IN THE MATTER OF	*	**BEFORE THE**
KIMBERLY M. FERN, PA-C	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: C04388	*	**Case Number: 2219-0100A**

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

CONSENT ORDER

On July 9, 2020, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **KIMBERLY M. FERN, PA-C** (the "Respondent"), License Number C04388, with violating the Maryland Physician Assistants Act (the "Act"), codified at Md. Code Ann., Health Occ. ("Health Occ.") §§ 15-101 *et seq.* (2014 Repl. Vol. and 2019 Supp.).

Specifically, Disciplinary Panel A charges the Respondent with violating the following provisions of the Act under Health Occ. § 15-314:

> (a) Subject to the hearing provisions of § 15-315 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum, may reprimand any physician assistant, place any physician assistant on probation, or suspend or revoke a license if the physician assistant:
>
> (22) Fails 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[.]

On November 4, 2020, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, Order, and Consent.

FINDINGS OF FACT

Panel A finds the following:

I. BACKGROUND

1. At all times relevant, the Respondent was, and is, licensed to practice as a physician assistant in the State of Maryland. The Respondent was originally licensed to practice as a physician assistant in Maryland on October 27, 2010, under License Number C04388. The Respondent's license is current through June 30, 2021.

2. At all times relevant, the Respondent practiced as a physician assistant at a pain medicine clinic (the "Pain Clinic")[1] in Annapolis, Maryland, under the supervision of a physician ("Physician A") licensed to practice medicine in Maryland.

3. The Board initiated an investigation of the Respondent after receiving a complaint on or about October 1, 2018, from a family member of a patient ("Patient A") alleging that the Pain Clinic continued to prescribe narcotic medications to Patient A despite Patient A's numerous hospitalization due to medication misuse.

II. BOARD INVESTIGATION

4. In the course of its investigation, the Board obtained ten patient medical records (including Patient A's medical record), obtained written summaries of care from the Respondent and interviewed the Respondent under oath.

[1] To ensure confidentiality, the names of individuals, hospitals and healthcare facilities involved in this case are not disclosed in this Consent Order.

5. The Board forwarded the ten medical records of patients whom the Respondent treated to a physician assistant (the "Reviewer") licensed in Maryland for an expert review. After review, the Reviewer determined that the Respondent failed to meet quality medical standards in six of the ten cases reviewed. A summary of the Reviewer's findings is set forth below.

III. PATIENT-SPECIFIC ALLEGATIONS

Patient A

6. Patient A, a female born in the 1970s, initially saw Physician A at the Pain Clinic on or about July 24, 2018, for pain management. Patient A had comorbidities that included: systemic lupus erythematosus, rheumatoid arthritis, scleroderma, myeloproliferative neoplasm requiring ongoing chemotherapy, left hip avascular necrosis, left knee arthritis, lumbar spondylosis, previous spinal fusion, ongoing spontaneous compression fractures with kyphoplasties secondary to chronic high dose steroid treatment, and ileostomy as a result of perforated diverticuli complicated by stoma infection requiring debridement and wound vac. In addition, Patient A had pulmonary fibrosis, interstitial lung disease, which required partial lung resection in March of 2018. At this initial visit, Physician A recommended increasing oxycodone 15 mg every four hours to oxymorphone extended release 40 mg twice a day and oxycodone 10 mg three times a day. (Physician A was unable to prescribe the medications due to delay in insurance approval).

7. Patient A's initial visit with the Respondent occurred on or about August 29, 2018, when the Respondent issued the prescriptions Physician A recommended on July 24, 2018. This new medication regimen increased Patient A's daily Morphine Milligram

Equivalent ("MME") from 135 to 285. The Respondent saw Patient A on three other occasions on or about October 15, 2018, November 12, 2018, and April 22, 2019. At the October 15, 2018 visit, the Respondent increased Patient A's oxycodone dosage to 15 mg three times a day, which increased Patient A's daily MME to 307.5. In between visits with the Respondent, Patient A was hospitalized frequently and often for extended period of time. On or about April 30, 2019, approximately a week after her last visit with the Respondent, Patient A was transported to a local hospital for oxycodone overdose.

8. The Reviewer found that although Patient A's medical record did not show drug abuse prior to her overdose, the Respondent should have provided naloxone and educate Patient A on its use in light of Patient A's circumstances.

