IN THE MATTER OF	*	**BEFORE THE**
LUCKRICIA OLIVACCE, PA-C	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: C05876	*	**Case Number: 2219-0047B**

* * * * * * * * * * * *

FINAL DECISION AND ORDER

INTRODUCTION AND PROCEDURAL HISTORY

Luckricia Olivacce, PA-C ("Ms. Olivacce" or the "Respondent"), practices as a physician assistant at a pain management group practice in Hagerstown, Maryland (the "Facility"). On September 10, 2018, the Maryland State Board of Physicians (the "Board") received a complaint alleging that Ms. Olivacce prescribed an inappropriate amount of Controlled Dangerous Substances (CDS) to a patient, thereby contributing to that patient's death. On November 29, 2018, the Board issued a Subpoena Duces Tecum that directed Ms. Olivacce to transmit "**a COMPLETE COPY of any and all medical records**" for ten named patients. On December 18, 2018, Ms. Olivacce transmitted the ten patient records to the Board and signed a certification under penalty of perjury that she was complying with the subpoena by providing the complete medical records for those patients. The Board subsequently sent the patient records to a peer review entity and the records were reviewed by a physician assistant peer reviewer who specializes in pain management. The peer reviewer found that Ms. Olivacce failed to meet the standard of care for pain management for six of the ten patients and failed to keep adequate medical records for seven of the ten patients.

On January 16, 2020, Disciplinary Panel B of the Board issued charges against Ms. Olivacce alleging that she violated Maryland Code Ann., Health Occupations Article § 15-314(a)(22) and (40), for failing to meet appropriate standards for the delivery of quality medical

and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State (the "standard of care") and failing to keep adequate medical records based on the peer review.

On April 29, 2020, after the charges in this case were issued, Ms. Olivacce transmitted to the Board approximately 1,182 pages of additional medical records that she had not previously transmitted to the Board pertaining to the patients whose care had been reviewed by the peer reviewer. Upon review of the additional documents, the peer reviewer found that there were still standard of care violations for six of the ten patients whose charts were reviewed, but amended many of her original findings, eliminating some of the reasons for standard of care violations for each patient. Upon review of the additional records, the peer reviewer revised her findings related to medical recordkeeping violations, finding violations for two patients and not the seven that she had initially found. On August 31, 2020, Panel B issued amended charges that included the updated charges related to Health Occ. § 15-314(a)(22) and (40) and added a new charge, under Health Occ. § 15-314(a)(33), for failing to cooperate with a lawful investigation based on Ms. Olivacce's failure to comply with the subpoena's directive that she produce a complete copy of any and all records for the named patients.

On May 12, 13, 14, 18 and June 2, 2021, Ms. Olivacce received a five-day evidentiary hearing before an Administrative Law Judge ("ALJ") at the Office of Administrative Hearings. At the hearing, the State introduced 23 exhibits and presented testimony from the peer reviewer who was accepted as an expert in Pain Management and the Board's compliance analyst. Ms. Olivacce introduced 32 exhibits, testified on her own behalf, and presented testimony from two experts in diagnosis and treatment of chronic pain patients, standard of care for the treatment of chronic pain patients, urinary drug screening, aberrant behaviors and documentation, as well as

testimony from her supervisor with whom she had a delegation agreement at the Facility, and the regional director of operations for the Facility.

The ALJ issued a proposed decision, on September 2, 2021, recommending dismissing all of the charges.

The State and Ms. Olivacce both filed written exceptions to the ALJ's Proposed Decision and Ms. Olivacce filed a response to the State's exceptions. Both parties appeared before Disciplinary Panel A of the Board for an oral exceptions hearing on April 13, 2022. After considering the entire record, the written exceptions and oral arguments by both parties, Disciplinary Panel A issues this Final Decision and Order.

FINDINGS OF FACT

The Panel adopts ALJ's Proposed Findings of Fact with limited modifications. The ALJ's Proposed Findings of Fact (pages 7-19, numbered paragraphs 1-9, 13-15, and 17-114) are incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. The Findings of Facts were proven by the preponderance of the evidence. The Findings of Fact 10-12 and 16 are removed and replaced with the following:

10. On November 29, 2018, the Board of Physicians selected ten of the Respondent's patients and issued a *Subpoena Duces Tecum* to the Respondent that stated the following:

> Pursuant to Sections 14-206(a) and 14-401.1(i) of the Health Occupation Article, Annotated of Maryland, YOU ARE HEREBY SUMMONED and COMMANDED by the MARYLAND BOARD OF PHYSICIANS to produce the following documents or objects, which are in your possession or your constructive possession and control, whether generated by you or any other health care entity: **a <u>COMPLETE COPY</u> of any and all medical records for the following patients.**

11. On December 21, 2018, after the Board received and granted a request for an extension from the Respondent's office, the Respondent responded to the subpoenas, and

produced medical records for the ten patients, but the Respondent did not send a complete copy of the medical records.

12. In responding to the subpoena, the Respondent returned a signed "Certification of Medical Records" for each of the ten patients that stated as follows:

> I Luckricia Olivacce, PA-C do hereby certify and solemnly affirm under the penalties of perjury, that to the best of my knowledge, information and belief, the enclosed medical records in response to the attached subpoena are an accurate reproduction of any and all records in my possession or constructive possession and are in compliance with the attached subpoena.
>
> I have personally reviewed the entire medical record and further certify to the best of my knowledge, information and belief, that I have provided the Maryland Board of Physicians (Board) with the **COMPLETE MEDICAL RECORDS** which include all records pertaining to the care and treatment of the patient **[Patient's Name]** in my possession or constructive possession and control, including all materials generated by me, or other health care providers, all laboratory reports, all jacket entries and all other entries as kept in the regular course of business for each patient in my medical practice.
>
> I understand that my failure to provide the complete medical records to the Board may constitute failure to cooperate with the Board's lawful investigation and may result in disciplinary action by the Board under the Maryland Medical Practice Act.

16. On April 29, 2020, three months after charges were issued and twenty-two months after the Respondent originally produced medical records, the Respondent produced 1,182 pages of medical records to the Board that had previously not been produced.

DISCUSSION

I. State's Exceptions Pertaining to the Standard of Care and Medical Recordkeeping

The State filed exceptions arguing that the ALJ erred in finding that Ms. Olivacce met the standard of care and in finding that Ms. Olivacce's recordkeeping was adequate. The Panel, based on its expertise and considering the State and Ms. Olivacce's experts' opinions, concludes that there is insufficient evidence to support a violation of the standard of care or for inadequate recordkeeping. The State's exceptions pertaining to the standard of care and recordkeeping, Health Occ. § 15-314(a)(22) and (40), are denied.

II. Ms. Olivacce's Exceptions

In Ms. Olivacce's exceptions, she renews arguments she made in her Motion to Dismiss that the State's expert was, as a matter of law, not qualified to render opinions about the standard of care for the practice of medicine because the expert was a physician assistant and not a physician. The ALJ rejected that argument and qualified the State's expert as an expert in pain management. The ALJ explained that the State's expert "can give me relevant information to help me, as the finder of fact, determine if the State can meet their burden." (T. 75.)

As the Board did not find a violation of the standard of care, this argument is moot. Nevertheless, the Board simply notes that Ms. Olivacce's error appears to be her conclusion that "practice medicine" is a "term of legislative art that specifically related to the conduct of a physician who has undergone four years of medical school internship and residency, and not a physician assistant" and as such only a physician may testify regarding the medical standard of care. The practice of medicine is performed both by physicians and physician assistants, the latter practicing under supervision. "Physician assistant" is defined as "an individual who is licensed under this title **to practice medicine** with physician supervision." Health Occ. § 15-101(o) (emphasis added). This is buttressed by the Maryland Physician Assistant Act statute which imposes discipline upon physician assistants for failing to meet "appropriate standards for the delivery of quality medical and surgical care." Health Occ. § 15-314(a)(22). As the ALJ stated in her ruling that the State's expert is qualified as an expert: "the standard of care, what [the State's expert] provides in her work every day as a pain management physician assistant, is the same as Ms. Olivacce." (T. 73-74). The Panel agrees with the ALJ that a physician assistant may serve as an expert for case involving another physician assistant. Regardless, Ms. Olivacce's exception is moot.

III. The State's Exception to Ms. Olivacce's Failure to Cooperate

A. ALJ's Analysis

The ALJ concluded that Ms. Olivacce cooperated with the State's investigation to the best of her ability when she signed a certification saying that she provided complete medical records to the best of her knowledge, information, and belief because she relied on her office managers to provide the documents in response to the Board subpoenas. The ALJ concluded that Ms. Olivacce credibly testified that she mistakenly did not provide all the records and had no intention of hiding any records from the State.

B. State's Exceptions

The State argues that Ms. Olivacce failed to meet her personal obligation to the Board by certifying under the penalties of perjury that the medical records she transmitted to the Board were the complete records in the case. She certified that she had personally reviewed the entire medical record to ensure the records were complete and certified that she understood that a failure to provide the complete medical records may constitute a failure to cooperate with the Board's investigation. The additional medical record documents later provided by Ms. Olivacce twenty-two months after she provided the initial documents necessitated a second review after charges had been issued, adding eight months to the length of the case, requiring the utilization of additional resources, and increasing the peer review costs to the Board. The State noted that Ms. Olivacce testified that she "browsed through" the records. The State criticized her cavalier and careless approach to the Board's subpoena.

C. Respondents' Response

Ms. Olivacce focused on the fact that her certification was complete "to the best of her knowledge" and that because she is not an electronic medical records specialist, she reasonably relied on the Facility providing her with all the records. She claims that she did not detect or

notice that the records were incomplete until she had reviewed the peer reviewer report and that she performed in her initial review a "good faith" review "to the best of her knowledge."[1]

D. Panel's Analysis

The Board is reliant on licensees to produce full copies of medical records in response to Board subpoenas. Without a full copy of records in response to subpoenas, accurate and complete peer reviews cannot be performed and the Board cannot perform its mission of protecting the public. Indeed, the Board expressly and emphatically informs respondents of the importance of providing full records. In the subpoena issued to Ms. Olivacce, the subpoena specifies that she is responsible for producing "**a COMPLETE COPY of any and all medical records for the following patients.**" The entire sentence is bolded and the requirement that the records are a complete copy is bolded, capitalized, and underlined. The Board also requires that the respondent send a certification of the records. The certification requires production of "any and all" records and is certified and affirmed "under the penalties of perjury." The certification affirms that Ms. Olivacce "personally reviewed the entire medical record" and by signing, Ms. Olivacce certified that she provided the "**COMPLETE MEDICAL RECORD.**" Finally, the certification specifically reminded Ms. Olivacce that the consequences for failing to produce the complete medical records to the Board may constitute a failure to cooperate with a lawful investigation and may result in disciplinary action by the Board.

