IN THE MATTER OF	*	BEFORE THE MARYLAND
MARC S. POSNER, M.D.	*	BOARD OF
Respondent	*	PHYSICIANS
License Number: D19640	*	Case Nos: 2001-482, 2004-0764 & 2006-0066

****

CONSENT ORDER

On January 29, 2008, The Maryland State Board of Physicians (the "Board"), charged Marc S. Posner, M.D. (the "Respondent") (D.O.B. 06/02/1950), License Number D19640, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("Health Occ.") § 14-404(a) (2005). Specifically, the Board charged the Respondent with the following provisions of the Act under Health Occ. § 14-404:

> (a) 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.

Additionally, the Board charged the Respondent with violating the following condition of his January 26, 2005 Consent Order, providing in pertinent part:

> (b) Within one (1) year of the date of this Consent Order, the Respondent's practice shall undergo a peer review by an appropriate peer review entity and the results of this peer review shall be satisfactory in the judgment of the Board.

FINDINGS OF FACT

I. BACKGROUND

The Board finds:

1. At all times relevant to these charges, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. He was initially licensed in Maryland on or about August 9, 1976, and his license is presently active.

2. At the time of the acts described herein, the Respondent was a physician engaged in the practice of family medicine, geriatric medicine and pain management, at 1147 S. Hanover Street, Baltimore, Maryland, 21230, and held hospital privileges at Harbor Hospital Center and Mercy Medical Center.

3. On May 12, 2000, the Board issued a non-public Advisory Letter to the Respondent based on the receipt of a complaint regarding his prescribing practices. The Board advised the Respondent in the letter:

    1. When prescribing controlled substances which have a significant abuse potential, the rationale for prescribing these medications should be in greater detail than could be found in your charts;

    2. The documentation and physical examination, medical records, narrative reports, as well as additional information to support the need for not only controlled substances but also for additional services such as physical therapy, is significantly deficient; and

    3. There was an unusual connection of repeated medical visits which necessitated frequent and excessive narcotic medications, particularly for those individuals participating in

physical therapy without sufficient detail to assist in reaching this conclusion.

4. The Board informed the Respondent in its May 12, 2000 Advisory Letter that a peer review of the Respondent's practice would be conducted. Based on the results of the peer review, the Board charged the Respondent with violating Health Occ. § 14-404(a)(22), (27)[1] and (40) and as a resolution of the charges, the Respondent agreed to enter into a January 26, 2005 Consent Order with the Board. The Consent Order imposed a reprimand and a minimum of two years of probation with conditions including completion of a Board-approved course in medical record documentation; and that within one year of the date of the Order, the Respondent's practice shall undergo another peer review and the results "shall be satisfactory in the judgment of the Board."

5. Pursuant to the terms of the 2005 Consent Order, the Respondent completed a Board-approved course in medical recordkeeping. Additionally, he requested that an independent reviewer, Dr. S, review patient records focusing on documentation.

6. On or about May 11, 2006 the Board transmitted 7 patient records to the Delmarva Foundation for peer review. Delmarva assigned the review to 2 physicians specializing in family medicine. Additionally, the Board requested that a third physician specializing

[1] Sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes.

in pain management, review the records.[2] The Board requested that all 3 reviewers focus on the Respondent's medical record entries after November 2005, following the completion of the documentation requirements outlined in his Consent Order. Two of the reviewers[3] concurred that the Respondent failed to meet the standard of quality medical care with regard to 3 patients.

7. Additionally, the reviewers found the Respondent's care and treatment of 3 patients to be "unsatisfactory," failing to conform with condition (b) of the January 26, 2005 Consent Order.

8. The Respondent remains under the Board's probationary order as of the date of this Consent Order.

9. On or about August 24, 2006, the Board referred 12 additional patient records to Delmarva for peer review.[4] The same 2 practitioners specializing in family medicine reviewed the records. *See* ¶ 6. Additionally, the Board requested that the same specialist in pain management (*see* ¶ 6) review 8 of the 12 records reviewed by the family medicine practitioners. One of the family medicine practitioners and the pain management specialist concurred that

---

[2] Although all 3 of the reviewers found deviations in the standard of quality medical care, all 3 were unable to concur as to the specific deviations.

[3] The specialist in pain management as well as one of the family medicine practitioners concurred, and this Consent Order represents an adoption of the allegations by 2 of the 3 reviewers.

