

IN THE MATTER OF
WILLIAM J. CRITTENDEN, III, M.D.

Respondent

License Number: D54547

*** BEFORE THE**
*** MARYLAND STATE**
*** BOARD OF PHYSICIANS**
*** Case Numbers: 2011-0744**
2011-0975

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ORDER FOR SUMMARY SUSPENSION
OF LICENSE TO PRACTICE MEDICINE

The Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **WILLIAM J. CRITTENDEN, III, M.D.** (the "Respondent") (Date of Birth, 11/26/1963), License Number D54547, to practice medicine in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Gov't Code Ann. ("S.G.") § 10-226(c)(2009 Repl. Vol. and 2011 Supp.), concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

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

BACKGROUND FINDINGS

1. At all times relevant to the events giving rise to the Board's findings, the Respondent was and is licensed to practice medicine in the State of Maryland. The

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

Respondent was originally licensed to practice medicine in Maryland on April 1, 1999, under License Number D54547.

2. At all times relevant to the events giving rise to the Board's findings, the Respondent was employed as the medical director at Healthy Life Medical Group ("Healthy Life"), a pain management practice located at 9607-9609 Reisterstown Road, Owings Mills, Maryland 21117.

3. The Respondent holds an active medical license in the District of Columbia.

4. On or about April 13, 2011, the Board received a police investigative report from a detective with the Baltimore County Police, Vice/Narcotics Section, regarding his investigation of out-of-state individuals who fraudulently obtained controlled dangerous substances ("CDS") at area pharmacies. Specifically, the report stated that on April 11, 2011, two Tennessee residents presented prescriptions for large quantities of CDS that the Respondent wrote while practicing at Healthy Life to a pharmacy. According to the report, the pharmacist ("Pharmacist A")² filled the prescriptions for the first individual from Tennessee. Shortly thereafter, when a second individual from Tennessee presented prescriptions written by the Respondent for similar narcotics and benzodiazepines, Pharmacist A became suspicious and refused to fill them.

5. The investigative report stated that after the detective spoke with Pharmacist A, he confronted and interviewed the individuals from Tennessee, who were

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

with two other companions from Tennessee. During the interview, the detective learned that all four individuals drove approximately eight hours from Tennessee to Maryland to obtain narcotic and benzodiazepine prescriptions from Healthy Life. One of the individuals stated that he learned of Healthy Life from a pain management clinic in Florida, where he used to obtain CDS prescriptions and may no longer be operating. Based on the police investigative report, the Board opened a preliminary investigation of the Respondent under Case Number 2011-0744.

6. Approximately two and one-half months later, on or about June 29, 2011, the Board received a second complaint against the Respondent from a licensed pharmacist ("Pharmacist B") in the Baltimore area. In his complaint, Pharmacist B stated that he became suspicious of the Respondent's prescribing practices after six individuals presented similar prescriptions written by the Respondent for Oxycodone and Alprazolam. Pharmacist B was suspicious because all six individuals were from out-of-state and all were paying cash for the narcotics and benzodiazepines. The Board investigated this complaint under Case Number 2011-0975.

7. Based on the above complaints, the Board opened a full investigation of the Respondent. The Board's investigation included, but was not limited to, conducting site visits, interviewing witnesses; interviewing the Respondent; conducting drug surveys; subpoenaing medical records; and submitting patient records for peer review.

8. Based on its investigative findings, which included findings by the peer reviewers, the Board determined that public health, safety, or welfare imperatively required that the Respondent's license to practice medicine be summarily suspended. The Board's investigative findings are set forth *infra*.

BOARD'S INVESTIGATION FINDINGS

Prior Disciplinary History

9. On or about March 27, 2002, the Respondent was formally reprimanded and fined \$1,200 by the District of Columbia Board of Medicine (the "DC Board") for filing a false affidavit in his DC Board application for medical licensure and for practicing as a physician assistant without a license from June 1996 to June 1997.

10. As a result of the DC Board disciplinary action, the Board charged the Respondent with violating Md. Health Occ. Code Ann. ("H.O.") § 14-404(a)(21) for being disciplined by a licensing or disciplinary authority and ordered him to pay an administrative fine in the amount of \$1,200.

General Investigative Findings

11. In furtherance of the Board's investigation, Board investigators conducted a surveillance of Healthy Life at its location on Reisterstown Road on or about July 15, 2011. Upon arriving at the parking lot in front of the practice, Board investigators observed approximately 15 individuals standing, smoking and conversing outside the entrance to the practice. Board investigators also observed several parked vehicles occupied by individuals who appeared to be sleeping inside the vehicles. After a scan of the parking lot, Board investigators noticed numerous vehicles with out-of-state license plates, including such states as New York, New Jersey, Kentucky, Ohio, West Virginia, Connecticut, Tennessee and Florida.

12. Board investigators returned to Healthy Life on or about August 4, 2011, to serve Board subpoenas and notices. Upon arrival, Board investigators again observed 10 to 20 individuals waiting around in the parking lot in front of the practice. A scan of

the parking lot again revealed numerous occupied and unoccupied vehicles displaying out-of-state license plates, including license plates from New York, Kentucky, Ohio, West Virginia, Connecticut, Tennessee and Florida.