[1] Ms. Olivacce also claims that the Board has not sanctioned any licensee for "failure to cooperate" unless there has been a refusal to cooperate or an intentional component to failing to cooperate. Ms. Olivacce is incorrect. The Board has pursued similar charges for a physician who produced records for nine patients and then, a year later, produced an additional approximately 3,000 pages for five of those patients. *See* Letter of Surrender, dated July 30, 2021, *In the Matter of Carol Posner, M.D.*, Case Number 2220-0115B. After charges were issued Dr. Posner surrendered her license to practice medicine to avoid a hearing, in part, based on her failure to cooperate. *Id.*

The Panel finds that Ms. Olivacce did not cooperate with the Board's lawful investigation. Ms. Olivacce takes no responsibility for failing to provide complete medical records instead blaming her office manager for failing to pull all of the required records. However, Ms. Olivacce's certification that she reviewed all the records and provided complete medical records was untrue. In her testimony, Ms. Olivacce admitted that she merely browsed through the records. Moreover, her failure to cooperate was not a *de minimis* violation. The missing records that she failed to produce numbered 1,182 pages, nearly a third of the total patient records. The Panel concludes that Ms. Olivacce is personally responsible for failing to cooperate with the Board's investigation because she did not perform the necessary review, despite the clear warnings, but still certified that she had produced all of the records in response to the Board subpoena. The missing records contained critical medical documents and the belated production of the records changed several of the allegations of violations in the amended charges. The Panel finds that Ms. Olivacce's review was careless and insufficient.

Ms. Olivacce testified that when she signed the certifications she understood the meaning of the forms. The certifications, signed under the penalty of perjury, gave notice that Ms. Olivacce should perform a thorough review to ensure a complete copy of the medical records were produced and that she reviewed all the records, provided the complete medical records, and that she understood that her failure to provide the *complete* medical records may result in disciplinary action based on a failure to cooperate with the Board's investigation.

Further, the Panel is not persuaded that Ms. Olivacce reviewed the records "to the best of her knowledge." Her testimony that she reviewed the records and did not recognize that nearly a third of the records were missing from the total patient files is implausible. The peer reviewer in this case noticed that for certain patients, Ms. Olivacce's notes did not contain documentation of physical examinations, her check of the Prescription Drug Monitoring Program (PDMP), and

opioid use agreements. The Panel finds it inconceivable that Ms. Olivacce carefully reviewed the records, but failed to notice that key elements that are integral parts of pain prescribing such as physical examinations, checking the PDMP and opioid use agreements were missing. Ms. Olivacce's failure to review her records in sufficient detail to notice these significant omissions constitutes a failure to cooperate. The State's exception regarding the failure to cooperate, disciplinary ground Health Occ. § 15-314(a)(33), is granted.

CONCLUSIONS OF LAW

Disciplinary Panel A concludes, as a matter of law, that Ms. Olivacce violated Health Occ. § 15-314(a)(33) for failing to cooperate with a lawful investigation conducted by the Board. The Panel dismisses the charges related to Health Occ. § 15-314(a)(22) and (40) for violating the standard of care and failing to keep adequate medical records.

SANCTION

The State recommended a sanction of a reprimand and two-years of probation to include a remedial course in opioid prescribing and medical documentation, a chart/peer review, and a $5,000 fine.

The Panel concludes that a sanction of a Reprimand and a $2,500 fine is appropriate for this violation of a failure to cooperate. Ms. Olivacce's failure to provide the critical documents to the Board in a timely fashion resulted in a delay of over six months between the initial and amended charges, necessitated a second peer review and an extra two weeks for the peer reviewer to re-review the records, and entailed significant additional financial costs to the Board.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by an affirmative vote of a majority of a quorum of Disciplinary Panel A, hereby

ORDERED that Luckricia Olivacce, PA-C is **REPRIMANDED**; and it is further

ORDERED that within **ONE YEAR**, Ms. Olivacce shall pay a civil fine of **TWENTY-FIVE HUNDRED DOLLARS ($2,500).** The Payment shall be by money order or bank certified check made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate the Respondent's license if the Respondent fails to timely pay the fine to the Board; and it is further

ORDERED that this Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

06/27/2022
Date

Signature On File
Christine A. Farrelly, Executive Director
Maryland State Board of Physicians

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 15-315(b), Ms. Olivacce has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Ms. Olivacce files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Executive Director
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

David Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit 1

MARYLAND BOARD OF	* **BEFORE TAMEIKA LUNN-EXINOR,**
PHYSICIANS	* **AN ADMINISTRATIVE LAW JUDGE**
v.	* **OF THE MARYLAND OFFICE**
LUCKRICIA OLIVACCE, P.A.	* **OF ADMINISTRATIVE HEARINGS**
RESPONDENT	* **OAH No.: MDH-MBP2-74-20-27860**
LICENSE NO. C05876	*

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
PROPOSED FINDINGS OF FACT
DISCUSSION
PRPOSED CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On August 31, 2020, the Maryland State Board of Physicians (Board) issued amended charges against Luckricia Olivacce, PA-C (Respondent) for alleged violations of the Maryland Physician Assistants Act (Act). Md. Code Ann., Health Occ. §§ 15-101 through 15-502 (2014 & Supp. 2020). Specifically, the Respondent is charged with violating the following sections of the Act: 15-314(a)(22), failing to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; 15-314(a)(33), failing to cooperate with a lawful investigation; and 15-314(a)(40), failing to keep adequate medical records. Code of Maryland Regulations (COMAR) 10.32.03.11.

The Board scheduled a Disciplinary Committee for Case Resolution Conference on or about October 21, 2020. COMAR 10.32.02.03E(9). The parties did not resolve the issues at that time. On December 21, 2020, the matter was delegated to the Office of Administrative Hearings (OAH) for a hearing.

I held a hearing on May 12, 2021, May 13, 2021, May 14, 2021, May 18, 2021, and June 2, 2021 at the OAH in Hunt Valley, Maryland. Victoria H. Pepper, Assistant Attorney General, represented the Board. Andrew E. Vernick, Esquire, and Megan L. Berey, Esquire, represented the Respondent who was present.

The contested case provisions of the Administrative Procedure Act (APA), the Rules of Procedure for the Board, and the Rules of Procedure of the OAH govern procedure in this case. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2020); Code of Maryland Regulations (COMAR) 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent fail to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, in violation of section 15-314(a)(22) of the Health Occupations Article?

2. Did the Respondent fail to cooperate with a lawful investigation, in violation of section 15-314(a)(33) of the Health Occupations Article?

3. Did the Respondent fail to keep adequate medical records, in violation of section 15-314(a)(40) of the Health Occupations Article?

4. If the Respondent committed any or all of the alleged violations listed above, what is the appropriate sanction?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits on behalf of the State, except as noted:

State Ex. 1 September 10, 2018 written complaint

State Ex. 2 November 29, 2018 letter to the Respondent from the Board with attached subpoena duces tecum ("SOT") for 10 named patients and blank Certification of Medical Records form

State Ex. 3 March 1, 2019 letter to Respondent from the Board with attached subpoena duces tecum.

State Ex. 4 March 11, 2019 letter to the Board from Respondent's counsel

State Ex. 5 April 4, 2019 Transcript of Respondent's interview with the Board

State Ex. 6 Patient #1 - Certification of Medical Records and extract of record

State Ex. 7 Patient #3 - Certification of Medical Records and extract of record

State Ex. 8 Patient #4 - Certification of Medical Records and extract of record

State Ex. 9 Patient #7 - Certification of Medical Records and extract of record

State Ex. 10 Patient #8- Certification of Medical Records and extract of record

State Ex. 11 Patient #9 - Certification of Medical Records and extract of record

State Ex. 12 Patient #10 - Certification of Medical Records and extract of record

State Ex. 13 Curriculum Vitae - [redacted], PA

State Ex. 14 July 5, 2019 Peer Review Report based on first submission of records

State Ex. 15 July 14, 2020 Amended Peer Review Report based on additional records

State Ex. 16 CDC Guideline - Calculating Total Daily Dose of Opioids for Safer Dosage

State Ex. 17 NOT ADMITTED

State Ex. 18 NOT OFFERED

State Ex. 19 Maryland Board of Physicians Guidance - Pain Treatment Toolkit

State Ex. 20 CDC Guideline for Prescribing Opioids for Chronic Pain

State Ex. 21 NOT OFFERED

State Ex. 22 NOT OFFERED

State Ex. 23 NOT OFFERED

State Ex. 24 NOT OFFERED

State Ex. 25 NOT OFFERED

State Ex. 26 January 16, 2020 Charges Under the Maryland Medical Practice Act

State Ex. 27 August 31, 2020 Amended Charges Under the Maryland Medical Practice Act

State Ex. 28 Dollars for Docs: Talk with your doctor, 2018 (Propublica)[1]

State Ex. 29 Complaint in Intervention of the United States, USDC for Central District of California, Western Division; No. CV 13-5861, filed April 3, 2018

State Ex. 30 Copy of Dr. [redacted]'s website

State Ex. 31 Upstate Alumni Magazine Article written by Dr. [redacted]; Fighting Opioid Abuse, Spring 2019

I admitted the following exhibits on behalf of the Respondent, except as noted:

Resp. Ex. 1 Curriculum Vitae (C.V.) of Luckricia Olivacce, PA-C

Resp. Ex. 2 August 10, 2019 Renewal application for licensure

Resp. Ex. 3 C.V. of [redacted], M.D.

Resp. Ex. 4 July 23, 2015 Delegation Agreement with Dr. [redacted]

Resp. Ex. 5 November 29, 2018 Subpoena Duces Tecum from the Board

Resp. Ex. 6 December 21, 2018 Response from Respondent (enclosures excluded)

Resp. Ex. 7 March 8, 2019 Supplemental response from Respondent to the Board

Resp. Ex. 8 April 29, 2020 Letter from Respondent to the Board

[1] https://projects.propublica.org/docdollars/doctors

Resp. Ex. 9 Example 15-minute report of patient signed by Dr. [redacted]

Resp. Ex. 10 Medication chronology for Patient #4

Resp. Ex. 11 Medication chronology for Patient #7

Resp. Ex 12 Medication chronology for Patient #10

Resp. Ex. 13 Medication chronology for Patient #9

Resp. Ex. 14 Medication Chronology for Patient #1

Resp. Ex. 15 Medication Chronology for Patient #3

Resp. Ex. 16 Medication Chronology for Patient #8

Resp. Ex. 17 C.V. of [redacted], M.D., J.D.

Resp. Ex. 18 C.V. of [redacted], M.D.