[4] This was precipitated by additional patient-related complaints received by the Board. Shortly after the Respondent entered into the Consent Order with the Board, by letter dated February 16, 2005, the Board notified the Respondent of additional complaints. The Respondent submitted a response to the Board on March 4, 2005.

the Respondent failed to meet the standard of quality medical care as to 4 patients.[5]

10. Based on its investigation, the Board voted to charge the Respondent with violating Health Occ. § 14-404(a)(22) and with a violation of Condition (b) of his January 26, 2005 Consent Order.

II. PATIENT RELATED FINDINGS OF FACT

Peer review #1[6]

PATIENT 1

11. Patient 1 was a 40 year-old male patient who began seeing the Respondent for pain management around September 6, 2001.[7] The Respondent treated Patient 1 for lumbar strain and lumbar degenerative disc disease. The medical records reviewed (from December 2005 through April 2006) reflected maintenance of Patient 1's opioid prescriptions and occasional prescriptions for non-steroidal anti-inflammatory drugs ("NSAID's").

12. The Respondent saw Patient 1 for an office visit on December 13, 2005. He cited the diagnosis of "lumbar disc," which is an anatomic description and not a diagnosis. The Respondent documented the office visit on a template form, checking off boxes. The Respondent prescribed Oxycontin[8] and Percocet[9] but failed to

[5] This Consent Order represents a concurrence by 2 of the 3 reviewers, the pain management specialist and 1 of the family medicine practitioners. All 3 reviewers found additional deviations in care as to other patients, but were unable to concur on the specific deviations.
[6] Patients identified as 1 through 3 were subjects of the peer review conducted as a condition of the Respondent's January 26, 2005 Consent Order.
[7] This was the date of the first progress report noted in Patient 1's medical record.
[8] Schedule II Controlled Dangerous Substance ("CDS").

document any explanation or justification for his treatment strategies.

13. The Respondent next saw Patient 1 on January 10, 2006. The second page of the note however, was dated November 15, 2005.

14. The Respondent saw Patient 1 on February 7, 2006. The second page of the note again was dated November 15, 2005.

15. The Respondent's notes dated January 10, 2006 and February 7, 2006, are virtually identical except for the patient's vital signs.

16. The Respondent saw Patient 1 for an office visit on March 7, 2006, and again he listed the diagnosis as "lumbar disc."

17. The Respondent's notes dated February 7, 2006 and April 4, 2006 are virtually identical except for the past surgical and medical history is updated on the later date and the vital signs differ.

18. The Respondent or his office staff appear to be "cutting and pasting" elements from previous notes as cited above.

19. The Respondent failed to document diagnostic studies including x-rays and MRI's to support any pathology in Patient 1's spine. Patient 1's chart failed to include any history of lumbar surgery or other interventions to support a diagnosis of degenerative disc disease.

20. In several notes between November 15, 2005, through and including April 4, 2006, the Respondent documented that Patient 1 needed imaging studies or "MRI."

---

[9] Schedule II CDS.

21. Between November 15, 2005, through and including April 4, 2006, the Respondent continued to "refer" Patient 1 for a Physical Medicine Evaluation, but there is no documentation supporting Patient 1's compliance with the Respondent's recommendation. Despite Patient 1's noncompliance, the Respondent continued to treat him with opioid therapy.

22. The Respondent failed to meet the standard of quality medical care with regard to Patient 1, and the Respondent's care was unsatisfactory in violation of Condition (b) of the Consent Order, for reasons including but not limited to:

    a. the Respondent's continued treatment of Patient 1 with chronic opioid therapy despite his failure to obtain and/or include diagnostic studies in Patient 1's chart supporting his pathology.

PATIENT 2

23. Patient 2 was a 44 year-old male patient when he began seeing the Respondent for pain management in September 2002[10] at the Downtown Baltimore Pain Center. The Respondent treated Patient 2 for low back pain and cervical pain. The Respondent's treatment included opioids, muscle relaxants and a brief course of Cymbalta.[11] The Respondent referred Patient 2 for psychological screening and for a consultation with a spine surgeon.

24. On or about March 7, 2006, the Respondent discharged Patient 2 from his practice secondary to receiving an "outside report

[10] This was the date of the first progress note documented in Patient 2's record.
[11] An antidepressant.

indicating narcotic addiction or diversion." According to the "report" Patient 2 had been receiving narcotic medications from 2 additional providers and having the prescriptions filled at 3 separate pharmacies. Patient 2 denied the validity of the report.