13. Upon entering the practice, Board investigators observed approximately 75 to 85 patients in a waiting area. After identifying themselves to a receptionist, Board investigators were escorted to an office where they were greeted by the Respondent, who identified himself as the medical director of the practice, and by another physician. During the visit and pursuant to Board subpoenas, Board investigators retrieved 35 patient medical records from the practice.

14. On or about August 17, 2011, Board investigators interviewed two medical assistants from Healthy Life. Both individuals stated that approximately 30 to 50 patients were seen daily at Healthy Life, of which 25% were new patients. They further stated that because Healthy Life did not accept medical insurance, new patients paid approximately \$300 in cash for initial visits, while established patients paid approximately \$250 to \$295 in cash for follow-up visits.

15. On or about October 28, 2011, the Board referred fifteen medical records of patients who had received treatment from the Respondent to a reviewing entity for peer review. The reviewers concluded that the Respondent failed to meet quality medical standards and keep adequate medical records in all fifteen patient charts reviewed. The reviewers' concluded that the Respondent:

- a) Prescribed high doses of narcotics without verifying patients' self-reported medical history and narcotic use by obtaining and documenting patients' prior medical records, to include information

such as previous work-up, previous treatment, referral notes, specialty notes, or other notes, to justify and support such prescribing;

- b) Prescribed high doses of narcotics and benzodiazepines despite obvious red flags, such as patients being from out-of-state with no verified medical history and making cash payments only; and patients from different states having had MRIs performed at imaging centers in Florida;
- c) Failed to investigate and determine the rationale for the initiation of patients' pain regimen;
- d) Failed to address patients' positive urine drug screens for illegal substances;
- e) Failed to address patients' abnormal urine toxicology screens;
- f) Inappropriately prescribed two short acting narcotics at the same time;
- g) Failed to refer patients for medical consultation, such pain specialist consultation, neurosurgical consultation, physical therapy, acupuncture, or mental health consultation; and
- h) Failed to keep adequate medical records to justify the course of treatment taken.

Patient-Specific Findings

16. Examples of the above investigative findings are set forth in the following patient-specific summaries. These summaries are not intended as, and do not

represent, a complete description of the evidence with respect to the Respondent's actions in this matter.

Patient A

17. Patient A, then a 48 year-old male resident of Kentucky, initially presented to Healthy Life on or about March 29, 2011, with complaints of pain, tingling and numbness in his back and legs. Patient A reported a history of coronary artery disease, diabetes and psoriatic arthritis, but no surgical history relating to his pain. Other than a Magnetic Resonance Imaging ("MRI") report, dated August 19, 2009, from a Florida imaging center, which found small disc protrusion with nerve root effacement in L5-S1 and mild bulging disc at L4-5 and L3-4, Patient A presented no prior medical records to verify his medical history. Patient A listed "Total Care Medical Center" in Orlando, Florida as his prior treating physician and self-reported being on Oxycodone³ 30 mg, Oxycodone 15 mg, Alprazolam⁴ 2 mg, Lovaza,⁵ Metformin⁶ and Carvedilol.⁷

18. At this initial visit, Patient A was treated by a physician assistant ("Physician Assistant A"), who prescribed Oxycodone 30 mg (#180), Oxycodone 15 mg (#30), Alprazolam 2 mg (#30) and Meloxicam⁸ 15 mg (#30). A urine drug screen performed that day was positive for presence of Oxycodone and negative for benzodiazepines. Patient A paid \$300 in cash for this initial visit.

³ Oxycodone is a Schedule II opioid analgesic indicated to relieve moderate to severe pain.

⁴ Alprazolam is a Schedule IV benzodiazepine primarily used to treat anxiety disorders, panic disorders, and nausea due to chemotherapy.

⁵ Lovaza is a brand name prescription drug indicated for lowering high triglyceride levels.

⁶ Metformin is a prescription only antidiabetic drug.

⁷ Carvedilol is a prescription only drug indicated for the treatment of congestive heart failure.

⁸ Meloxicam is a prescription-only nonsteroidal anti-inflammatory drug ("NSAID") which has analgesic and fever-reducing effects.

19. According to records provided by Healthy Life, Patient A returned on four subsequent visits between April and July 2011. On all four visits, the Respondent treated Patient A.

20. Patient A initially saw the Respondent on or about April 27, 2011, for “medication refills.” The Respondent noted that Patient A suffered from chronic low back pain since 1982 secondary to a motor vehicle accident and had evidence of L5-S1 bulging disc with nerve root effacement. The Respondent prescribed Oxycodone 30 mg (#118), Oxycodone 15 mg (#118), Xanax⁹ 2 mg (#28) and Mobic¹⁰ 15 mg (#28). Patient A paid \$295 in cash for this visit.

21. Patient A returned on or about May 25, 2011, and complained of “reduced analgesia” and a burning sensation to his legs when walking. The Respondent changed Patient A’s medications to Oxycodone 30 mg (#168), Dilaudid¹¹ 2 mg (#56), Alprazolam 2 mg (#56) and Gabapentin¹² 600 mg (#28).

