, urine screens or pill counts.

²³ Schedule IV CDS.

²⁴ Elavil is not a controlled substance.

²⁵ There is one operative report dated October 5, 2001 in which the Respondent states that the patient “is 33 weeks pregnant, supposedly unbeknownst to the patient until recently.” The Respondent further states that Patient F was unaware of a previous pregnancy until approximately 20 weeks gestation, when she developed an epidural abscess secondary to a Dupens epidural catheter. According to the operative note, that infant suffered from withdrawal symptoms and required Methadone. A handwritten note on the operative report states that Patient F “was advised to D/C all her medications.” However, the Respondent continued to prescribe narcotics for Patient F without explanation. Further, the Respondent saw Patient F for pain management procedures in the months prior to Patient F discovering her pregnancy, but there is no record of a physical examination or testing performed by the Respondent.

²⁶ Duragesic, a transdermal patch, is typically changed every three days. However, Patient F needed it changed every two days and requested 200 mcg/hour dosing, which is very high.

Patient G

87. According to the Respondent, she had been involved in the treatment of Patient G, a male born in 1947, for over 30 years. As Patient G's medical records are incomplete, it is impossible to substantiate this assertion. His diagnoses include: epidural adhesions, arthritis of the hip, spinal enthesiopathy, sacroilitis, lumbrosacral spondylosis, degenerative disc disease of the thoracic and lumbar spine, post-laminectomy syndrome of lumbar and cervical spine, lumbar radicular pain, trochanteric bursitis, and Hepatitis C.

88. The Respondent states that since 1992, Patient G had undergone 180 interventional block therapy procedures at Facility A, and that she had seen him for pharmacologic management at these visits.

89. In Patient G's medical record, which was provided by the Respondent in response to a subpoena issued by the Board, the Respondent failed to document any office visits or pharmacologic management. Further, Patient G's medical record is incomplete and contains information from 2000, at the earliest.

90. The Respondent failed to conduct or failed to document conducting an initial history and physical examination prior to prescribing narcotics to treat Patient G's pain.

91. The Respondent failed to establish or failed to document establishing a plan of care for Patient G.

92. Patient G's medical record contains a handwritten prescription log indicating that the Respondent began prescribing narcotics to Patient G in September 2000. According to the log, from September 2000 through March 2010, the Respondent

prescribed the following medications in various combinations: Percodan²⁷, Dilaudid²⁸, Oxycontin, as well as Duracef, Lidoderm, Flexeril, and Lyrica.

93. The prescriptions were not always provided on a monthly basis, and often, without explanation, several months would elapse between prescriptions.

94. The Respondent utilized monthly renewal forms, most of which are undated.

95. Often Patient G would communicate with the Respondent about his medications and dosages by writing notes on his renewal forms. On one occasion, Patient G reported a broken rib of unknown origin and requested an increase in the dosage of his medication. It is unclear whether the Respondent complied with Patient G's request because the renewal form was undated.

96. A letter dated February 7, 2007 from Patient G's spouse to the Respondent reported that Patient G was not doing well and had been falling down frequently. Patient G's spouse reported issues with Patient G's speech, weight gain and incontinence of bladder and bowels. There is a handwritten note at the top of the letter that states, "I saw," but it is unsigned. The Respondent failed to document an office visit after receiving this letter.

97. Patient G's medical records from Facility A contain operative notes from monthly pain management procedures in 2008 and 2009, but the Respondent failed to conduct or failed to document conducting a history and physical examination prior to these procedures, or at any other time.

98. Under the physical examination section of the Respondent's operative reports, the Respondent documented "see nurses' notes."

²⁷ Schedule II CDS.

²⁸ Schedule II CDS.

Patient H

99. Patient H, a male born in 1955, began seeing the Respondent for treatment of chronic intractable lumbar pain secondary to degenerative disc disease and acquired spondylolisthesis. Patient H resided in West Virginia, but sought treatment from the Respondent because his primary care physician refused to write prescriptions for his narcotics.

100. According to the Respondent, Patient H received a series of 10 lumbar pain blocks between October 13, 2005 and October 12, 2006. The Respondent opted to treat Patient H with pharmacologic management when Patient H's insurance company refused payment for future procedures.

101. The Respondent stated that she sees Patient H "1-2 time/year [sic] before he is given his prescriptions." The Respondent failed to document these office visits in Patient H's medical record.

102. Patient H's medical record indicates that he submitted monthly renewal forms, many of which are undated, along with a check for \$25.00, and received his prescriptions by mail in return. Patient H followed this protocol from approximately March 2006 through December 2009.

103. During this time period, the Respondent prescribed Oxycontin and Percocet for Patient H.

104. The Respondent failed to perform or failed to document performing an initial history and physical prior to prescribing narcotics to treat Patient H's pain.