25. The Physician Assistant (hereinafter, "P.A.") supervised by the Respondent referred Patient 2 to "detox," which "he declined" and provided him with contact information for other pain management centers.

26. Despite having received the report indicating addiction or diversion, the Respondent provided Patient 2 with a month supply of his pain medications including 15 Duragesic patches,[12] 90 tablets of OxyIR[13] 5 mg. and 90 tablets of Soma[14] 350 mg.

27. The Respondent immediately discharged Patient 2 from his practice. He documented "he will not be seen here again for pain."

28. The Respondent failed to meet the standard of quality medical care for Patient 2 and the Respondent's care of Patient 2 was unsatisfactory for reasons including but not limited to:

    a. providing Patient 2 with a month's supply of CDS after receiving a report that he was addicted or diverting narcotics; and/or

    b. a failure to provide Patient 2 with reasonable notice before discharging him from care, allowing Patient 2 time to identify alternative care providers.

PATIENT 3

[12] Fentanyl Transdermal Patch, a Schedule II CDS.
[13] Schedule II CDS.
[14] Muscle relaxant that may be habit-forming.

29. Patient 3 was a 48 year-old male patient when he began seeing the Respondent for pain management at the Downtown Baltimore Pain Center in or around July 20, 2000.[15] The Respondent treated Patient 3 for both cervical and lumbar pain with a combination of opioids and NSAID's. Patient 3 was also receiving SSRI's[16] and benzodiazapines for generalized anxiety and depression.

30. Patient 3's medical records did not include any formal imaging studies of the Patient's neck or back. In several visits including December 1, 2005, December 29, 2005, February 2, 2005 (*sic*),[17] March 3, 2006 and April 4, 2006, the Respondent and the P.A. noted that there were no imaging studies in Patient 3's medical record.

31. On December 1, 2005, the Respondent documented that the imaging study was scheduled.

32. On December 29, 2005, the Respondent documented that the imaging study had been scheduled for March 2006.

33. In the subsequent notes, the Respondent and the P.A. noted the imaging studies were "pending insurance (April/May 2006)" but also documented "no later than this; already overdue."

34. Patient 3's medical record did not include any consultations from surgeons or other specialists regarding his pain conditions.

---

[15] Patient 3 signed a Pain contract on this date, but the initial progress note is dated October 11, 2002.
[16] Selective serotonin reuptake inhibitors are a class of antidepressants.
[17] According to the note's placement in the chart, it appears that the intended date is 2006.

35. During several visits dated December 1, 2005 through and including April 4, 2006, the Respondent documented "Physical Medicine Consult" and "scheduled." Patient 3's record however, does not support that this consultation was carried out or pursued.

36. With regard to Patient 3, the Respondent failed to meet the standard of quality medical care and the Respondent's care of Patient 3 was unsatisfactory for reasons including but not limited to:

   a. his long term management with opioid therapy of Patient 3's "herniated lumbar disc" without obtaining the appropriate diagnostic workup including imaging studies and consultations.

Peer Review #2[18]

PATIENT 4

37. Patient 4 was brought to the attention of the Board through a complaint filed by an employee insurance company. The complaint alleged that the Respondent was prescribing large amounts of analgesic pain medication for an extended period of time to Patient 4.

38. Patient 4 was a 27 year-old male patient when he began seeing the Respondent for back pain in January 2000. According to the medical records received by the Board, the Respondent saw Patient 4 through June 2004.

[18] Patients identified as 4 through 7 were subjects of a peer review conducted based on the Board's receipt of additional complaints outlined above in the "Background" section of this document, and were reviewed independently of Patients 1 through 3.

39. On Patient 4's first office visit in January 2000, the Respondent started him on long acting narcotics (Oxycontin and Percocet)[19] for "thoracic strain, chronic back pain" without obtaining any prior records or conducting any studies.[20] The record indicated that Patient 4 was on "no medications" prior to this visit. From January 2000 through May 2004, the Respondent prescribed monthly Oxycontin and Percocet to Patient 4 for "lumbar disc." Initially the Respondent prescribed 90 tablets of Oxycontin and 20 tablets of Percocet monthly; this was occasionally increased to 30 tablets of Percocet beginning in August 2003 through at least June 2004.