22. For Patient A’s two remaining visits on or about June 22, 2011, and July 20, 2011, the Respondent continued her on the same doses of Oxycodone 30 mg, Dilaudid 2 mg, Alprazolam 2 mg and Gabapentin 600 mg. Patient A paid \$225 in cash for the June visit and \$250 in cash for the July visit.

Patient B

23. Patient B, then a 50 year-old female resident of Ohio, initially presented to Healthy Life on or about May 23, 2011, with complaints of low back and bilateral leg

⁹ Xanax is a trade name for Alprazolam.

¹⁰ Mobic is a trade name for Meloxicam.

¹¹ Dilaudid is a trade name for hydromorphone, a Schedule II CDS of the opioid class.

¹² Gabapentin is a prescription only drug used primarily for the treatment of seizures and neuropathic pain.

pain burning down the outside of both legs. Patient A reported a 19-year history of low back pain secondary to a fall injury and prior lumbar laminectomy and spinal fusion. Other than a MRI report, dated November 15, 2010, from an imaging center in Florida, which found post-operative changes from her spinal fusion, but no significant abnormalities of disc herniation, central or foraminal stenosis, Patient B presented no prior medical records to verify her medical history. Patient B listed no current medications in the patient questionnaire.

24. At this initial visit, the Respondent treated Patient B and prescribed Oxycodone 30 mg (#84), Percocet¹³ 10/325 mg (#168), Alprazolam 2 mg (#28), Gabapentin 600 mg (#28) and Flexeril¹⁴ 5 mg (#112). A urine drug screen performed that day was negative for the presence of CDS. Patient B paid \$310 in cash for this initial visit.

25. Based on the records Healthy Life provided, Patient B made one other visit, on or about June 6, 2011, during which he complained of "inadequate analgesia with Flexeril and Percocet." The Respondent then changed Patient B's medications to Oxycodone 30 mg (#84), Oxycodone 15 mg (#84), Alprazolam 2 mg (#28), Gabapentin 1200 mg (#28), Neurontin¹⁵ 300 mg (#28) and Parafon Forte¹⁶ 500 mg (#56). The Respondent lowered Patient B's oxycodone dosage despite her complaint of inadequate analgesia. Patient B paid \$295 in cash for this second visit.

¹³ Percocet is a trade name for a combination of oxycodone and paracetamol. It is a Schedule II narcotic pain reliever used to treat moderate to severe acute pain.

¹⁴ Flexeril is a trade name for cyclobenzaprine, which is a prescription only muscle relaxant.

¹⁵ Neurontin is a trade name for Gabapentin.

¹⁶ Parafon Forte is a trade name for chlorzoxazone, which is a prescription only muscle relaxant.

Patient C

26. Patient C, then a 54 year-old male resident of Tennessee, initially presented to Healthy Life on or about May 25, 2011, with complaints of low back pain that was constant, achy and sharp, and which radiated down his legs, purportedly from a crush injury two and one-half years prior. Patient C reported a history of hypertension and prior appendectomy, but no surgical history relating to his pain. Other than a MRI report, dated June 22, 2009, from an imaging center in Florida, which found moderate profusion with bulging and nerve root effacement at L3-4, L4-5 and L5-S1, Patient C presented no prior medical records to verify his medical history. Patient C listed "word of mouth" as his referral source and reported being on Oxycodone and Xanax.

27. At this initial visit, the Respondent treated Patient C and assessed him with radiculopathy and bulging discs, and placed him on Oxycodone 30 mg (#84), Oxycodone 15 mg (#168), Gabapentin 600 mg (#28) and Ambien¹⁷ 5 mg (#28). Patient C paid \$300 in cash for this initial visit.

28. Based on the records Healthy Life provided, the Respondent saw Patient C on two subsequent occasions in June and July 2011. During his visit on or about June 22, 2011, Patient C reported adequate pain and the Respondent changed his medications to Oxycodone 30 mg (#112), Oxycodone 15 mg (#112), Gabapentin 600 mg (#28) and Ambien 5 mg (#28). Patient C paid \$295 in cash for this visit.

29. During his visit on or about July 20, 2011, Patient C presented a MRI report dated the same date, which found central herniated discs at L3-4 and L4-5. The Respondent noted that Patient C reported "adequate analgesia" and changed his

¹⁷ Ambien, a trade name for zolpidem, is a prescription only drug used to treat insomnia.

medications to Oxycodone 30 mg (#168), Neurontin 600 mg (#28) and Ambien 5 mg (#28). Patient C paid \$250 in cash for this visit.

Patient D

30. Patient D, then a 34 year-old male resident of Kentucky, initially presented to Healthy Life on or about April 4, 2011, with complaints of low back pain radiating down his right leg, which he described as sharp and burning pain associated with numbness. Patient A D reported no medical or surgical history related to his pain and claimed that he was taking Oxycodone 30 mg (#180), Oxycodone 15 mg (#90) and Xanax 2 mg (#60) until his prior pain clinic was closed. Other than a MRI report, dated November 23, 2009, from an imaging center in Florida, which found a herniated disc at L5-S1, Patient D presented no prior medical records to verify his medical history. In a patient questionnaire, Patient D listed no primary physician and only the name of an individual as the source of referral.