Resp. Ex. 19 Report of [redacted], M.D., J.D. regarding Patient #4 and corresponding exhibits

Resp. Ex. 20 Report of [redacted], M.D., J.D. regarding Patient #7 and corresponding exhibits

Resp. Ex. 21 Report of [redacted], M.D., J.D. regarding Patient #10 and corresponding exhibits

Resp. Ex. 22 Report of [redacted], M.D. regarding Patient #9 and corresponding exhibits

Resp. Ex. 23 Report of [redacted], M.D. regarding Patient #1 and corresponding exhibits

Resp. Ex. 24 Report of [redacted], M.D. regarding Patient #3 and corresponding exhibits

Resp. Ex. 25 Report of [redacted], M.D. regarding Patient #8 and corresponding exhibits

Resp. Ex. 26 Records for Patient #4

A) Full Medical Records
B) Extract of additional records produced April 29, 2020

Resp. Ex. 27 Records for Patient #7

A) Full Medical Records
B) Extract of additional records produced April 29, 2020

Resp. Ex. 28 Records for Patient #10

A) Full Medical Records
B) Extract of additional record produced April 29, 2020

Resp. Ex. 29 Records for Patient #9

A) Full Medical Records
B) Extract of additional records produced April 29, 2020

Resp. Ex. 30 Records for Patient #1

A) Full Medical Records
B) Extract of additional records produced April 29, 2020

Resp. Ex. 31 Records for Patient #3

A) Full Medical Records
B) Extract of additional records produced April 29, 2020

Resp. Ex. 32 Records for Patient #8

A) Full Medical Records
B) Extract of additional records produced April 29, 2020

Resp. Ex. 33 NOT OFFERED

Testimony

The State presented the testimony of the following witnesses:

- [redacted] PA-C, who was accepted as an expert in Pain Management, including diagnosis, treatment, and application of care for chronic pain patients, reviewing treatment plans and documenting treatment.
- [redacted], Compliance Analyst for the Board of Physicians

The Respondent testified on her own behalf. She also presented the testimony of the following witnesses:

- [redacted] – Regional Director of Operation for [redacted] (NSPC)
- [redacted], M.D. – accepted as an expert in Diagnosis and Treatment of Chronic Pain Patients, Standard of Care for the treatment of Chronic Pain Patients, Urinary Drug Screening, Aberrant Behaviors and Documentation
- [redacted], M.D., J.D. – accepted as an expert in Diagnosis and Treatment of Chronic Pain Patients, Standard of Care for the treatment of Chronic Pain Patients, Urinary Drug Screening, Aberrant Behaviors and Documentation
- [redacted], M.D. – Anesthesiologist, Pain Management physician at [redacted]

PROPOSED FINDINGS OF FACT

I find the following facts by a preponderance of the evidence:

1. The Respondent was first licensed as a physician assistant in Maryland on September 11, 2015 (license number C0005876). She has remained continuously licensed since that time.

2. At all times relevant to this matter, the Respondent was employed as a physician assistant at the [redacted] located in Hagerstown, Maryland.

3. At all times relevant to this matter, [redacted], M.D., was employed as a pain management specialist at [redacted].

4. A physician assistant may only perform medical acts delegated by a physician through a Delegation Agreement. The Delegation Agreement must be filed with the Board of Physicians.

5. On July 23, 2015, the Respondent began her employment with [redacted] and signed a Physician Assistant/Primary Supervising Physician Delegation Agreement for Core Duties with Dr. [redacted] as her primary supervising physician.

6. The Delegation Agreement was filed with the Board of Physicians.

7. In the Delegation Agreement, the Respondent's scope of practice was Pain Management. The Respondent's delegated medical acts were "History and Physical, Evaluate and interpret patient data, Prescribe narcotics/opioids, Evaluate laboratory reports, medication management." (Resp. Ex. 4)

8. The Delegation Agreement explained that the primary physician will review the physician assistant's practice by "face to face review, electronic record review, written instructions/lectures." The primary physician will provide continuous physician supervision "on site, electronic means, written instructions and alternate supervising physician." (Resp. Ex. 4)

THE INVESTIGATION

9. On an unknown date, the Board of Physicians received a complaint about the prescribing practices of the Respondent. The Complainant alleged that the Respondent overprescribed her daughter-in-law opioid pain medication.

10. On November 29, 2018, the Board of Physicians randomly selected ten of the Respondent's patients and issued a Subpoena Duces Tecum to the Respondent requesting all medical records for the ten patients.

11. On December 21, 2018, the Respondent responded to the subpoena and sent medical records to the Board of Physicians for the ten patients.

12. The Respondent certified that "to the best of her knowledge, information and belief" the medical records were complete. (State Ex. 5)

13. The Respondent did not provide patient case summaries for the ten patients.

14. On July 5, 2019, the Board of Physician's peer reviewer, [redacted] PA-C, submitted a summary to the Board after her review of the medical records. (State Ex. 14)

15. On January 16, 2020, the Board of Physicians issued charging documents to the Respondent alleging that the Respondent: 1) failed to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, and 2) failed to keep adequate medical records. (State Ex. 26)

16. The Respondent discovered a search error was made with the electronic medical records (EMR) system at [redacted] and on April 29, 2020, the Respondent provided additional medical records to the Board of Physicians for the ten patients.

17. On July 14, 2020, the Board of Physicians peer reviewer, [redacted], PA-C, completed her review of all the medical records and issued a summary to the Board of Physicians. (State Ex. 15)

18. On August 31, 2020, the Board of Physicians issued amended charging documents to the Respondent adding a third allegation of failure to cooperate with a lawful investigation. (State Ex. 27)

19. The Board of Physicians alleged violations for Patients #1, #3, #4, #7, #8, #9 and #10.

PATIENT #1

20. Patient #1 is a 51-year-old woman who first presented at [redacted] on June 9, 2015 with complaints of moderate to severe back pain and hip pain.

21. On November 23, 2015, Patient #1 was treated by the Respondent. Patient #1 was already prescribed MSER (Morphine)-15mg QHS[2] and Oxycodone-10mg TID[3]. The Respondent increased the MSER prescription to twice per day (BID).

22. Patient #1 was offered chiropractic treatment, physical therapy, a TENS unit, a cervical collar and intervention to treat her pain which she denied due to the cost of the treatments. The patient had one epidural injection in 2015 with little relief.

23. On December 16, 2015, Patient #1 had a non-compliant drug urine test which was positive for Tramadol which was not prescribed by the Respondent. The test was negative for Morphine which was prescribed by the Respondent. Patient #1 was counseled by the Respondent.

24. In 2016, Patient #1 had suicidal ideations.

25. On September 28, 2016, the Respondent increased Patient #1's prescription for Oxycodone to 10mg QID[4].

26. On October 26, 2016, the Respondent changed Patient#1's prescription for Morphine to 30mg QHS.

27. On May 11, 2017, the Respondent added Cyclobenzaprine-10mg TID PRN to the patient's medication regimen.

28. On June 8, 2017, the Respondent added Movantix-25mg QD[5] PRN[6].

29. On July 6, 2017, Patient #1 had a non-compliant drug urine test that was negative for Oxycodone.

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[2] Every night at bedtime (https://medical-dictionary.thefreedictionary.com/q.h.s., last reviewed: September 2, 2021)
[3] Three times per day (https://medical-dictionary.thefreedictionary.com/t.i.d., last reviewed: September 2, 2021)
[4] Four times per day (https://medical-dictionary.thefreedictionary.com/q.i.d., last reviewed: September 2, 2021)
[5] Every day (https://medical-dictionary.thefreedictionary.com/q.d, last reviewed: September 2, 2021)
[6] Take as needed (https://www.safemedication.com, last reviewed September 1, 2021)

30. On March 15, 2018, Patient #1 had a non-compliant drug urine test that was positive for Fentanyl which was not prescribed for the patient.

31. Patient #1 was able to perform her activities of daily living and work as a tax auditor while prescribed a stable opioid medication regimen.

32. Patient #1 died in August of 2018.

33. The Respondent did not conduct any physical exams on Patient #1.

34. The Respondent did not prescribe Naloxone for Patient #1.

PATIENT #3

35. Patient #3 is a 50-year-old man with ongoing pain issues following an injury at work on July 13, 2007.

36. Patient #3 has a history of depression and admitted to fleeting suicidal ideations.

37. Patient #3 had surgery on his left knee and developed complex regional pain syndrome. He also had four lumbar spine surgeries. He also has chronic right knee pain but is reluctant to have knee surgery due to his issues with his left knee post-surgery.

38. Patient #3 had a pain pump which was explanted because it did not provide relief.

39. Patient #3 first presented to [redacted] on April 13, 2015 after being treated at another pain clinic. The prior pain clinic prescribed him the following medications: Tramadol-50mg QID, Fentanyl-75mcg Q48hrs, and Oxycodone-15mg, 5 tablets per day.

40. At his first visit at NPSC, all of his prior medications were stopped and he was prescribed Exalgo-32mg BID, Opana ER-10mg up to 3 tablets per day, and Lyrica-50mg TID.

41. On May 4, 2015, Dilaudid-8mg TID was added to his medications.

42. On August 26, 2015, Oxycodone-10mg QID PRN was added to his medication regimen.

43. The Respondent began treating Patient #3 on November 9, 2015 and did not make any changes to his medications until July 25, 2016 when she increased the Oxycodone to 15mg QID PRN.

44. On July 12, 2018, the Respondent stopped the Exalgo-16mg QD to comply with Worker's Compensation dosing requirements.

45. During the three years of reviewed records, Patient #3 had two non-compliant drug urine tests: July 25, 2016 – he was positive for Tramadol, which was an old prescription, and negative for Lyrica, a current prescription. Patient #3 was counseled by the Respondent. On September 19, 2016, Patient #3 was compliant but there no Lyrica in his urine which is a prescribed medication.

46. The Respondent did not conduct any physical exams on Patient #3.

47. The Respondent did not prescribe Naloxone for Patient #3.

PATIENT #4

48. Patient #4 is a 36-year-old woman with headaches, spine pain, and right ankle pain.

49. Patient #4 was initially treated for pain by her primary care physician, chiropractor, and emergency medicine physician.

50. On August 1, 2016, Patient #4 presented to [redacted] and was previously prescribed Oxycodone-10mg 2 tablets QID. At her initial visit, [redacted] added Cyclobenzapine-10mg BID PRN and Meloxicam-15mg 1 tablet PRN.

51. Patient #4 received occipital nerve blocks bilaterally and a C2 dorsal ramus block. She was offered physical therapy but declined. Patient #4 went to aqua therapy.

52. Patient #4 had electrodiagnostic testing done that showed tarsal tunnel and she had three injections in her foot during her course of treatment at [redacted].