40. The standard of quality medical care requires that the decision to institute and maintain chronic opioid therapy should include the following: 1) an assessment that there is a medical condition present that would warrant the use of chronic opioids; 2) documentation to substantiate conservative therapies have been either tried or were contraindicated; and 3) careful consideration be given to the risks verses the benefits of the opioid therapy. This requires a careful assessment of the patient's addiction risk.

41. Patient 4's medical record did not include an adequate assessment indicating he had a medical condition that would warrant the use of chronic opioids, documentation to substantiate conservative therapies had been tried or were contraindicated or risks verses

---

[19] Schedule II CDS.

[20] There was no record in Patient 4's chart that the Respondent requested Patient 4's records from previous providers.

benefits of opioid therapy, including an assessment of the patient's addiction risk.

42. The Respondent's physical examination was cursory, failing to complete a neurologic evaluation.

43. The Respondent failed to document any alternatives to narcotics such as antiinflammatories or muscle relaxants.

44. On April 3, 2000 Patient 4 had an x-ray that showed mild partial compression of his L-4 vertebral region.

45. On March 19, 2001, Patient 4 underwent an MRI that showed questionable disc herniation at L4-5, and the radiologist recommended a repeat study, as Patient 4 was moving during the exam. The Respondent made repeated requests for Patient 4 to have the study, but Patient 4 failed to comply.

46. In August 2002, Patient 4 was evaluated by a neurologist at the request of his insurance company. The neurologist noted that Patient 4 "reportedly" had an appointment with a neurosurgeon for evaluation and that if surgery was not undertaken, Patient 4 should be referred to more intensive physical therapy coupled with weight loss. Additionally, he recommended that Patient 4's medications not be limited to analgesics alone. He further recommended laboratory work. The Respondent failed to follow the consultant's recommendations.

47. Patient 4's Pain Contract with the Respondent required that he have these studies done as a requirement to receiving the narcotics.

48. The Respondent continued to prescribe opiates to Patient 4 despite his non-compliance.

49. The Respondent failed to meet the standard of quality medical care for Patient 4 for reasons including but not limited to:

    a. the initiation of opioid therapy without an adequate assessment of Patient 4 indicating that he had a medical condition that would warrant the use of chronic opioids;

    b. his failure to document that conservative therapies had been either tried or were contraindicated;

    c. his failure to document that careful consideration had been given to the risks verses the benefits of the opioid therapy; and/or

    d. his continued prescribing of increasing doses of narcotics for back pain despite Patient 4's non-compliance with referrals for follow-up imaging studies and neurology.

PATIENT 5

50. Patient 5 was a 21 year-old male Patient when he began seeing the Respondent for medical care in June 2000. He saw him for care for approximately 2 years.[21] Patient 5 had a history of Crohn's disease according to the Respondent, but the diagnosis was never verified by any objective data in Patient 5's medical record, such as

---

[21] On several visits, Patient 5 was seen by a P.A. in the practice, who was supervised by the Respondent.

radiology or laboratory reports, consultation reports from any gastroenterologists or reports from any GI procedures.[22]

51. The Respondent failed to document the Respondent's medical history, family or social history prior to initiating treatment with Oxycontin and Percocet.

52. On or about February 22, 2001, the Respondent documented his plan was "GI consult." In April 2001, the P.A. documented that "Pt seeing GI this month;" and in May 2001, the P.A. documented "get old/new records GI," however, there are no GI records or reports contained in Patient 5's medical record. Additionally, as of December 27, 2001, the P.A. was continuing to prescribe Asacol (a medication used in the treatment of Crohn's disease).

53. On May 17, 2001, Patient 5 requested a dosage increase in his Oxycontin because it is "not helping anymore with his pain." On June 14, 2001, the Respondent doubled his Oxycontin dosage to 80 mg. every 8 hours (increased from 40 mg. over the past year). There was no documentation regarding the GI consult ordered in February.

54. On February 21, 2002, the P.A. documented as a plan "Colonoscopy." There is no indication in Patient 5's record however, that Patient 5 had the procedure; in March, there was documentation that he couldn't schedule the procedure because of

---

22 The sole indication that Patient 6 had Crohn's was the Respondent's prescription of medications to Patient 6 such as Asacol.

insurance issues, and in April, there was documentation that he "should have insurance by next month." There was no further documentation by the Respondent or the P.A. regarding the procedure or that Patient 6 was followed by a gastroenterologist.