105. Further, the Respondent failed to establish or failed to document establishing a plan of care for Patient H.

106. The Respondent failed to conduct or failed to document conducting physical evaluations of Patient H.²⁹

107. The Respondent failed to monitor or failed to document monitoring Patient H's medication compliance using a pain management contract, urine screens or pill counts.

Patient I

108. Patient I, a female born in 1961, began seeing the Respondent in September 2008 for treatment of chronic pain syndrome, degenerative disc disease, spondylosis, and lower extremity radicular pain. According to the Respondent, Patient I's primary care physician was not willing to continue writing narcotic prescriptions and referred Patient I to the Respondent for a series of epidural blocks and steroids.

109. Patient I was treated with multiple epidural injections before the Respondent began prescribing Oxycontin in October 2008.

110. The Respondent failed to investigate or failed to document investigating why Patient I's primary care physician was unwilling to write prescriptions for narcotics. However, the Respondent prescribed narcotics for Patient I without conducting an initial physical examination or follow-up examinations and without establishing a plan of care.

111. From October 16, 2008 through February 17, 2010, the Respondent prescribed Oxycontin and Percocet for Patient I.

112. In order to receive her prescriptions, Patient I submitted a monthly renewal form, along with \$25.00.

²⁹ There is one physical examination dated October 5, 2007 documented in Patient G's medical record. It is unclear who performed the physical examination.

113. The Respondent failed to re-evaluate or failed to document re-evaluating Patient I at regular office visits to assess her continued need for narcotics.

114. Patient I's medical records from Facility A do not contain any documentation of physical examinations conducted by the Respondent prior to her pain management procedures, or at any other time.

115. The Respondent failed to monitor or failed to document monitoring Patient I's medication compliance using a pain management contract, urine screens or pill counts.

Patient J

116. Patient J, a male born in 1961, was referred to the Respondent in 2002 for epidural steroids and blocks to treat his severe pain syndrome and degenerative disc disease of the lumbar spine. According to the Respondent, Patient J's surgeon and primary care physician were unwilling to write prescriptions for his pain medication.

117. The Respondent states that Patient J had over 30 invasive pain blocks at Facility A since 2002 and that she has "personally evaluated the patient."

118. The Respondent failed to conduct or failed to document conducting an initial history and physical examination of Patient J.

119. The Respondent failed to establish or failed to document establishing a plan of care prior to prescribing narcotics for Patient J.

120. Patient J's medical record consists primarily of monthly renewal forms, most of which are undated.

121. Under the physical examination section of the Respondent's operative notes, the Respondent documented merely "see nurses' notes".

122. Patient J's medical record contains two follow-up notes dated June 16, 2006 and October 22, 2008. The Respondent failed to conduct or failed to document conducting a physical examination on those dates.

123. According to the detailed prescription log and check ledger, from September 2002 through November 2009, the Respondent primarily prescribed Oxycontin, Avinza, Duragesic, and Percocet in various combinations. Patient J sent \$25.00 to the Respondent on a monthly basis in order to receive his narcotics.

124. According to the peer reviewers, the dosage of Oxycontin was high toward the end of the prescribing period.

125. The Respondent documented that Patient J had a history of abusing prescription pain medication. However, the Respondent failed to monitor or failed to document monitoring Patient J's medication compliance using a pain management contract, urine screens or pill counts.

126. The Respondent stated that following a laminectomy and discectomy of the lumbar spine in 2008, Patient J underwent a detoxification program and she has not prescribed any narcotics since November 2009.³⁰ The Respondent failed to document any information regarding Patient J's surgery and subsequent detoxification.

Patient K

127. Patient K, a female born in 1952, was referred to the Respondent in 1996 for treatment of chronic pain status-post laminectomy of the lumbar spine. Based on information in Patient K's medical record, she suffered a work-related injury, but there is no detailed information regarding the etiology of her pain.

³⁰ The last prescription copied in Patient J's medical record is from April 2009.

128. According to the Respondent, Patient K underwent periodic epidural blocks until 1997 when her insurance denied further procedures. As a result, the Respondent began prescribing narcotics to treat Patient K's pain.

129. The Respondent failed to conduct or failed to document conducting an initial history and physical examination prior to prescribing opioids to treat Patient K's pain.

130. Patient K's medical record consists primarily of monthly renewal forms, some of which are undated. Often, Patient K typed or wrote notes to the Respondent regarding her medication needs. On a renewal form dated November 6, 2003, Patient K asked, "how am I going to get in touch with you if I need to?"

131. Patient K's medical record also includes multiple requests from her insurance company to the Respondent for information regarding Patient K's care. The Respondent provided cursory information that did not meet the insurance company's needs.

132. According to the detailed prescription log in Patient K's medical record, from September 2000 through October 2007, the Respondent prescribed high doses of Dilaudid, Oxycontin, and Ritalin for Patient K.³¹

133. The Respondent failed to conduct or failed to document conducting physical examinations of Patient K, either before the Respondent began prescribing narcotics or during that time.