53. On November 17, 2016, Patient #4 was prescribed Xtampza ER, an abuse deterrent with the goal of limiting the amount of short acting opioids. Dr. [redacted] also decreased Patient #4's Oxycodone prescription to 10mg BID.

54. On February 3, 2017, Patient #4 was experiencing additional pain due to a uterine fibroid so she was prescribed one extra Oxycodone dose per day by the Respondent.

55. On May 1, 2017, Patient #4 was prescribed Sprix[7] Nasal Spray-15.75mg 1 spray per nostril Q6-8 hrs.

56. On June 21, 2017, Patient #4 stopped the use of Sprix.

57. On January 11, 2018, Patient #4 was prescribed two weeks of Tylenol with Codeine due to an accident and trauma to the left side of her face.

58. On May 21, 2018, Patient #4 began having problems with her insurance paying for Xtampza so on July 23, 2018, the Respondent changed the patient's Xtampza prescription to Oxycodone ER.

59. On August 17, 2018, Patient #4 reported an allergic reaction to Oxycodone ER and agreed to check her insurance pricing for Xtampza and Morphine.

60. On October 9, 2018, Patient #4's Oxycodone ER prescription was changed to Morphine and trigger point injections.

61. Patient #4 had no non-compliant drug urine screens.

62. The Respondent did not conduct any physical exams on Patient #4

[7] Sprix (ketorolac) is a nonsteroidal anti-inflammatory drug (NSAID). Ketorolac works by reducing substances in the body that cause pain, fever, and inflammation. (https://www.drugs.com/sprix.html, last reviewed: September 2, 2021)

63. The Respondent did not prescribe Naloxone for Patient #4.

PATIENT #7

64. Patient #7 is a 53-year-old woman with a history of two prior neck surgeries with residual pain.

65. On October 19, 2017, Patient #7 was initially seen and evaluated at [redacted] by [redacted], D.O. The Patient was given a physical exam and was offered trigger point injections and medication for relief, but the Patient deferred.

66. At the time of her initial visit, Patient #7 was prescribed Morphine ER – 15 mg BID[8] and Percocet – 15mg QID[9]. [redacted] prescribed Ibuprofen -600 mg PRN and Cyclobenzaprine – 5mg 1 tablet BID PRN.

67. Patient #7 signed an opioid agreement and urine drug screens were performed regularly.

68. Patient #7 was compliant with medications and urine drug screens.

69. On November 6, 2017, the Respondent assumed the care of Patient #7 and added Oxycodone – 10mg BID to her prescription regimen.

70. On December 5, 2017, the Respondent added Cyclobenzaprine – 10mg BID PRN back to her medication regimen. There were no other medication changes for Patient #7 through November 5, 2018.

71. The Respondent met the standard and quality of care when treating Patient #7. The patient signed an opioid agreement, a treatment plan was established and opioids were only continued if the pain and functionality improvement outweighed the risks. There was appropriate screening and monitoring for Patient #7.

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[8] Two times per day (https://www.medicinenet.com, last reviewed: September 1, 2021)
[9] Four times per day (https://www.medicinenet.com, last reviewed: September 1, 2021)

72. The Respondent does not conduct physical exams at medication management visits. There are no records of physical exams for Patient #7 after her initial visit.

73. Patient #7 was also being treated by a Rheumatologist for reported tingling in her hands and feet, tenderness in her hands, and dropping things.

74. The Respondent did not conduct any physical examinations of Patient #7.

75. The Respondent did not prescribe Naloxone for Patient #7.

PATIENT #8

76. Patient #8 is a 61-year-old woman with a history of bi-polar disorder and cocaine abuse and complains of neck and back pain. Patient #8 has had prior neck surgeries.

77. Patient began treating with [redacted] in 2012.

78. Patient #8 received cervical facet joint injections in 2012 with Dr. [redacted] and he advised against opioid medications.

79. Patient #8 had numerous occurrences of non-compliance with inconsistent urine drug screen results, failing compliance plans, and taking her husband's medications: December 12, 2014, January 29, 2015, March 13, 2015, June 3, 2016, August 25, 2016, September 22, 2017, October 25, 2017, and April 26, 2018. (Resp. Ex. 32)

80. In June 2016, Nurse Practitioner (NP) [redacted] restarted Patient #8 on opioid pain medications under the stipulations of close monitoring and frequent urine drug screens.

81. On June 22, 2016, Patient #8 was prescribed Fentanyl patches-25 mcg[10]/hr q 72, Soma-350mg QID PRN for spasms and Oxycodone-5mg PRN take 1 tablet daily for breakthrough pain.

[10] micrograms

82. Patient #8 was also being followed by psychology and neurology for headaches and seizures.

83. On August 1, 2016, the Fentanyl patches were discontinued due to skin ulcerations. Patient #8 was prescribed Morphine ER-15mg Q12HRS and the Oxycodone was increased to once or twice per day.

84. On August 25, 2016, NP [redacted] increased Patient #8's Morphine to 30mg Q12HRS. The goal was to titrate short acting opioids and adjust long-acting opioids.

85. On September 28, 2016, the Respondent took over the care of Patient #8. Patient #8 complained that her pain was 10 out of 10 and the Respondent increased the Oxycodone to 10mg TID, discontinued Gabapentin, and started Lyrica-75mg BID. Patient #8 was continued on Soma 350 mg QID and Morphine ER-30mg BID.

86. The September 28, 2016 medication change increased Patient #8 to a morphine equivalent of 105 which is very high. The Respondent increased her opioids due to breakthrough pain.

87. On October 26, 2016, Patient #8's pain was better but not tolerable so the Respondent increased her Lyrica to 100mg BID and all the opioid medications stayed the same.

88. On August 23, 2017, the Respondent increased Patient #8's opioids due to a motor vehicle accident and an increase in pain.

89. Patient's #8's opioid prescriptions remained the same for another year with no changes.

90. The Respondent did not conduct any physical examinations on Patient #8.

91. The Respondent did not prescribe Naloxone for Patient #8.

PATIENT #9

92. Patient #9 is a 50-year-old man who presented to [redacted] on June 19, 2015 with complaints of pain from fibromyalgia and back pain from a rock-climbing accident. He also had a history of depression and anxiety.

93. Patient #9 works as a painter and requests opioids to maintain his activities of daily living and his employment.

94. In 2015, [redacted] declined to prescribe opioids to Patient #9.

95. Patient #9 returned to [redacted] on March 18, 2016 when his pain management office was shut down by the Drug Enforcement Agency.

96. On March 18, 2016, the Respondent and Dr. [redacted] examined Patient #9 and agreed to take over his opioid regimen which consisted of Fentanyl patch-100mcg/hrq48 and Oxycodone-30mg TID. The Respondent lowered Patient #9's Oxycodone to 10mg TID.

97. Patient #9 was also prescribed Lyrica; NSAID's were avoided due to gastrointestinal issues.

98. The Respondent and Patient #9 discussed a plan to wean his pain medication and slowly come off of opioids and Patient #9 agreed. Patient #9 was given a back brace, TENS Unit, and a topical compound cream. Lumbar facet injections were recommended but never done.

99. The Respondent did not conduct any physical exams in Patient #9.

100. The Respondent did not prescribe Naloxone to Patient #9.

PATIENT #10

101. Patient #10 is a 56-year-old woman who presented to [redacted] on May 21, 2013 with chronic pain syndrome and migraines. Patient #10 had a 20-year history of pain due to migraines and abdominal pain secondary to adhesions from bowel surgery.

102. Patient #10 previously tried epidural injections, a back brace, yoga, acupuncture and Botox injections with minimal or no pain relief.

103. Patient #10 was prescribed high doses of opioids for pain by her neurologist. She was on Fentanyl patch 100mcg/hr, 6 patches, q72hrs and Oxycodone-10mg, Tylenol with Codeine, Ambien CR, Reglan Topamax, and Ativan-1mg PRN.

104. Patient #10's neurologist stopped prescribing narcotics for long term use in May 2013 and referred the patient to [redacted].

105. Patient #10 was treated by many practitioners at [redacted] prior to being treated by the Respondent. The other practitioners at [redacted] focused on reducing the patient's opioid prescriptions and reduced her Fentanyl patches from six 100mcg applied every 72 hours to two Fentanyl-100mcg patches applied every 72 hours.

106. In 2015, Patient #10 was able to finish nursing school, passed her nursing boards and began working in the field of nursing.

107. In July 2016, Patient #10 moved to Australia for work and was prescribed a three-month supply of her medications.

108. On August 25, 2017, the first time the Respondent treated Patient #10, she was taking the following medications: Oxycodone-10mg TID PRN, Tylenol-Codeine #3-300-30mg, 1-2 tablets QD PRN and Fentanyl patch- 100mcg, 2 patches Q72hrs.

109. In five years of treatment of [redacted], Patient #10 had one non-compliant drug urine test on January 22, 2015 when she was negative for prescribed Codeine. Patient #10 reported intermittent use of the prescribed Oxycodone.

110. The Respondent maintained Patient #10 on the same medication regimen for a year.

111. On May 3, 2018, Patient #10 reported difficulty obtaining her Fentanyl patches and asked to be weaned off of them over the next few months.

112. On September 19, 2018, the Respondent reduced Patient #10's Fentanyl patches to 100mcg to be applied every 72 hours and 75mcg to be applied every 48 hours. The Respondent kept Patient #10 on the Tylenol with Codeine and Oxycodone.

113. The Respondent did not conduct any physical examination on Patient #10.

114. The Respondent did not prescribe Naloxone for Patient #10.

DISCUSSION

Legal Standards

The Board is responsible for the licensure of physician assistants in Maryland. Md. Code Ann., Health Occ. §§ 15-301(d)(1) and 15-305 (2014 & Supp. 2020). A physician assistant is an individual who is licensed to practice medicine with physician supervision. In addition to licensing authority, the Board also has disciplinary authority. Accordingly, the Board may reprimand any physician assistant, place any physician assistant on probation, or suspend or revoke a physician assistant's license for violations of that section. Md. Code Ann., Health Occ. § 15-314 (Supp. 2020). Before the Board takes such action, the physician assistant is entitled to a hearing before an administrative law judge. Md. Code Ann., Health Occ. § 15-315 (Supp. 2020). Furthermore, if after a hearing under section 15-315, the Board finds there are grounds for discipline under section 15-314(a), the Board may impose a fine subject to the Board's regulations instead of or in addition to suspending or revoking the license or reprimanding the licensee. Md. Code Ann., Health Occ. § 15-316 (2020).