55. In June 2002, the P.A. increased Patient 5's Percocet to 75 per month as he noted a "really bad month [with] abdominal pain."

56. In July 2002, the P.A. increased the Percocet to 90 per month as again Patient 5 indicated he had "a bad month." The Respondent continued this prescription (along with the prescription for Oxycontin) from August through December 2002.

57. On December 8, 2002, there was a note in Patient 5's chart stating "Oxycontin 80 mg. not filled, getting it from another doctor."

58. The standard of quality medical care requires that the decision to institute and maintain chronic opioid therapy requires that an assessment be done establishing there is a medical condition present that would warrant the use of chronic opioids; and that documentation exists to substantiate conservative therapies have either been tried or were contraindicated and that careful consideration be given to the risks verses benefits of the opioid therapy for the patient.

59. The Respondent failed to meet the standard of quality medical care for Patient 5 for reasons including but not limited to:

    a. Patient 5's history and physical examinations were inadequate to properly assess his condition or arrive at the

determination that chronic opioid therapy was medically appropriate;

b. the provision of opioid therapy for a diagnosis of Crohn's disease that was not verified anywhere in the record through objective data such as records from a gastroenterologist, reports following GI procedures, radiology or laboratory studies; and/or

c. the Respondent's continued issuance of prescriptions to Patient 5 for opioid therapy for his Crohn's disease despite the patient's failure to obtain a GI consult, a colonoscopy or GI records (or ensuring that Patient 5 obtain this data).

PATIENT 6

60. Patient 6 was a 37 year-old male patient when he saw the Respondent for medical care on or about June 25, 2001, for "lumbar strain." Patient 7 had a history of Hepatitis C.[23]

61. Patient 6 had MRI scans on November 28, 2000 and May 25, 2001. The results demonstrated routine degenerative findings.

62. The Respondent's history and physical examination was inadequate to assess and treat Patient 6.

63. On June 25, 2001, the Respondent initially prescribed Duragesic patches and Elavil.[24]

64. On July 30, 2001, the Respondent prescribed MS Contin[25] after noting "Patches not helpful." Over time, the Respondent treated Patient 6 with escalating doses of opioids despite minimal evidence that he had any significant pathology.

---

[23] This was not noted in Patient 7's chart until on or about January 2005, when a laboratory report was sent to the Respondent's office.
[24] An antidepressant.
[25] Schedule II CDS; time released formulation of Morphine.

65. The Respondent's treatment of Patient 6's lumbar strain was inconsistent with established guidelines for the low back pain.[26]

66. The standard of quality medical care requires that the decision to institute and maintain chronic opioid therapy should include the following: 1) an assessment that there is a medical condition present that would warrant the use of chronic opioids; 2) documentation to substantiate conservative therapies have been either tried or were contraindicated; and 3) careful consideration be given to the risks verses the benefits of the opioid therapy. This requires a careful assessment of the patient's addiction risk.

67. Patient 6's medical record did not include an adequate assessment indicating he had a medical condition that would warrant the use of chronic opioids, documentation to substantiate conservative therapies had been tried or were contraindicated or risks versus benefits of opioid therapy, including an assessment of the patient's addiction risk.

68. On September 9, 2002, Patient 6 had a behavioral medicine evaluation that indicated he had no psychopathology. This was inconsistent with the Respondent's course of treatment, in diagnosing Patient 6 with a generalized anxiety disorder and treating him with daily benzodiazapines.

[26] Low Back Pain: AHCPR Clinician Guidelines, U.S. Agency for Health Care Policy Research (1994).

69. Patient 6 had a history of alcoholism that was never identified by either the Respondent or by the behavioral medicine specialist.[27]

70. On October 27, 2005, the Respondent advised Patient 6 to discontinue his MS Contin and prescribed Methadone 40 mg. ii (2), (start with 1 every 12 hours) every 12 hours. The Methadone dose was inappropriately high relative to the MS Contin he had been taking. Methadone acts slowly and would be expected to be more effective since Patient 6 had not taken it before; therefore, the standard of quality medical care would require that the Respondent prescribe a low dose and increase it slowly.

71. A potential side effect of Methadone soon after beginning the medication, is sedation. This routinely can be attributed to the dose being too high; patients do not routinely experience the full effects of the first dose for a few days. There is no documentation in Patient 6's chart that the Respondent or the P.A. provided this information to Patient 6 prior to starting the Methadone.