31. At this initial visit, Physician Assistant A treated Patient D and prescribed Oxycodone 30 mg (#90), Oxycodone 15 mg (#50), Alprazolam 2 mg (#42) Meloxicam 15 mg (#30) and Zantac 300 mg (#30). A urine drug screen performed that day was positive for presence of Oxycodone and marijuana. Patient D paid \$300 in cash for this initial visit.

32. According to records Healthy Life provided, Patient D returned on four subsequent occasions between April and July 2011, and on all four occasions (i.e., April, May, June and July 2011), the Respondent treated Patient D.

33. Patient D initially saw the Respondent on or about April 25, 2011. The Respondent noted that Patient D reported "ineffective analgesia" and increased his

medications to Oxycodone 30 mg (#112), Oxycodone 15 mg (#112) and Xanax 2 mg (#56). Patient D paid \$295 in cash for this visit.

34. For his next three visits, on or about May 25, June 21, and July 19, 2011, the Respondent continued Patient D on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112) and Xanax 2 mg (#56). During his June 21, 2011, visit, Patient D complained of "ineffective analgesia," and the Respondent added Parafon Forte 500 mg (#56). During his July 19, 2011, visit, Patient D reported "adequate analgesia" and the Respondent added Gabapentin 600 mg (#28) to his medication regimen. Patient D paid \$250 in cash for each of the three visits.

Patient E

35. Patient E, then a 32 year-old male resident of Kentucky, initially presented to Healthy Life on or about April 6, 2011, with complaints of low back pain, which he described as sharp, throbbing, numbing and tight. Patient E reported being pinned against the wall by a cow while working at a cattle farm six months prior to the visit. Patient E reported no medical or surgical history related to his pain and claimed that he was taking Oxycodone 30 mg, Oxycodone 15 mg, Xanax 2 mg and Parafon Forte. Other than a MRI report, dated December 6, 2010, from an imaging center in Georgia, which found a disc bulge at L5-S1, Patient E presented no prior medical records to verify his medical history and reported narcotic use.

36. At this initial visit, Physician Assistant A treated Patient E and prescribed Oxycodone 30 mg (#120), Oxycodone 15 mg (#30), Alprazolam 2 mg (#60) and Meloxicam 15 mg (#30). A urine drug screen performed that day was positive for

presence of Oxycodone and benzodiazepines. Patient E paid \$300 in cash for this initial visit.

37. According to records Healthy Life provided, Patient E returned on four subsequent occasions between May and July 2011. On all four occasions, the Respondent treated Patient E.

38. Patient E initially saw the Respondent on or about May 4, 2011. The Respondent noted that Patient E reported "great improvement/reduction in low back pain" and continued him on Oxycodone 30 mg (#112), Oxycodone 15 mg (#84), Xanax 2 mg (#56) and Meloxicam 15 mg (#28). Patient E paid \$295 in cash for this visit.

39. For his next three visits, on or about June 1, June 29, and July 27, 2011, the Respondent noted "adequate analgesia" each time and continued Patient E on Oxycodone 30 mg (#112), Oxycodone 15 mg (#84), Xanax 2 mg (#56) and Mobic 15 mg (#28). Patient D paid \$250 in cash for each of the three visits.

Patient F

40. Patient F, then a 32 year-old female resident of Kentucky, initially presented to Healthy Life on or about April 4, 2011, with complaints of low back pain, which she described as sharp, throbbing, numbing and tight. Patient F reported no medical or surgical history related to her pain and claimed that she was taking Oxycodone 30 mg, Oxycodone 15 mg and Xanax 2 mg until her prior pain clinic was closed. Other than a MRI report, dated September 21, 2009, from an imaging center in Florida, which found herniated discs at L3-4, L4-5 and L5-S1, Patient F presented no prior medical records to verify her medical history and reported use of narcotics.

41. At her initial visit, Physician Assistant A treated Patient F and prescribed Oxycodone 30 mg (#63), Percocet 10/325 mg (#30), Alprazolam 2 mg (#20) and Meloxicam 15 mg (#30).¹⁸ A urine drug screen performed that day was positive for presence of Oxycodone and Marijuana. Patient F paid \$310 in cash for this initial visit.

42. According to records Healthy Life provided, Patient F returned on four subsequent occasions between April and July 2011. On all four occasions, the Respondent treated Patient F.

43. Patient F initially saw the Respondent on or about April 25, 2011. The Respondent noted that Patient F worked at a cattle farm, even though Patient F reported working at Applebees for the past three years. Patient F complained of ineffective analgesia in between doses and the Respondent changed her medications to Oxycodone 30 mg (#112), Oxycodone 15 mg (#112), Xanax 2 mg (#28) and Lyrica¹⁹ 50 mg (#56). Patient F paid \$295 in cash for this visit.

44. For his next three visits, on or about May 25, June 21, and July 19, 2011, the Respondent noted effective analgesia each time and continued Patient F on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112) and Xanax 2 mg (#28). The Respondent also continued to prescribe Lyrica 50 mg (#56) in Patient F's May and June visits, but when she complained that Lyrica was too expensive, the Respondent switched her to Gabapentin 600 mg (#28).