In an administrative hearing, the State, as the moving party, has the burden of proof by a preponderance of the evidence to demonstrate that the Respondent violated the statutory and

regulatory sections at issue. *Comm'r of Labor and Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34 (1996), citing *Bernstein v. Real Estate Comm'n*, 221 Md. 221, 231 (1959); Md. Code Ann., State Gov't § 10-217 (2014). *See also Schaffer v. Weast,* 546 U.S. 49, 56 - 58 (2005).

In this case, the Board alleges that the Respondent violated provisions of section 15-314(a) as follows:

> (22) failing to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;
>
> . . .
>
> (33) failing to cooperate with a lawful investigation;
>
> . . .
>
> (40) failing to keep adequate medical records;
>
> . . .

Md. Code Ann., Health Occ. § 15-314(a)(22), (a)(33), and (a)(40).

Arguments of the Parties

The State contends that the Respondent violated the Health Occupations Article sections 15-314(a)(22), failing to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; 15-314(a)(33), failing to cooperate with a lawful investigation; and 15-314(a)(40), failing to keep adequate medical records. The State further contends that the Respondent's actions and/or inactions in managing patients and prescribing medications at [redacted] resulted in violations and charges against her. The State asserts that it is its responsibility to protect Maryland residents and to take action if necessary.

The State contends that [redacted], PA-C conducted a thorough peer review of the patient's medical records and recommended the charges against the Respondent. The State also argues that the Respondent failed to cooperate with its investigation by failing to provide the full medical records for the patients when initially requested, requiring its peer reviewer to review additional records and issue an updated report. Finally, the State contends that the Respondent should be found in violation of Md. Code Ann., Health Occ. § 15-314(a)(22), (a)(33), and (a)(40). The State recommends the following sanction: the Respondent should be placed on probation for two years; the Respondent should be required to take a CDS and medical documentation training class within six months; and the Respondent will be subject to another peer review and fined $5,000.00.

The Respondent disagrees that she has violated the Health General Article in her management of chronic pain patients at [redacted]. The Respondent described the patients she treats as complex chronic pain patients that have already tried and failed other modalities such as injections, physical therapy, and even surgery. She understands that there is an opioid crisis in the United States but she also understands that only 5% of opioids are prescribed by pain management specialists. According to the Respondent, the problem with opioid prescriptions comes from Primary Care Physicians and Family Physicians, not Pain Management specialists.

The Respondent maintains that every aspect of the care she gave to her patients was supervised by Dr. [redacted] and that he signed every medical note approving the care. The Respondent contends that she closely monitors her patients with drug screens, pill counts, and limited prescriptions for four weeks so they are required to return every month to be re-evaluated. The Respondent states that her goal is that her patients can function in society and she has many success stories. The Respondent contends that when she submitted the first set of

records to the State, she honestly believed that she was giving the State all of the medical records, but when she determined there was an error, she fixed it immediately. The Respondent does not generate the records: [redacted] office staff handled the subpoena requests. The Respondent asserts that she had no intention to hide anything from the State and she cooperated fully with the State's investigation.

Testimony

[redacted] PA, C

[redacted], PA-C, testified on behalf of the State. Ms. [redacted] is a licensed pain management physician assistant in the states of Maryland, Pennsylvania, and New Jersey. She became board certified in 2009. Ms. [redacted] currently works for [redacted] as a chronic pain management physician assistant where she handles interventions, physical therapy, and prescription pain management. She is a lead physician assistant at [redacted] and assists with the training of physician assistants. Ms. [redacted] testified as to the difference between acute and chronic pain management. Acute pain has an identifiable trigger and usually lasts less than three months, while chronic pain lasts longer than three to six months. Ms. [redacted] testified that there should be a multidisciplinary approach to pain management, not just medication management. Ms. [redacted] stated that the standard or quality of care provided by a physician assistant is that which a reasonable physician assistant working under a physician would do.

Ms. [redacted] explained that she became a peer reviewer for the State in 2016. She took on the job as a peer reviewer because she wanted to help her profession. In this matter, she stated that she was directed to evaluate quality of care, whether the medical records were adequate, and controlled dangerous substance (CDS) prescriptions. Ms. [redacted] testified that

the Respondent failed to provide a summary of care for any of the patient records she reviewed. She stated that the review of the records provided by the Respondent took a total of four weeks for which she issued an initial report on July 5, 2019, and an updated report on July 14, 2020. Ms. [redacted] reviewed the medical records for all ten patients chosen by the State.

Ms. [redacted] testified that prior to 2015, there were no CDC Guidelines for the prescribing and dosing of opioids. She stated that the CDC Guidelines were promulgated to be used by physicians as guidance. Ms. [redacted] testified that the physician in a pain management office handles the interventions such as injections while the physician and the physician assistant handle risk assessments and evaluations such as oral swabs, urine tests, opioid agreements, patient mental stability checks and documentation of care rendered. Pain management physicians and physician assistants also utilize the Prescription Drug Monitoring Program (PDMP) to investigate whether a patient is receiving prescription drugs from any other facility or State.

As for the Standard of Care required by a physician assistant, Ms. [redacted] references her updated report on page 3 which states as follows for the Standard of Quality Care:

> The standards of care include: having a patient provider agreement, establish a treatment plan and only continue prescribing opioids if the pain and functionality improvement outweighs the risks, conduct frequent follow up assessments with appropriate medical documentation, have current diagnostic imaging, screen for substance use disorder, perform frequent toxicology screens to confirm presence of prescribed medications and for undisclosed prescription drug or illicit substance abuse, prescription monitoring/checking the [PDMP] to review patient medical history of Controlled Dangerous Substance prescriptions, evaluate and inform patient of the risks and benefits of opioid use, consider red flags indicating potential abuse, misuse, and diversion, and utilize non-opioid therapies such as physical therapy, interventional treatment and psychosocial treatment.

State Ex. 15 (pg. 3)

Ms. [redacted] described opioids as a broad-spectrum analgesic used to treat pain. Opioids come in pills, intravenously, patches and sprays. She stated that there are five schedules of drugs and that Schedule 1 is the most likely to be abused while Schedule 5 drugs are the least likely to be abused. Ms. [redacted] testified that opioids such as Oxycodone, Fentanyl, and Morphine are Schedule 2 drugs. She also stated that there are short acting opioids like Percocet and Oxycodone with Tylenol that last for two to six hours. The short acting opioids give quick help with pain issues but also are highly likely to be abused because of how fast they work. She testified that long-acting opioids such as Oxycontin and Fentanyl patches last twelve hours and deter abuse because the patient is taking less medication and the medication is in the patient's system for longer. Ms. [redacted] testified that medical professionals who prescribe opioids utilize a medical morphine equivalent (MME) chart to assist in prescribing opioids. (State Ex. 16) The chart indicates that 50mg of morphine is low, 50-90 mg of morphine is moderate, and 90+mg of morphine is a high dose. For example: if a patient is taking 15mg of Oxycodone four times per day, the morphine equivalent is 90mg which is a high dose of Oxycodone.

Ms. [redacted] stated that there is an inherent risk in prescribing opioids which is why proper documentation of the medical record for chronic pain patients is so important. Ms. [redacted] testified that the medical records tell the patient's story and that the focused physical examination helps the physician or the physician assistant to develop a plan of action for the patient. She stated that adequate pain management records should include the reason the patient is present, changes or new complaints, medication information, a functionality assessment, and a clear rationale is medication are being changed.

[redacted], M.D.

Dr. [redacted] testified that he has been board certified in anesthesiology and pain management since 1994. He is currently a partner with [redacted] in New York. He testified that pain management originated in anesthesiology but pain does not just occur in the operating room and there are people who need routine pain management. Dr. [redacted] stated that he teaches and mentors in the field of pain management. He also testified that he has utilized physician assistants in his private practice since 2000.

Dr. [redacted] testified that the Respondent is an extender of Dr. [redacted]' care through the use of the Delegation Agreement. He stated that Dr. [redacted] reviewed and signed off on all of the Respondent's medical notes for each patient. At [redacted], the medical notes were not complete until they were signed by Dr. [redacted]; therefore, he had to approve the Respondent's plan of care for each patient. Mr. [redacted] stated that Dr. [redacted] and the Respondent worked in the office together and he was available to ask questions or review a patient's record whenever the Respondent needed him.

Dr. [redacted] explained that people feel pain from the cerebral cortex of our brains. He stated that modalities such as physical therapy and chiropractors become less effective after a person has been experiencing pain for more than a year because these modalities cannot change the signal to the cerebral cortex in the brain. Dr. [redacted] testified that opioids work because they attach to the pain receptors in the brain and shut off the pain. He testified that the majority of the patients he treats ae chronic pain management patients.

Dr. [redacted] defined chronic acute pain as localized pain like sciatica, where the pain lasts two or three months. He testified that chronic acute pain is reasonably easy to treat with

minimal modalities. In comparison, Dr. [redacted] defined complex chronic pain as pain that lasts more than two or three months and is coupled with social and psychological issues in addition to the pain. He stated that depression and anxiety can impact pain. Dr. [redacted] testified that if alternative modalities such as physical therapy, acupuncture, exercise, heat or ice treatment, or injections failed to work for a patient in the past or only provided temporary relief – it is not worth the time or the wait if it does not change the patient's life. He stated that patients want long term solutions and opioids can be used for long-term treatment of pain management. Dr. [redacted] testified that opioid use must be monitored by a professional and is beneficial to the patient if it allows them to keep working and interacting with family and friends. He stated that he believes that 40-50% of opioid prescriptions are generated by family practitioners and primary care physicians, not pain management specialists and that the actions of those in these disciplines has led to the opioid crisis in the United States. Dr. [redacted] testified that pain management doctors are trained to handle complex pain patients and that the CDC was not concerned about pain management doctors when they promulgated the CDC Guidelines for Opioids. He stated that pain management specialists issue only 8-10% of opioid prescriptions in the United States.

Dr. [redacted] testified that the standard of care is the care that a practitioner in a similar circumstance would take under similar circumstances. He testified that it is not a violation of the standard of care that a patient who is prescribed opioids is not prescribed Narcan. Dr. [redacted] also stated that it is not a violation of the standard of care for the Respondent not to conduct a physical examination during a fifteen-minute medication management visit. He explained that no physical exam is required if there have been no changes to the patient's complaints and the complaints are being managed by medication

provided. Dr. [redacted] testified that a physical exam is performed at the patient's initial consultation with [redacted] and there is also objective evidence collected as to the patient's pain. He testified that physician exams do not diagnose pain.