72. On October 29, 2005, the Patient was found dead after "nodding off" according to Patient 6's girlfriend. The Medical Examiner found Patient 6's cause of death to be secondary to "methadone intoxication complicating cirrhosis."

73. The Respondent failed to meet the standard of quality medical care for Patient 6 for reasons including but not limited to the following:

---

[27] As documented in the Autopsy report.

a. The Respondent's initial history and physical examination of Patient 6 was inadequate to evaluate and treat this Patient with chronic opioid therapy;

b. the Respondent's initial treatment of Patient 6's lumbar strain with Duragesic patches; and/or

c. the Respondent's conversion and titration from MS Contin to an inappropriately high dose of Methadone.

PATIENT 7

74. Patient 7 was a 32 year-old male patient when he began seeing the Respondent for medical care in October 1996 for right thigh pain. He had a history of morbid obesity, severe obstructive sleep apnea and chronic pain. Patient 7 had arthroscopic knee surgery in July 1996 for a torn ligament and torn lateral meniscus in his left knee.

75. In December 1996 Patient 7 was evaluated by St. Agnes' pain clinic for an evaluation for right thigh pain and numbness, unrelated to his knee. At the time, he was taking Lorcet[28] and Tegretol.[29] The evaluating physician recommended nerve blocks.

76. In January 1997, the Respondent began prescribing Oxycontin 10 mg., #28 to Patient 7, along with the Tegretol at each visit. He was seeing Patient 7 approximately every two weeks.

77. In April 1997, the Respondent again referred Patient 7 to St. Agnes Hospital's Pain Management Service ("PMS") for an evaluation. The recommendations from the team included weight loss, a diagnostic nerve block and a physical therapy evaluation. The

[28] Schedule III CDS.

[29] Anticonvulsant used in the treatment of trigeminal neuralgia.

pharmacy evaluator noted that Patient 7 may benefit from an increased Oxycontin dosage until the weight loss and physical therapy "take effect." The substance abuse evaluator noted that Patient 7 had a past history of alcohol abuse (drinking a 12 pack nightly).

78. In May 1997, the Respondent increased Patient 7's Oxycontin to 20 mg. twice daily, #28, continuing to prescribe for Patient 7 approximately every 2 weeks.

79. From July 17 through October 9, 1997, the Respondent began prescribing monthly for Patient 7 and increased Patient 7's monthly Oxycontin to 40 mg., and providing him with 60 tablets each month.

80. An August 13, 1997 note from St. Agnes' PMS noted that Patient 7 had two blocks which were not effective and had a physical therapy session on that date.

81. On August 15, 1997, the Respondent also began prescribing monthly Xanax, .5 mg. as needed at bedtime, #30.[30]

82. On December 19, 1997, the Respondent increased Patient 7's monthly Oxycontin to 80 mg. and provided him with 60 tablets.

83. On January 19, 1998, St. Agnes' PMS discharged Patient 7 from the pain management program as he indicated "his doctor said not to have physical therapy on his right leg at this time."

84. On April 23, 1998, Patient 7 was seen by a neurologist who learned the Respondent was treating him for "panic attacks" and his

[30] Schedule IV CDS used in the treatment of anxiety and panic attacks.

medications included Paxil[31] and Xanax. The neurologist indicated he "stopped [Patient 7's] Xanax" and recommended that he take Elavil at bedtime. He also stated that if Patient 7's unpleasant symptoms continued, he recommended a referral to a neurosurgeon.

85. During Patient 7's May 4, 1998, visit, however, the Respondent prescribed Xanax to Patient 7, and continued to do so through 2003.

86. On May 14, 1998, Patient 7 returned to the neurologist for follow-up who wrote a letter to the Respondent stating "you have restarted his Tegretol and Xanax." He recommended that Patient 7 see a neurosurgeon but that Patient 7 declined to consider this option. The neurologist released Patient 7 from his "active care."

87. On May 28, 1998, the Respondent increased Patient 7's monthly Oxycontin 80 mg., to 90 tablets.

88. On November 30, 1998, a P.A. in the Respondent's practice only provided 60 tablets of 80 mg. Oxycontin to Patient 7 (along with Paxil and Xanax). On December 24, 1998, however, the Respondent again provided Patient 7 with 90 tablets of 80 mg. Oxycontin (prescribing it every 12 hours).