Patient G

45. Patient G, then a 22 year-old female resident of Ohio, initially presented to Healthy Life on or about May 27, 2011, and reported a one-year history of low back pain,

¹⁸ For her narcotics and benzodiazepines prescriptions dated April 4, 2011, Patient F had an Irvine, Tennessee address listed.

¹⁹ Lyrica, a trade name for pregabalin, is a prescription only drug used to relieve neuropathic pain.

which she described as pulling, throbbing and sharp, as a result of a motor vehicle accident. Patient G reported no prior medical or surgical history relating to her pain. Although in her patient questionnaire, Patient G listed "depo shea" as the only current medication she was taking, she reportedly told the Respondent at the initial visit that she was taking Oxycodone 30 mg, Oxycodone 15 mg, Xanax 2 mg and Depo Provera.²⁰ Other than a MRI report, dated February 9, 2011, from an imaging center in Florida, which found broad-based disc bulge at L4-5, Patient G presented no prior medical records to verify her medical history or reported use of narcotics. In the patient questionnaire, Patient G listed no primary physician and only the name of an individual as the source of referral.

46. At this initial visit, the Respondent treated Patient G. The Respondent assessed Patient G with scoliosis and bulging disc, and placed her on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112), Alprazolam 2 mg (#28) and Parafon Forte 250 mg (#84). A urine drug screen performed that day on Patient G was positive for the presence of Oxycodone, Marijuana, opiates and benzodiazepines. Patient G paid \$310 in cash for this initial visit.

47. Based on the records Healthy Life provided, Patient C returned on two occasions in June and July 2011, and was seen by the Respondent on both occasions. During her visit on or about June 24, 2011, Patient G reported adequate analgesia and the Respondent continued her on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112), Alprazolam 2 mg (#28) and Parafon Forte 250 mg (#84). The Respondent noted that Patient G denied marijuana use, but her urine drug screen taken that day was positive for marijuana. The Respondent noted that if Patient G's urine drug screen on the next

²⁰ Depo Provera, a trade name for medroxyprogesterone, is an injection used to prevent pregnancy.

visit came positive for marijuana again, she would be discharged from the clinic. Patient G paid \$330 in cash for this visit.

48. During her visit on or about July 25, 2011, Patient G complained of the onset of bilateral radicular leg pain, and the Respondent changed her medication regimen to Oxycodone 30 mg (#112), Oxycodone 15 mg (#112), Neurontin 600 mg (#28) and Parafon Forte 500 mg (#56). Patient G paid \$285 in cash for this visit.

Patient H

49. Patient H, then a 56 year-old female resident of Kentucky, initially presented to Healthy Life on or about May 6, 2011, with a self-reported seven-year history of low back and neck pain, which she described as aching, throbbing and sharp, as a result of chemotherapy and pre-existing degenerative disc disease. Patient H reported a history of breast cancer and arthritis but no surgical history relating to her pain. For her current medications, Patient H listed Roxycodone²¹ 30 mg, Roxycodone 15 mg, Xanax 2 mg and Boniva. Patient G presented two MRI reports, a neurological consultation report and a chiropractic consultation report, which found degenerative disc disease at C3-4 through C6-7 with central canal stenosis and mild degenerative changes at L5-S1. The neurological consultation report listed her current medications to include Percocet and Claritin.

50. At this initial visit, the Respondent treated Patient G and assessed her with radiculopathy, leg weakness, bulging disc of lumbar region and cervical spine stenosis, and initiated her on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112),

²¹ Roxycodone is a trade name for Oxycodone.

Alprazolam 2 mg (#56) and Soma²² 350 mg (#56). A urine drug screen performed that day on Patient G was negative for narcotics. Patient H paid \$310 in cash for this initial visit.

51. Based on the records Healthy Life provided, Patient H returned on three subsequent occasions between June and August 2011, and was seen by the Respondent on each occasion. During her visit on or about June 7, 2011, Patient H reported adequate pain relief but stated that she experienced nocturnal left leg numbness. The Respondent continued Patient H on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112), Alprazolam 2 mg (#28) and Soma 350 mg (#56), and added Gabapentin 600 mg (#28). Patient H paid \$270 in cash for this visit.

52. For the next two visits, on or about July 5 and August 2, 2011, Patient H reported adequate to good pain relief, and the Respondent continued her on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112), Alprazolam 2 mg (#28), Soma 350 mg (#56) and Gabapentin 600 mg (#28).

Patient I

53. Patient I, then a 25 year-old male resident of Ohio, initially presented to Healthy Life on or about April 12, 2011, with a self-reported two-year history of low back pain, which he described as achy and throbbing, secondary to a motor vehicle accident. Patient I reported no prior medical or surgical history relating to his pain and reportedly was not on any medications at the time of the initial visit. Patient I presented a MRI report, dated April 14, 2010, from an imaging center in Florida, which found bulging discs at L4-5 and L5-S1 with fluid in the facet joints. Patient I presented no prior medical records to verify his history of pain and admitted to using pain medications

²² Soma, a trade name for carisprodol, is a prescription only muscle relaxant.

prescribed to his family members. In the patient intake form, Patient I listed no primary physician, or source of referral.