On cross-examination, Dr. [redacted] was asked about his website, articles he wrote, his experience, and the amount of money he is paid to review records and testify at hearings, his speaking fees for pharmaceutical companies, and a federal lawsuit in which he was a witness. The purpose of these questions was to challenge Dr. [redacted]'s credibility. I am not persuaded by these questions. It is expected that a doctor in his field with his level of experience would be published and called upon by many entities to speak about his expertise and assist litigants in legal matters. In his response to the questions, Dr. [redacted] was very calm in his delivery and I found him to be credible. Dr. [redacted] was clearly not trying to hide any information and willingly provided his fees and costs for his expert participation in this case. Dr. [redacted] testified that physicians have been asked to attend speaking engagements for pharmaceutical companies since before he began practicing medicine; it is a tool for pharmaceutical companies to promote their medications. Dr. [redacted] testified that he is given a Federal Drug Administration (FDA) approved presentation with slides, and the drug representative chooses the venue and invites the guests.

[redacted], M.D., J.D.

Dr. [redacted] is the Medical Director of the [redacted] where she is in charge of physicians, nurses, and nurse practitioners who treat chronic pain patients. Dr. [redacted] is board certified in Anesthesiology and Anesthesiology (Pain Medicine). Dr. [redacted] also assists with writing and promulgating opioid prescribing guidelines for pain management and she is the editor for articles in the Pain Management Journal.

Dr. [redacted] testified that she reviewed the Respondent's patient records for Patients #4, #7 and #10 and she found no violations of the standard of care or medical documentation. She opined that the care the Respondent gave to her patients was reasonable and appropriate. Dr. [redacted] testified that a chronic pain patient can seek relief from a primary care physician while the complex chronic pain patient has more challenges and needs to be treated by a pain management professional. Dr. [redacted] stated that once a patient has tried other modalities with limited or no pain relief , they should then go to a pain clinic for help with their pain. She explained that the central nervous system restructures itself when someone has chronic pain and the person is bombarded by pain impulses from the brain. Dr. [redacted] testified that when the pain first starts, other modalities such as physical therapy, ice and heat therapy, acupuncture, and injections may work but as the pain persists, they stop working. Dr. [redacted] testified that there is no need to waste the patient's time sending them for modalities that do not work for the patient.

Luckricia Olivacce, PA-C

The Respondent testified that she began her employment at [redacted] in August of 2015 and she received additional education training from Dr. [redacted]. She stated that she signed a Delegation Agreement on July 23, 2015 with Dr. [redacted] as her supervising physician. The Respondent testified that she and Dr. [redacted] have open communication – in which he reviews her charts and signs off on all of her notes. She is adamant that she followed all of the protocols in treating the patients in question. She testified that her goal is to stabilize complex chronic pain management patients. If there are no negative changes to their functionality, then she stays the treatment course prescribed.

The Respondent testified that every patient received a comprehensive physical examination at the initial consultation and she only does a physical examination if there is a drastic change in the patient's quality of life, activities of daily living, or they look different. The Respondent testified that there is no need to perform a physical exam when making a medication change because medications lose their efficacy because pain patients are on medications for a long period of time, so medications need to be changed in order for them to benefit the patient. She also stated that if a patient has an acute event that is treated by someone else such as an emergency room doctor or a primary care physician, she will not conduct a physical examination and aggravate the issue when it's being handled by another practitioner.

As for records, the Respondent testified that the patients complete an intake form and she had access to the EMR to review other medical notes and tests results for the patient. She testified that she also utilizes the Virginia PDMP to check her patients' medication compliance. The Respondent testified that urine drug screens are performed on patients randomly to ensure the integrity of the system. If a urine drug screen is non-compliant for a patient, she talks to the patient with a level of compassion; she does not jump to conclusions and prefers to talk and counsel her patients before taking more drastic measures.

The following is the testimony of Ms. [redacted], Dr. [redacted], Dr. [redacted], and the Respondent regarding each of the patients at issue in this case:

Patient #1

Ms. [redacted] testified that Patient #1 was deemed a moderate risk for opioid misuse but throughout her treatment would fluctuate to high risk for monitoring. Ms. [redacted] stated that Patient #1 had one cervical epidural injection where she reported temporary relief at 50% and a noted history of trying other modalities with little or no relief. Ms. [redacted] testified that Patient

#1 began using opioid medication in September 2015. Ms. [redacted] stated that despite inconsistent drug urine tests, the Respondent continued to increase and alter Patient #1's opioid medications. Ms. [redacted] testified that Patient #1 had a total of thirteen drug urine screens during her treatments at [redacted] and three were non-compliant. Ms. [redacted] testified that although the Respondent noted that Patient #1 was high risk, she failed to implement more rigorous monitoring such as more frequent toxicology screens, pill counts, attempts to wean off of opioids, more frequent visits, or a psychiatric evaluation. Ms. [redacted] also testified that the Respondent made no notes regarding any physical examinations of Patient #1 and that her complaints of hip pain were not fully evaluated and assessed by the Respondent. Ms. [redacted] opined that for all of these reasons, the Respondent failed to provide the appropriate standard of quality of care for Patient #1 and also failed to keep adequate medical records.

Dr. [redacted] reviewed the records for Patient #1. He testified that Patient #1 had a history of back pain, neck pain, and lower back pain going down to her hips. Patient #1 had radiology study that correlated to her pain showing degenerative disc disease. Dr. [redacted] testified that there was a change in Patient #1's medication on July 21, 2015 (prior to the Respondent treating Patient #1) and there was no physical examination performed because the diagnosis was the same or similar. Dr. [redacted] opined that it is not necessary for a pain management specialist to perform a physical examination during a 15-minute medication management appointment. Dr. [redacted] testified that Patient #1 had her first non-compliant drug urine test on September 2, 2015 (prior to being treated by the Respondent) but there was no need to discharge the patient for a single mistake. Dr. [redacted] stated that it is better to closely monitor a patient rather than endanger them by essentially putting them out on the streets. He stated that when there is hope for a patient, it is best to keep them in the practice.

Patient #1 had a second non-compliant urine drug test on October 26, 2015. Dr. [redacted] testified that non-compliance is a common occurrence with complex pain patients and that the standard of care requires the Respondent to counsel the patient, which she did on December 16, 2015 after Patient #1 was non-compliant. Dr. [redacted] explained that the Respondent had a rationale for changing Patient #1's morphine prescription to twice per day on November 23, 2015 as it improved the patient's sleep.

Dr. [redacted] noted that the Respondent did not change any of Patient #1's medications from October 26, 2016 through August 2, 2018. Dr. [redacted] stated that based on the record, the Respondent did not notice any maladaptive behaviors from Patient #1. He testified that there a team approach to the treatment of Patient #1 with at least seven different pain management specialists reviewing her file. Dr. [redacted] opined that the Respondent met the standard of care in her treatment of Patient #1 and that her medical documentation was adequate and appropriate.

The Respondent testified that Patient #1 presented with the same chief complaints for three years – pain in her neck, back, hips, and feet. The Respondent stated that when Patient #1 had a non-compliant drug screen, she would counsel the patient but Patient #1 was stable and her medications were providing her a benefit.

Patient #2

Ms. [redacted] did not find any violations for Patient #2.

Patient #3

Ms. [redacted] opined that the Respondent failed to meet the appropriate standard for quality care as she continued to prescribe high doses of opioids that were in excess of the MME recommendations. Ms. [redacted] testified that when Patient #3 arrived at [redacted], he was taking

248 MME and during his course of treatment his medications were titrated to 410 MME. Ms. [redacted] stated that Patient #3 was not offered any other interventions by the Respondent and despite the high dose of opioids, Patient #3 did not have much functional improvement as his pain level was consistently 7 or 8 out of 10, he was unable to work, and he was having suicidal ideations due to his pain and depression. Ms. [redacted] testified that the Respondent does not note any physical examinations for Patient #3, other than his initial consultation. Ms. [redacted] opined that the Respondent maintained adequate medical records for Patient #3.

Dr. [redacted] reviewed the records for Patient #3. Dr. [redacted] testified that Patient #3 tried other modalities and they failed. Patient #3 was being treated at [redacted] and by an orthopedist at the same time. Patient #3 had knee surgery and four spine surgeries and noted that he received no relief from acupuncture, physical therapy, or chiropractic care. Dr. [redacted] opined that there is very little that could help this complex patient who has pain all day. He testified that it was reasonable for [redacted] to place Patient #3 on a long acting pain medication, Exalgo-32mg BID. The Respondent never changed the Exalgo prescription but did increase his Oxycodone on July 25, 2016 from 10mg to 15mg because Patient #3 was not getting relief for his breakthrough pain. Dr. [redacted] opined that Patient #3 was not showing signs of opioid abuse or diversion. Dr. [redacted] testified that on August 22, 2016, Patient #3 indicated that the increase in his Oxycodone prescription helped him. Dr. [redacted] testified the Patient #3 was struggling with depression and suicidal ideations due to the stress of his Worker's Compensation case because Worker's Compensation requested that his opioid doses be decreased to 90 MME, and also discontinued payment for his psychiatrist. Dr. [redacted] stated that a prescription for Naloxone was not necessary for Patient #3 because he had no maladaptive behaviors and was stable on his medication regimen. Dr. [redacted] opined that

the Respondent provided the standard of quality care for Patient #3 and that the Respondent's medical documentation for Patient #3 was appropriate.

The Respondent testified that Patient #3's case was made even more complex by Worker's Compensation and the barriers they can put up for treatment when they refuse to pay for some treatment and request a decrease in pain medications. She testified that functionality for the patient is the ultimate goal of pain management and medications help Patient #3 to function. She testified that Patient #3 brought his wife to his appointments as a "second set of eyes" to assist in his care. The Respondent testified that she witnessed no maladaptive behaviors from Patient #3 and she had no concerns about his medication regimen.

Patient #4

Ms. [redacted] opined that the Respondent failed to provide the proper standard of quality care for Patient #4. Ms. [redacted] testified that the Respondent failed to offer Patient #4 any other modalities besides opioid medications and failed to conduct any physical examinations on Patient #4. Ms. [redacted] testified that the Respondent was concerned about Patient #4 self-escalating her medications and required her to come into the office more often for monitoring, pointing out that the Respondent required Patient #4 to have weekly medication management visits for twelve weeks with urine drug screens and pill counts to show compliance. Ms. [redacted] testified that Patient #4 should have been offered Naloxone due to her compliance issues. Ms. [redacted] also stated that the Respondent failed to document any physical examinations of Patient #4. Ms. [redacted] opined that the Respondent kept adequate medical records for Patient #4.