89. On January 22, 1999, the Respondent documented the monthly Oxycontin 80 mg., #90 was to be taken every 8 hours. These prescriptions continued along with Xanax and Paxil.

---

[31] Used in the treatment of depression, panic attacks, anxiety and post-traumatic stress.

90. In August 2000, Patient 7 was seen at the "Center for Pain Management" for a pain consultation. The consulting pain specialist recommended a selective nerve root block or to try a Lidoderm patch[32] on the thigh.[33]

91. On September 11, 2000, the Respondent documented "saw pain management –no new suggestions." He continued to refill Patient 7's medications.

92. In November 2000, Patient 7 underwent arthroscopic surgery on his left knee. The orthopedic surgeon noted during his follow-up visits that Patient 7 takes Oxycontin "when needed."

93. On November 13, 2000, Patient 7 complained of sleep apnea and the Respondent documented "will order C-Pap after sleep apnea test."

94. On November 30, 2000, a staff person documented that Patient 7's wife was given sleep study results and informed that he has "severe sleep apnea and CPAP machine was ordered."

95. On December 4, 2000, the Respondent continued prescribing Oxycontin 80 mg., #90, Xanax and Paxil.

96. In January 2001, the Respondent increased Patient 7's dosage of Xanax to .5 mg three times daily, #90.

97. In March 2001, Patient 7 underwent an excision of a popliteal cyst from his left knee by an orthopedic surgeon.

---

[32] Lidocaine patch.

[33] Page 2 of the consultation was missing from the chart.

98. On June 7, 2001, the Respondent added Soma[34] to Patient 7's monthly prescriptions for Oxycontin and Xanax.

99. On July 9, 2001, a P.A. working with the Respondent prescribed Oxycontin 80 mg. every 8 hours (#90), Soma 3 times daily (#90), Xanax, .5 mg three times daily (#90) and Paxil, 20 mg. (with 3 refills) to Patient 7.

100. On August 6, 2001, the Patient stated the "medicine is not holding him like it used to." The P.A. prescribed OxyIR[35] 5 mg. in addition to the Oxycontin, Soma and Xanax (with the dosages as noted in ¶ 99). These prescriptions were also provided on September 4, 2001, with the addition of Paxil 20 mg. every day (#30).

101. On October 2, 2001, Patient 7 had edema of the lower extremities and complained of a right knee injury and the P.A. documented "feels pain meds isn't enough." He was going to see his "knee doctor." The P.A. prescribed Percocet 10 (#30) in addition to the above dosages of Oxycontin, Xanax and Soma. The P.A. noted in her plan that an echocardiogram was to be scheduled.[36]

102. From October 30, 2001 through April 2002, the Respondent continued prescribing Oxycontin, Percocet, Xanax, Soma and Paxil at the above doses, despite the results of a Sleep Study[37] that was done on January 30, 2002. The consulting Sleep Medicine

---

[34] Centrally acting muscle relaxant that is not controlled by the DEA, but can lead to tolerance.
[35] Schedule II CDS; narcotic analgesic.
[36] There is no echocardiogram report in Patient 7's chart confirming the test was done.
[37] Nocturnal Polysomnogram (NSPG) with Nasal CPAP interpretation.

specialist recommended that CNS depressants be avoided, but the Respondent continued prescribing these contraindicated medications through September 2002.

103. In May 2002, the P.A. discontinued Patient 7's Percocet because he indicated it did not help with the pain, and substituted a Duragesic patch 25 mg., every three days (#10), in conjunction with the Oxycontin, Xanax and Soma.

104. On June 11, 2002, Patient 7 reported he did not like the Duragesic patch as it made him feel drowsy. The P.A. prescribed OxyIR 5 mg. again (#30) along with Oxycontin, Xanax and Soma.

105. On July 9, 2002, Patient 7 reported his heart was racing and he had increased panic attacks. He felt the Paxil was not helping him, so the P.A. prescribed Zoloft[38] instead. The P.A. also prescribed extra medications to Patient 7 as she documented that the office was closed.[39] She prescribed 111 tablets of Oxycontin (80 mg every 8 hours), 111 tablets of Soma (three times daily), 111 tablets of Xanax (.5 three times daily) and 37 tablets of OxyIR 5 mg.