134. The Respondent stated that Patient K was last seen in 2007 and is no longer under her care.

³¹ The prescription log indicates that the Respondent began prescribing narcotics for Patient K in September 2000. However, the earliest copied prescription in the medical record is dated March 2001.

Patient L

135. Patient L, a male born in 1954, was referred to the Respondent in 2004 for treatment of chronic pain status-post lumbar surgery. Patient L sustained a low back injury in July 1989, for which he had surgery in October 1989, and again in October 1990.³²

136. The Respondent began prescribing narcotics for Patient J in September 2001, and she continued to do so through early 2010, even after Patient J moved to Kentucky.

137. According to the detailed prescription log, for over eight years, the Respondent prescribed Oxycontin, Percocet, Avinza, and Duragesic for Patient L.

138. The Respondent failed to conduct or failed to document conducting an initial history and physical examination prior to prescribing narcotics for Patient L.

139. Patient L's medical record consists of monthly renewal forms, most of which are undated and incomplete. Patient L sent in a renewal form with \$25.00 in order to receive his prescriptions.

140. Patient L often requested early refills of his medication, or changes in his medications and dosages, by writing notes to the Respondent on the monthly renewal forms.

141. The Respondent stated that Patient L is seen 8-10 times per year; however, the Respondent failed to document those office visits in Patient L's medical record.

³² This information was found in a March 2008 consultation letter from another physician. The Respondent failed to document any information regarding Patient L's medical history.

142. The Respondent failed to take or document taking an appropriate medical history, including a history of present illness, social, psychiatric and surgical history, or obtain prior medical records.

143. The Respondent failed to perform or document performing appropriate initial or follow-up physical examinations to assess the etiology and status of her patients' complaints of pain.

144. The Respondent's medical records are cursory and incomplete, and largely do not contain essential elements of a medical record, including prior medical history, assessment, treatment plan and imaging studies.

145. The Respondent did not establish or document establishing a comprehensive treatment plan to address her patients' respective complaints.

146. The Respondent did not record adequate documentation in her patients' medical records with respect to medication prescribing, including potential drug interactions, side effects, and prior responses to the medications.

147. The Respondent failed to justify prescribing opioid and other medications that have habituating potential.

148. The Respondent did not reassess or document reassessing her patients' regularly to substantiate their continued need for narcotics.

149. The Respondent did not utilize pain management contracts, urine screens and/or pill counts to minimize drug abuse and diversion, despite evidence that one or more of her patients had a history of substance abuse.

150. The Respondent prescribed high doses of narcotics, through the mail, over a period of several years without evaluating her patients.

151. Based on the above investigative facts, the Board has probable cause to believe that the Respondent has committed acts in violation of the Act. Specifically, the Board has cause to believe that the Respondent has violated the following provisions of H.O. § 14-404(a):

- (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;
- (27) Sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes; [and]
- (40) Fails to keep adequate medical records as determined by appropriate peer review.

152. The Board considers the Respondent's continued licensure in the State of Maryland to constitute a danger to the public, and that the public health, safety and welfare require that her license be summarily suspended.

CONCLUSIONS OF LAW

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

ORDER

It is this 13th day of January 2011, 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 hereby is **SUMMARILY SUSPENDED**; and be it further

ORDERED that a post-deprivation hearing on the Summary Suspension has been scheduled for **Wednesday, January 26, 2011 at 1:00 p.m.** at the Maryland

Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215; 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 the following items:

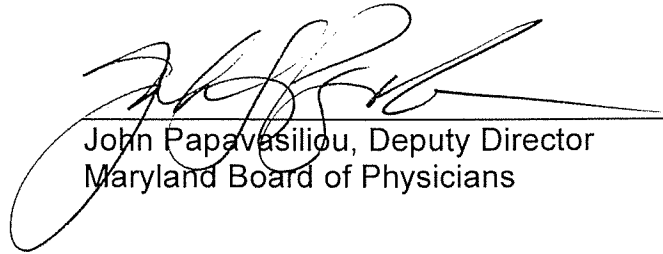
- (1) Her original Maryland License;
- (2) Her current renewal certificate;
- (3) Her current DEA registration;
- (4) All controlled dangerous substances in her possession and/or practice;
- (5) All Medical Assistance prescription forms;
- (6) All prescription forms and pads in her possession and/or practice; and
- (7) Any and all prescription pads on which her name and DEA number are imprinted; and be it further

ORDERED that the Respondent shall immediately **SURRENDER** to the Maryland Division of Drug Control, 4201 Patterson Avenue, Baltimore, Maryland 21215 her Maryland Controlled Dangerous Substance Registration; 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; 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 Govt. Code Ann., § 10-611 *et seq.*

1/13/2011
DATE


John Papavasiliou, Deputy Director
Maryland Board of Physicians