Dr. [redacted] reviewed the medical records and reports for Patient #4. Dr. [redacted] testified that Patient #4 was offered physical therapy in 2016 and declined. However, Patient #4 did

undergo numerous injections for pain relief in 2016. Dr. [redacted] opined that the Respondent had rational reasons to increase Patient #4's opioid medications despite the arguments made by Ms. [redacted]. Dr. [redacted] testified that Patient #4's opioid medication was increased in February 2017 due to increased breakthrough fibroid pain. The second increase in opioids was on January 11, 2018 when the patient experienced trauma to her face and her Oxycodone prescription was increased by one pill per day. Dr. [redacted] testified that the Respondent closely monitored the patient when there were concerns of self-escalating her medications, requiring Patient #4 to come into the office weekly for 12 weeks with urine drug screens and pill counts. Dr. [redacted] stated that there were no other indications of non-compliance by Patient #4. Dr. [redacted] opined that the Respondent provided reasonable and appropriate care to Patient #4 and her documentation was appropriate.

Patient #5

Ms. [redacted] did not find any violations for Patient #5.

Patient #6

Ms. [redacted] did not find any violations for Patient #6.

Patient #7

Ms. [redacted] updated report states that the Respondent met the standard of quality care for Patient #7. (State Ex. 15, pg. 22) However, Ms. [redacted] testified that there were inadequate medical records for Patient #7. She references the Respondent ordering tests for Patient #7 without a physical examination. Ms. [redacted] states that the Respondent should have assessed the patient before ordering tests. She stated that on August 13, 2018, September 10, 2018 and November 15, 2018, Patient #7 had new and/or aggravated complaints and there is no indication in the medical record that the Respondent examined the complaint areas.

The Respondent argues that if she met the standard of quality care for Patient #7 then she should also meet the standard for adequate medical documentation. Dr. [redacted] stated that she and Ms. [redacted] agree that physical exams are not required to comply with the standard of care; therefore, it is unclear how the Respondent can violate documentation requirements for an assessment that is not required. In her updated report, Ms. [redacted] indicates many areas where the Respondent's documentation for Patient #7 was appropriate. Dr. [redacted] opines that Ms. [redacted]' conclusion that the Respondent failed to have appropriate documentation for Patient #7 is "nonsensical". (Resp. Ex. 20, pg. 2)

Patient #8

Ms. [redacted]' updated report indicates that Patient #8 was offered pain medications in a unimodal approach and physical therapy and interventions were never revisited. She stated that Patient #8 continued to have inconsistent urine drug screens in addition to psychiatric hospitalizations. However, the Respondent continued to prescribe pain medications, often giving the patient enough medication for eight weeks at a time. Ms. [redacted] also testified that Patient #8 was involved in a motor vehicle accident in August of 2017 and the Respondent did not conduct a physical exam but ordered an MRI of the patient's cervical and lumbar spine. However, it appears that Patient #8 never completed the MRI study.

In December 2017, Patient #8 followed up with physician assistant [redacted] and she had an inconsistent urine drug screen which was negative for prescribed medications Soma and Morphine. Mr. [redacted] reduced the amount of medications the Patient could receive to 4 weeks. Patient #8 followed up with the Respondent and was counseled regarding her inconsistent drug screen and given a warning. The Respondent maintained the patient on four weeks of medication. On April 26, 2018, Patient #8 had another inconsistent urine drug screen and was

struggling with a mental illness, homelessness, and limited transportation. The Respondent gave Patient #8 an eight-week supply of medications. The Patient returned to [redacted] prior to the eight weeks and explained that she was moving and her medications were locked in storage. On May 24, 2018, the Respondent counseled the patient regarding her inconsistent drug urine screens but did not wean the patient's medications and allowed the patient to stay on monthly medications. The Respondent did not require pill counts, nor did she prescribe Naloxone to the patient. Ms. [redacted] testified that the Respondent increased the patient's short acting opioids with no rationale for the increase in medications. Ms. [redacted] opined that the Respondent failed to provide the standard quality of care in her treatment of Patient #8 but the Respondent did keep adequate medical records for Patient #8.

Dr. [redacted] reviewed the medical records for Patient #8 and Ms. [redacted] report. Dr. [redacted] testified that Patient #8 was treated at [redacted] for more than four years and received care from numerous providers at [redacted]. Dr. [redacted] stated that Patient #8 was extremely complex because she has a history of medical pain management and mental health issues. She had two failed spinal surgeries. He testified that it is understandable for Patient #8 to have sporadic non-compliance with regard to her treatment because of her mental health and pain concerns. Dr. [redacted] testified that it is not reasonable to expect perfect compliance from pain management patients who are struggling with physical and mental challenges. Dr. [redacted] testified that Patient #8 first presented with back and neck symptoms and her activities of daily living were severely compromised. Patient #8 also had hypertension, coronary disease, prior stroke, seizure disorder, asthma, and only one functioning kidney. Patient #8 had no relief from injections, physical therapy, exercise, heat treatment, ice treatment, psychotherapy, acupuncture, hypnosis, or biofeedback. Therefore, Patient #8 was diagnosed as

a complex pain management patient. (Resp. Ex. 25, pg. 2). Dr. [redacted] testified that initially, Dr. [redacted] wanted to avoid narcotic medications for Patient #8 but in 2016, he agreed with the appropriateness of Patient #8 starting opioids. Dr. [redacted] opines that the prescriptions given to Patient #8 were well within the manufacturer's recommendations. Dr. [redacted] testified that under the care of the Respondent, Patient #8 basically remained on the same regimen of opioids for two years and was able to reasonably live her life without any significant problems or decompensation. Dr. [redacted] opines that the medication regimen implemented by the Respondent was not excessive; rather it was reasonable and moderate for Patient #8 and placed the patient's pain at a tolerable level.

Dr. [redacted] also opines that no reasonably competent physician assistant or pain management physician would perform a physical examination on a follow-up medication maintenance evaluation. Dr. [redacted] testified that a physical examination would be warranted if there was a change in the patient's condition which was not the case for Patient #8. Dr. [redacted] testified that Patient #8's pain waxed and waned but there were no acute changes for her. He stated that she was stable throughout the course of treatment and there was no indication that she should be prescribed Naloxone and she would not be able to administer Naloxone to herself if she overdosed. Dr. [redacted] testified that Patient #8 did not show any maladaptive behaviors that warranted her being discharged from [redacted]'s care and discharging a patient like Patient #8 could be dangerous for her due to the complexity of her issues.

The Respondent testified that she reviewed the prior medical records for Patient #8 before the first visit with her. The Respondent testified that she treated Patient #8 for two years and only increased her opioid prescriptions twice (September 28, 2016 and August 23, 2017). She stated that she increased Patient #8's opioids on September 28, 2016 due to breakthrough

pain she was reporting and she increased them on August 23 2017 due to a recent motor vehicle accident. The Respondent testified that when Patient #8 had a non-compliant drug urine test, she would counsel Patient #8 and take all of her mitigating circumstances into consideration. The Respondent testified that the answer to non-compliance is not always decreasing opioids or discharging a patient. The Respondent testified that Patient #8 had no maladaptive behaviors to warrant checking her pills.

Patient #9

Ms. [redacted] testified that Patient #9 was prescribed very high doses of opioids by a previous provider. She noted that Patient #9 originally came to [redacted] in 2015 and when [redacted] declined to prescribe him opioids, he found another provider. Patient #9 returned t[redacted] on March 19, 2016 and was evaluated by the Respondent and Dr. [redacted]. Ms. [redacted] testified that Patient #9's records indicate that he received moderate relief from back pain with physical therapy, heat and ice, and he received no relief from injections and the chiropractor. Ms. [redacted] stated that there were no physical therapy or procedure records to show that Patient #9 actually tried more conservative modalities.

Ms. [redacted] testified that Patient #9 is a complex pain management patient with anxiety, depression, fibromyalgia, multiple pain clinic treatments, and prior history of probation at pain management clinics due to non-compliance. Patient #9 arrived to [redacted] taking Fentanyl-100mcgQ48hrs, Oxycodone-30mg QID and Lyrica-75mg BID. At the first visit, the Respondent decreased his Oxycodone to 10mg QID and discussed a plan to wean him off of pain medications and slowly remove him from opioids. Ms. [redacted] testified that on August 5, 2016, Patient #9 asked for an increase in his Oxycodone and his request was denied by the Respondent who instead increased his Lyrica prescription to 150mg BID. On September 20,

2017, the Respondent had a non-compliant drug urine test that showed all his prescribed medications except for Oxycodone. Ms. [redacted] opined that a reasonable physician assistant would place the patient on probation with the clinic for suspicion of diverting his medications. Then on August 22, 2018, Patient #9 had another non-compliant drug urine test that was positive for Oxycodone but negative for Fentanyl. Ms. [redacted] stated that the Respondent continued to prescribe Patient #9 Fentanyl and required him to return to [redacted] every four weeks.

Ms. [redacted] also testified that the Respondent never took Patient #9's vitals when he came for his pain medical maintenance appointments. Ms [redacted] opines that a physical examination is warranted whenever the Respondent changes the treatment plan and the Respondent does not note any physical examination for Patient #9 except at the initial visit. Ms. [redacted] opines that the goal of weaning Patient #9's pain medications did not happen and the Respondent did not offer Patient #9 any modalities other than pain medication. Ms. [redacted] was also concerned that there was never any notation as to whether Patient #9 was wearing his Fentanyl patch at his appointments.

Dr. [redacted] testified that Patient #9 had degenerative changes and disc protrusions in his lumbar spine. Dr. [redacted] stated that during the March 18, 2016 initial consultation between Patient #9, the Respondent and Dr. [redacted], different options other than pain medications were offered to the patient and he declined. Dr. [redacted] testified that a medical professional can make suggestions to the patients but the patients ultimately decide what they want to do. He described Patient #9 as a complex (?) pain patient with limited ability to perform his activities of daily living due to pain. Dr. [redacted] testified that the initial goal was to wean Patient #9 off of pain medications and the Respondent was successful in

maintaining the patient's medications with no increases for two years which allowed Patient #9 to maintain his employment. Dr. [redacted] testified that despite Patient #9's sporadic non-compliant drug urine tests, he had no maladaptive behaviors that would suggest a need for pill counting, more frequent management appointments, or a prescription for Naloxone. Dr. [redacted] testified that there was no need to make a radical change in Patient #9's care because when a pain management professional looks at the totality of the circumstances, Patient #9 was having complex personal issues during the time of non-compliance. Dr. [redacted] noted that on October 25, 2016, the Respondent declined to increase the patient's Oxycodone and took the safer route and increased his anti-inflammatory medication.

Dr. [redacted] testified that the goal of pain management is to assist the patient with functioning and Patient #9 was functioning.