54. At this initial visit, the Respondent treated Patient I and assessed him with muscle spasm and bulging disc with nerve involvement. At this visit, the Respondent placed Patient I on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112) and Chlorzoxazone²³ 250 mg (#84). A urine drug screen performed that day on Patient I revealed the presence of Oxycodone. Patient I paid \$300 in cash for this initial visit.

55. Based on the records Healthy Life provided, Patient I returned on four subsequent occasions between May and August 2011, and was seen by the Respondent on each occasion. During his visit on or about May 10, 2011, Patient I reported adequate analgesia and the Respondent continued him on Oxycodone 30 mg (#112) and Oxycodone 15 mg (#112), but added Xanax 2 mg (#28) and Parafon Forte 250 mg (#84) to his medication regimen. Patient I paid \$270 in cash for this visit.

56. For the next three visits, Patient I reported either good or adequate analgesia, and the Respondent continued to him on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112), Xanax and Parafon Forte. During the July 5, 2011, visit, the Respondent increased Patient I's dosage for Parafon Forte to 500 mg (#56). During the August 2, 2011, visit, the Respondent added Elavil 25 mg (#28) to Patient I's medication regimen. For the three visits, Patient I paid between \$225 and \$250 in cash for each visit.

Patient J

57. Patient J, then a 28 year-old female resident of Kentucky, initially presented to Healthy Life on or about May 11, 2011, with a self-reported five-year

²³ Chlorzoxazone is a prescription only muscle relaxant.

history of low back pain, which she described as sharp and throbbing and extending down her legs, secondary to a motor vehicle accident. Patient J reported a medical and surgical history that included wrist fracture and Ureteropelvic Junction Obstruction relating to her pain and listed Roxycodone 30 mg, Roxycodone 15 mg, Xanax 2 mg as medications she was then taking. In a patient questionnaire, Patient J admitted to occasional use of alcohol, amphetamines and marijuana. A urine drug screen performed that day of Patient J was positive for the presence of Opiates, Oxycodone and Marijuana. Relating to her back pain, Patient J presented no prior medical records to verify her medical history and self-reported narcotic use, other than a MRI report, dated the same date as her visit, from an imaging center in Maryland, which found mild discogenic disease, spondylosis and diffuse posterior bulges at L4-5 and L5-S1, and herniated discs.

58. At this initial visit, the Respondent treated Patient J and assessed her with herniated disc, degenerative disc disease, radiculopathy and muscle pain. The Respondent then initiated Patient J on a medication regimen that included Oxycodone 30 mg (#84), Oxycodone 15 mg (#168), Alprazolam 2 mg (#28) and Parafon Forte 500 mg (#56). Patient J paid \$310 in cash for this initial visit.

59. Based on the records Healthy Life provided, Patient J returned on three subsequent occasions between June and August 2011, and was seen by the Respondent on each occasion. During her visit on or about June 8, 2011, Patient J reported an increase in pain secondary to increased workload and heavy lifting. The Respondent changed Patient J's medication regimen to Oxycodone 30 mg (#112),

Oxycodone 15 mg (#112), Alprazolam 2 mg (#28) and Parafon Forte 500 mg (#56). Patient J paid \$295 in cash for this visit.

60. For the next two visits, on or about July 6 and August 3, 2011, Patient J reported new discomfort and ineffective analgesia, and the Respondent maintained her on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112) and Alprazolam (#28). During July 6, 2011, visit, the Respondent added Gabapentin 600 mg (#28). During the August 3, 2011, visit, the Respondent discontinued Gabapentin and Parafon Forte, and added Elavil 25 mg (#28) and Soma 350 mg (#56).

Patient K

61. Patient K, then a 26 year-old male resident of North Carolina, initially presented to Healthy Life on or about April 28, 2011, with a self-reported two-year history of low back pain, which he described as sharp and achy, secondary to two prior motor vehicle accidents. In the patient questionnaire, Patient K reported no medical or surgical history relating to his pain and did not claim to be on any medications. A urine drug screen performed that day of Patient K was negative for the presence of CDS. Patient K presented a drug history printout, which showed that he was prescribed narcotics and benzodiazepine in or around January 2011, and a MRI report, dated July 14, 2009, from an imaging center in North Carolina, which found mild early degenerative facet disease with no neural foraminal or spinal canal or lateral recess narrowing at any level. Other than those documents, Patient K presented no prior medical records to verify his self-reported medical history.

62. At this initial visit, the Respondent treated Patient K and assessed him with osteoarthritis of the lumbar spine, and placed him on a medication regimen that

included Oxycodone 30 mg (#84), Oxycodone 15 mg (#84) and Alprazolam 2 mg (#28). Patient K paid \$300 in cash for this initial visit.

63. Based on the records Healthy Life provided, Patient K returned on three subsequent occasions between May and July 2011, and saw the Respondent on all three occasions. During his visit on or about May 26, 2011, Patient K reported sufficient pain relief but complained of numbness to his leg. The Respondent also noted, “[Patient K] wants more pain meds despite lack of spinal pathology outside of facet [osteoarthritis].” The Respondent continued Patient K on Oxycodone 30 mg (#84), Oxycodone 15 mg (#84) and Alprazolam 2 mg (#28). Patient K paid \$295 in cash for this visit.