106. On August 4, 2002, Patient 7 was admitted to Harbor Hospital Center for panic attacks, shortness of breath and edema. Although on admission the Respondent noted that he would be continued on his pain medication, in his discharge summary, another physician who worked with the Respondent, noted that he was withholding all

[38] An antidepressant.
[39] Patient 7 returned for an office visit, however, on August 13, 2002.

of Patient 7's sedating medications, including Oxycontin and Xanax as he was hypersomnolent. The physician noted that Patient 7's hypersomnolence was most likely due to medications, his main suspicion being the Oxycontin 80 mg. three times daily.

107. On August 13, 2002, the Respondent continued prescribing Patient 7's Oxycontin along with Zoloft and Xanax.

108. On September 10, 2002, the P.A. prescribed Oxycontin, Xanax and Soma.

109. Patient 7 refused to continue physical therapy, have surgery or try nerve blocks from the pain management consultant as recommended in 2000, in lieu of continuing chronic opioid therapy, and the Respondent continued prescribing long-term CDS to him.

110. In September 2002, Patient 7 began seeing another physician for pain management. The Respondent saw Patient 7 however, for approximately one more year (through September 23, 2003) for medical problems as well as anxiety and depression. The Respondent continued to prescribe Zoloft, Xanax and Soma.

111. The Respondent failed to meet the standard of quality medical care for Patient 7 for reasons including but not limited to:

a. his failure to adequately assess the safety of prescribing a combination of opioids, benzodiazapines and Soma for a patient with morbid obesity, severe sleep apnea and documented hyper-somnolence from these medications; and/or

b. his ongoing prescribing of opioids, benzodiazapines and Soma for a patient with morbid obesity, severe sleep apnea and documented hyper-somnolence from these medications.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions and inactions as outlined herein constitute violations of Health Occ. § 14-404(a)(22) and with violating the following condition of his January 26, 2005 Consent Order:

(b) Within one (1) year of the date of this Consent Order, the Respondent's practice shall undergo a peer review by an appropriate peer review entity and the results of this peer review shall be satisfactory in the judgment of the Board.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 25th day of June, 2008, by a quorum of the Board considering this case:

ORDERED that the Respondent be and is hereby **REPRIMANDED**; and it is further

ORDERED that within **sixty (60) days** of this executed Consent Order, the Respondent shall permanently terminate his pain management practice and provide satisfactory evidence to the Board thereof; and it is further

ORDERED that the Board shall conduct a chart review and/or a peer review six (6) months to one (1) year after the execution of this Consent Order and thereafter at the Board's discretion. An unsatisfactory report may constitute a violation of the Consent Order; and it is further

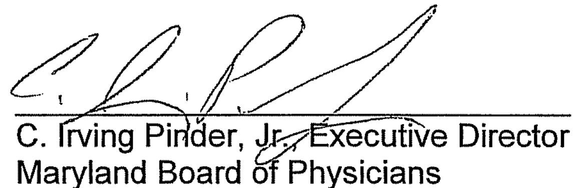
ORDERED that the Respondent shall comply with all laws governing the practice of medicine under the Maryland Medical Practice Act and all rules and regulations promulgated thereunder; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that if the Respondent violates any of the terms and conditions of this Order, the Board may impose any sanction that the Board may have imposed in this case under Health Occ. § 14-404(a) of the Medical Practice Act, including probation, suspension, revocation and/or a monetary fine; and it is further

ORDERED that this Consent Order shall be a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 et seq. (2004 & Supp. 2007).

6/25/08
Date



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

CONSENT ORDER

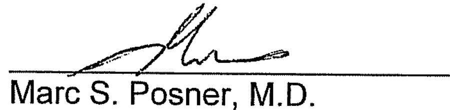
I, Marc S. Posner, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own

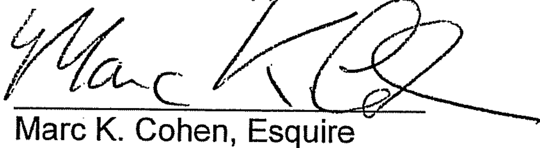
behalf, and to all other substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

5-30-08
Date


Marc S. Posner, M.D.

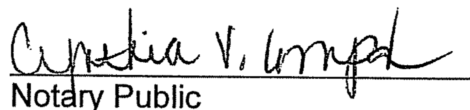
Reviewed and Approved by:


Marc K. Cohen, Esquire

STATE OF MARYLAND
CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 30th day of May, 2008, before me, a Notary Public of the foregoing State and City/County personally appeared Marc S. Posner, M.D., License Number D19640, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.


Notary Public