Patient #10

Ms. [redacted] testified that Patient #10 presented a [redacted] in 2013 on very high doses of opioids totaling 415 MME. She testified that the Respondent was able to wean the patient down to 370 MME on September 19, 2018, however no further weaning was done due to the patient's home life stressors. Ms. [redacted] stated that the Respondent did not provide a clear rationale for maintaining Patient #10 on such high levels of opioid medications. Ms. [redacted] also testified that the Respondent did not conduct any physical exams on Patient #10, did not offer alternative modalities, did not note whether Patient #10 was wearing her patches at the appointments, never performed pill counts, and never prescribed Naloxone to Patient #10. For these reasons, Ms. [redacted] opined that the Respondent failed to meet the standard of quality of care. Ms. [redacted] opined that the Respondent did maintain adequate medical records for Patient #10.

Dr. [redacted] opined that the Respondent's care of Patient #10 met the standard of care as the patient had no relief from surgery, traction, heat, ice, hypnosis, or chiropractic care. Dr. [redacted] testified that Patient #10 had experienced pain for the twenty years. She stated that the Respondent was able to wean Patient #10 on the Fentanyl patches and there was no need for the Respondent to monitor Patient #10 more closely or prescribe Naloxone because there was no indication that Patient #10 was misusing or abusing her medications. Dr. [redacted] testified that Patient #10 was able to finish nursing school and work as a nurse on her medication regimen, showing that she was productive and functional. Dr. [redacted] testified that pain management professionals focus on function and not pain scores. Dr. [redacted] explained that complex patients may require higher doses of opioids with close monitoring in order to function.

Dr. [redacted] opined that Patient #10 is a high-risk patient for medication management but she is compliant with her medications and shows no maladaptive behaviors that would warrant a Naloxone prescription. Dr. [redacted] testified that Naloxone could be prescribed if there was a concern that the patient would overdose on medications but many insurance companies will not cover the prescription and if the patient overdoses, they cannot administer Naloxone to themselves. Therefore, a prescription for Naloxone is not necessary. As for physical examinations, Dr. [redacted] testified that a physical examination is required at the initial consultation and is not required at follow-up appointments if the patient is stable. She also stated that the Respondent had a rationale for allowing Patient #10 to follow-up every six to eight weeks instead of monthly and that was due to her busy nursing career.

On cross-examination, Dr. [redacted] testified that she had never worked for the Respondent's counsel before but that she had testified as a peer reviewer for the State in 2020.

This information actually bolsters Dr. [redacted]'s credibility as it shows that she works as an expert for the State and for medical professionals – there is no bias.

The Respondent testified that she began treating Patient #10 in March of 2016 and she was already prescribed very high doses of opioids. The Respondent testified that she was concerned about the continuity of care for Patient #10, building a relationship and familiarizing herself with Patient #10. She knew that Patient #10 was able to complete nursing school and work as a nurse on the medication regimen already in place. The Respondent stated that there was no evidence of drug seeking or maladaptive behaviors from Patient #10 and she was functioning on a consistent dose of opioids.

Cooperation with the State Investigation

The Respondent testified that she received the Subpoena Duces Tecum from the State requesting any and all medical records for ten patients. She stated that she gave the subpoena request to her office staff who utilized the EMR system to print the requested medical records. The Respondent stated that she did not go through each paper file or electronic file and pull out all of the documents to copy. The Respondent testified that she received the first group of medical records and did not notice that the pain management agreements and initial visits for the ten patients were missing. The Respondent admits that she signed under penalty of perjury that the records she was producing were complete to the best of her knowledge. The Respondent testified that she did not notice that records were missing until she was reviewing Ms. [redacted]' first report dated July 5, 2019. She stated that she had no intention to keep medical records from the Board. The Respondent testified that she immediately contacted the Office Manager to resolve the issue of the missing records and mailed a second set of records to the State immediately upon receipt of the additional medical records.

[redacted] Regional Director of Operations, testified that she oversees the day-to-day operations for sixteen[redacted] centers in Maryland and one in West Virginia. Ms.[redacted] testified that when[redacted] receives a subpoena, it goes to their general counsel and then it is given to the provider. The provider provides the subpoena for to the[redacted] center manager who can pull the medical records from the EMR system. Ms.[redacted] testified that the EMR system in 2018 and 2019 only printed office visit notes and was missing radiology reports, attachments, and phone notes. She stated that currently all of the information can be printed by pressing the "all" button on the print screen. Ms.[redacted] testified that a similar issue occurred at a[redacted] center in a different region leading to a change in the EMR records search system.

Dr.[redacted]

Dr.[redacted] testified about the Delegation Agreement executed by him and the Respondent on July 23, 2015. Dr.[redacted] stated that he hired the Respondent and trained her for three to six months on how to evaluate patients, reviewing physical exams and treatment plans, various types of pain and various medications and their categories. He testified that the Respondent then shadowed him for a period of time and later conducted her own visits with him observing until he felt secure that she could handle pain management cases on her own.

Dr.[redacted] testified that the[redacted] is a collaborative office with physicians, physician assistants, and nurse practitioners who work together for all of their patients. He stated that he is the direct supervisor for the Respondent and he reviews and signs all of the Respondent's treatment plans. Dr.[redacted] testified that he is available on site for questions and he is never too far for the Respondent to reach him. He stated that he is in the same office as the Respondent so they have daily interaction. He testified that all new patients are initially evaluated by him and he develops a treatment plan. The Respondent or another

staff member may eventually take over the care of the patient and will communicate with him any changes they wish to make to the treatment plan.

Dr. [redacted] testified that he complied with his supervisory requirements under the Delegation Agreement and he believes that the Respondent's medical documentation was adequate and that the Respondent met the standard of care in her treatment of Patients #1, #3, #4, #7, #8, #9 and #10.

Analysis

The State presented credible testimony from a peer reviewer, [redacted] PA-C. Ms. [redacted] was clear and concise in her testimony and is extremely knowledgeable in her field of study as a physician assistant. The Respondent testified credibly as well and presented clear and persuasive testimony from Dr. [redacted] and Dr. [redacted] to refute the alleged violations and charges by the State against the Respondent. The Respondent also elicited credible and persuasive evidence from Ms. [redacted] and Dr. [redacted]. Therefore, based on the record before me and explained in the analysis below, I find that the State has failed to show violations of sections 15-314(a)(22), (30), and (40) of the Health Occupations Article.

The State alleges that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State in violation of section 15-314(a)(22). The crux of the State's argument is that the Respondent failed to conduct physical examinations on patients before altering medication regimens, she failed to have a rational basis for increasing the dosage of opioid medications for numerous patients, she failed to follow the CDC guidelines for prescribing opioids, she failed to offer alternative modalities other than pain medications, and she failed to properly monitor non-compliant patients. I have laid out the testimony of the

State's expert with regards to these allegations for each patient at issue. However, the Respondent and her expert witnesses vehemently disagree that physical examinations are a required standard of care to alter medication and they also rebutted every instance in which the State's expert asserts that the Respondent lacked the rationale to increase opioid medications. The Respondent and her experts point to the medical records for every rationale the Respondent used to change medications. The State's witness conceded that conducting a physical exam is more a best practice rather than a standard of care issue.

The Respondent's experts also successfully refuted the State's argument that the Respondent failed to offer alternate modalities to the patients. Dr. [redacted] and Dr. [redacted] both assert that every patient was either offered or participated in other modalities with no benefit to the patient's functionality. They agreed that if physical therapy does not work for the patient, it is pointless to keep wasting the patient's time with that modality if the goal is to make the patient function. The Respondent's witnesses also opined that if other modalities did not work for patient, the practitioner should move on to another method of relief. Dr. [redacted] and Dr. [redacted] both testified that opioid medication pain management works because the medication stops the pain receptors in the brain and complex chronic pain patients need to utilize opioids for relief. The Respondent's witnesses also successfully refuted the assertion that the Respondent did not properly monitor non-compliant patients. The medical records clearly show that the Respondent counseled non-compliant patients, made them come in more frequently for appointments and conducted pill counts. The expert testimony from the Respondent's witnesses was well supported by the medical records. There is overwhelming evidence to support the Respondent's following the standard of care for the patients at issue.

The State also alleges that the Respondent failed to cooperate in the investigation in violation of section 15-314(a)(30) when she failed to provide the complete medical records for all Patients on December 21, 2018 with her first disclosure of documents, despite signing a certification stating that "to the best of her knowledge, information and belief" the medical records were complete. The Respondent testified and provided the credible testimony from Ms. [redacted] that the EMR system had a document search error where numerous documents were not printed in the first disclosure. The Respondent testified that she realized that some documents were missing when she reviewed the first peer review report from Ms. [redacted], PA-C, at which time, she reached out to her supervisor at [redacted] about the missing records and began working to solve the issue. On April 29, 2020, the Respondent disclosed a second set of documents to the State, requiring a second peer review by Ms. [redacted].

The Respondent reviews the EMR system in her daily work at [redacted] but she does not print documents from the system or search for patient records in the EMR system. All subpoena requests are handled by office managers, not the physician assistants; therefore, the Respondent thought that the first disclosure included all the patient records. She admits that she was mistaken but that she had no intention of hiding any records from the State. I find the testimony of the Respondent on this issue to be credible as it is supported by Ms. [redacted]. The Respondent cooperated with the State's investigation to the best of her ability and did not violate section 15-314(a)(30).

The Respondent's expert witnesses also successfully refuted the State's allegation that the Respondent failed to keep adequate medical records for many of the Patients. I find that if the standard of care is met for all the patients, then the medical records are adequate. The Respondent's witnesses testified that every patient record was complete and adequate. I find the

testimony of the Respondent's witnesses to be credible and supported by the record. I've received and reviewed over 1000 pages of medical records in this matter. The records were extremely detailed for all the patients.

PROPOSED CONCLUSIONS OF LAW

I conclude as follows:

1. The Respondent did not fail to meet the appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, in violation of section 15-314(a)(22) of the Health Occupations Article;

2. The Respondent did not fail to cooperate with a lawful investigation, in violation of section 15-314(a)(33) of the Health Occupations Article; and

3. The Respondent did not fail to keep adequate medical records, in violation of section 15-314(a)(40) of the Health Occupations Article;

PROPOSED DISPOSITION

I **PROPOSE** that the amended charges filed by the Board on August 31, 2020, against the Respondent based on her alleged violation of Sections 15-314(a)(22), (a)(33) and (a)(40) of the Health Occupations Article be **DISMISSED**.

[redacted]

September 2, 2021
Date Decision Mailed

Tameika Lunn-Exinor
Administrative Law Judge

TLE/kkc
#192074

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of the Maryland State Board of Physicians that delegated the captioned case to the Office of Administrative Hearings (OAH), and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2014); COMAR 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the Disciplinary Panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the other party will have fifteen (15) days from the filing of exceptions to file a written response addressed as above. *Id.* The disciplinary panel will issue a final order following the exceptions hearing or other formal panel proceedings. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2014); COMAR 10.32.02.05C. The OAH is not a party to any review process.