64. For the next two visits, on or about June 23 and July 25, 2011, Patient K reported adequate pain relief but continued to complain of radicular leg pain. During the June 23, 2011, visit, the Respondent continued Patient K on Oxycodone 30 mg (#84) and Oxycodone 15 mg (#84) and added Gabapentin 300 mg (#28) and Mobic 15 mg (#28). Patient K underwent a urine drug screen that day that revealed the presence of benzodiazepines, oxycodone and marijuana. During the July 25, 2011, visit, the Respondent continued the previous medication regimen, but increased the Gabapentin dosage to 600 mg and added Elavil 25 mg (#28). Patient K paid \$285 in cash for the June visit and \$250 in cash for the July visit.

Patient L

65. Patient L, then a 53 year-old male resident of Kentucky, initially presented to Healthy Life on or about April 13, 2011, with complaints of progressive low back pain since 1989, which he described as achy, burning, throbbing and sharp. Patient L

described the pain as radiating down his legs. In a patient questionnaire, Patient L reported a surgical history that included colon cancer and cholecystectomy, and claimed that he was taking Roxycodone 30 mg, Roxycodone 15 mg and Zanax. A urine drug screen performed that day on Patient L was positive for the presence of benzodiazepines and Oxycodone. Patient L presented MRI reports, dated May 11, 2010 and performed in Kentucky, which found multilevel spondylosis with mild spinal stenosis of the cervical spine and moderate central canal stenosis due to broad based disc bulge of the lumbar spine. Other than the MRI reports, Patient L presented no prior medical records to verify his self-reported medical history and narcotic use.

66. At this initial visit, the Respondent treated Patient L and who assessed him with chronic spinal stenosis, lumbar spinal stenosis, chronic low back pain and muscle spasm. The Respondent then placed Patient L on a medication regimen that included Oxycodone 30 mg (#112), Oxycodone 15 mg (#112) and Chlorzoxazone (Parafon) 250 mg (#84). Patient L paid \$300 in cash for this initial visit.

67. Based on the records Healthy Life provided, Patient L returned on three subsequent occasions between May and July 2011, and saw the Respondent on all three occasions. During his visit on or about May 23, 2011, Patient L reported a recent fall that resulted in a pulled ligament in his left knee and complained of ineffective muscle relaxant. The Respondent then changed Patient L's medication regimen to Oxycodone 30 mg (#168), Percocet 10/325 mg (#84), Alprazolam 2 mg (#28) and Parafon Forte 500 mg (#56).

68. Patient L returned on or about June 23, 2011, and reported adequate analgesia. The Respondent continued Patient L on Oxycodone 30 mg (#168), Percocet

10/325 mg (#84), Alprazolam 2 mg (#28) and Parafon Forte 500 mg (#56), but added Gabapentin 600 mg (#28).

69. Patient L saw the Respondent again on or about July 21, 2011. The Respondent noted that Patient L lost weight and ambulated with a cane instead of crutches. The Respondent continued Patient L on Oxycodone 30 mg (#168), Percocet 10/325 mg (#84) and Parafon Forte 500 mg (#56), but lowered his Xanax dosage to 1 mg and his Gabapentin dosage to 300 mg. The Respondent also added Dalmane 15 mg (#28). Patient L paid \$250 in cash for this visit.

Patient M

70. Patient M, then a 69 year-old male resident of Kentucky, initially presented to Healthy Life on or about April 13, 2011, with a self-reported history of low back pain, right hip pain and right leg pain, secondary to a motor vehicle accident three years prior. Patient M was unable to answer almost all of questions in a patient questionnaire form, and the Respondent noted that he was a poor historian and had poor ability to comprehend. A urine drug screen performed that day on Patient M was positive for the presence of benzodiazepines and Oxycodone. Patient M presented a MRI report of his right hip, dated May 11, 2010, from an imaging center in Tennessee, which showed some arthritic changes and a focal lesion which could possibly be a lytic lesion. Other than the MRI report, Patient M presented no prior medical records to verify his self-reported medical history.

71. At this initial visit, the Respondent treated Patient M and assessed him with right hip osteoarthritis, and right/left femur lytic lesion. The Respondent then placed Patient L on a medication regimen that included Oxycodone 30 mg (#112),

Oxycodone 15 mg (#112) and Alprazolam 2 mg (#56). Patient L paid \$300 in cash for this initial visit.

72. Based on the records Healthy Life provided, Patient M returned on two occasions between May and June 2011, and saw the Respondent on both occasions. During Patient M's visit on or about May 23, 2011, the Respondent noted that Patient L was unable to understand his recommendations and that he should be accompanied by family members for his next visit. The Respondent then changed Patient L's medication regimen to Oxycodone 30 mg (#168) and Alprazolam 2 mg (#56). During the June 23, 2011, visit, the Respondent noted that Patient M was a poor historian. The Respondent continued Patient M on Oxycodone 30 mg (#168) and Alprazolam 2 mg (#56), and added Mobic 15 mg (#26) for osteoarthritis of the hip.

Patient N

73. Patient N, then a 34 year-old male resident of Kentucky, initially presented to Healthy Life on or about April 6, 2011, with a self-reported history of low back pain, which he described as achy and sharp, secondary to a work related injury in 2001. Patient N reported no prior medical or surgical history relating to his pain and claimed that he was taking Oxycodone 30 mg and Oxycodone 15 mg at the time of the initial visit. Other than a MRI report, dated January 4, 2010, from an imaging center in Florida, which found a herniated disc at L4-5, Patient N presented no prior medical records to verify his self-reported narcotic use. Handwritten notes on the MRI report indicated that Patient N was previously seen at "Total Care Medical Center" located in Florida.

74. At this initial visit, the Respondent treated Patient N and noted, “[Patient N] is able to work. No difficulties with other activities.” The Respondent then placed Patient N on a medication regimen that included Oxycodone 30 mg (#112), Oxycodone 15 mg (#112) and Alprazolam 2 mg (#56). A urine drug screen performed that day on Patient N was positive for the presence of Oxycodone and benzodiazepines. Patient N paid \$300 in cash for this initial visit.

75. Based on the records Healthy Life provided, Patient N returned on four subsequent occasions between May and July 2011, and saw the Respondent on all four occasions. During Patient N’s visits on or about May 4 and June 1, 2011, the Respondent noted “satisfactory analgesia” and continued Patient N on the same medication regimen of Oxycodone 30 mg (#112) and Oxycodone 15 mg (#112) and Alprazolam 2 mg (#56). Patient N paid \$295 in cash for the May 4, 2011, visit and \$250 in cash for the June 1, 2011, visit.

76. For the remaining two visits, on or about June 29 and July 27, 2011, Patient N reported pain to the right knee and radicular pain the his legs. The Respondent maintained Patient N on Oxycodone 30 mg (#112), Oxycodone 15 mg (#112) and Alprazolam 2 mg (#56), but added Gabapentin 600 mg (#28) on the July 27, 2011, visit. Patient N paid \$250 in cash for each visit.

Patient O

77. Patient O, then a 26 year-old male resident of Florida, initially presented to Healthy Life on or about April 5, 2011, with complaints of low back pain secondary to a jet ski accident. Patient O reported no prior medical or surgical history relating to his pain and claimed that he was taking Oxycodone 30 mg and Oxycodone 15 mg. Other

than a MRI report, dated November 10, 2010, from an imaging center in Florida, which found bulging disc and neural encroachment at L5-S1, Patient O presented no prior medical records to verify his medical history or self-reported use of narcotics. A urine drug screen performed that day on Patient O was positive for the presence of cocaine, marijuana, oxycodone and benzodiazepines.

78. At this initial visit, the Respondent treated Patient O and assessed him with bulging lumbar disc and prescribed Motrin 800 mg (#42). The Respondent advised Patient O to return in one to two weeks, at which time he would consider opiate analgesics. Patient O paid \$300 in cash for this initial visit.

79. Based on the records Healthy Life provided, Patient O returned on two subsequent occasions on or about April 12 and May 10, 2011, and saw the Respondent on both occasions. During her visit on or about April 12, 2011, Patient O underwent another urine drug screen, which was positive for marijuana, oxycodone and benzodiazepines. On this occasion, the Respondent placed Patient O on Oxycodone 30 mg (#112), Percocet 10/325 mg (#112) and Xanax 1 mg (#56). Patient O paid \$45 in cash for this visit.

80. During his visit on or about May 10, 2011, the Respondent noted that Patient O's pain was well under control and changed his medication regimen to Oxycodone 30 mg (#112), Oxycodone 15 mg (#84) and Alprazolam 1 mg (#56). Patient O paid \$295 in cash for this visit.

CONCLUSIONS OF LAW

Based upon the foregoing Investigative Findings, the Board concludes as a matter of law that the public health, safety, or welfare imperatively requires emergency

action, pursuant to Md. State Gov't. Code Ann. § 10-226(c)(2)(2009 Repl. Vol. and 2011 Supp.).

ORDER

It is this 29th day of MARCH, 2012, by a majority of the quorum of the Board;

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

ORDERED that a post-deprivation hearing in accordance with Code Md. Regs. tit. 10 § 32.02.05B(7) on the summary suspension will be held on **Wednesday, April 11, 2012, at 11:00 a.m.**, at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215; and it is further

ORDERED that at the conclusion of the Summary Suspension Hearing 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 set 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 it is further

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


- (1) The Respondent's original Maryland license D54547;
- (2) The Respondent's current renewal certificate;
- (3) The Respondent's current Federal DEA Certificate of Registration number BC6289676;

- (4) Any Maryland Controlled Dangerous Substance Registrations in his name;
- (5) All controlled dangerous substances in his possession and/or practice;
- (6) All Medical Assistance prescription forms in his possession and/or practice;
- (7) All prescription forms and pads in his possession and/or practice; and
- (8) Any and all prescription pads on which his name and DEA number are imprinted.

AND BE IT FURTHER ORDERED that a copy of this Order of Suspension shall be filed with the Board in accordance with Md. Health Occ. Code Ann. § 14-407(2009 Repl. Vol. and 2011 Supp.); and it is further

ORDERED that this is a Final Order of the Board, and as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.*(2009 Repl. Vol. and 2011 Supp.)

3-29-12
Date


Carole J. Catalfo
Executive Director
Maryland State Board of Physicians