9. The Reviewer found the Respondent failed to meet appropriate standards for the delivery of quality medical care based on her failure to provide Patient A with naloxone and educate her on its use.

Patient B

10. Patient B, a female born in the 1950s, initially saw the Respondent in or around 2016 after having been a patient at the Pain Clinic for more than ten years. Patient B sought pain management at the Pain Clinic for lumbar pain secondary to arthritis and stenosis, bilateral knee osteoarthritis and migraines. Patient B had a history of severe sleep apnea, sarcoidosis, anxiety, depression, gastric bypass followed by abdominoplasty, and hypercoagulability secondary to morbid obesity (body mass index of 60 plus).

11. During the time period she treated Patient B, the Respondent maintained Patient B on oxycodone 30 mg once every four hours, diazepam 5 mg once every eight

hours, fioricet with codeine and topamx. The Respondent generally issue 90 days-worth of prescriptions and saw Patient B generally once every three months. On or about November 19, 2018, the Respondent decreased the diazepam dosage from three times per day to once daily due to Patient B expressing relief from medical cannabis.

12. The Reviewer found that the Respondent's prolonged prescribing of a combination of Fioricet with codeine, high dose short-acting oxycodone and diazepam to Patient B was to be avoided per CDC guidelines given Patient B's health conditions.

13. The Reviewer found the Respondent failed to meet appropriate standards for the delivery of quality medical care based on her prolonged prescribing of a combination of Fioricet with codeine, high dose short-acting oxycodone and diazepam to Patient B given Patient B's health conditions.

Patient C

14. Patient C, a male born in the 1960s, had been a patient at the Pain Clinic for approximately 17 years before he saw the Respondent. Patient C had a history of spinal cord injury, Brown Sequard syndrome, C3-4 myelomalacia, significant spasticity, C3-6 fusion, T11-12 fusion, anxiety, depression, urinary retention and a 2007 motor vehicle accident that worsened his pain symptoms.

15. The Respondent saw Patient C from August 24, 2017, until November 6, 2018. During this time period, the Respondent continued Patient C on a medication regimen prescribed by Physician A, which included Oxycontin 40 mg one tablet every 12 hours, oxycodone 30 mg two tablets every four hours and Valium 10 mg four times a day for a MME of 660.

16. The Respondent generally prescribed two months-worth of medications each time. During Patient C's treatment period with the Respondent, she ordered only one urine toxicology screening, which occurred on or about May 22, 2018. Patient C's record further showed that he had not had a urine toxicology screening for many years prior to May 22, 2018.

17. Patient C's medical record prior to seeing the Respondent showed frequent signs of red flags and drug-seeking behaviors such as taking more medications than prescribed, not taking medications in the correct manner and reporting that his wife accidently threw away his medications.

18. The Reviewer found the Respondent failed to meet appropriate standards for the delivery of quality medical care based on her treatment of Patient C for:

a) Prescribing high-dose opioids in conjunction with benzodiazepine;

b) Failing to provide Naloxone and educate Patient C on its use;

c) Failing to see Patient C on a more frequent basis for follow up (at least once every four weeks); and

d) Failing to properly monitor Patient C through more frequent urine toxicology screens.

Patient D

19. Patient D, a female born in the 1970s, began treatment at the Pain Clinic in or around August 2014 for interstitial cystitis, chronic headaches, low back pain. Patient D had a history of cyclic vomiting syndrome, anxiety, depression and seizures, and was

already opioids. Physician A sought to gradually wean down Patient D's need for opioids and refer her for standard treatments for interstitial cystitis, such as pelvic physical therapy.

20. Patient D initially saw the Respondent in or around January 2015. The Respondent referred Patient D for transcranial magnetic stimulation for depression and anxiety and maintained her on Opana ER 40 mg twice daily, Opana 10 mg four times per day, sumatriptan 100 mg as needed, Soma 350 mg four times per day, ibuprofen 800 mg three times per day, gabapentin 600 mg three times per day and Fioricet with codeine four times per day for a MME of 360 to 378.

21. Patient D's medical record showed that she reported to the Respondent that she was being prescribed alprazolam and lorazepam concurrently by other providers and was taking diphenhydramine 25 mg once daily.

22. During Patient D's treatment period, the Respondent did not provide her with Naloxone and educate her on its use and did not require Patient D to sign an opioid contract.

23. The Reviewer found the Respondent failed to meet appropriate standards for the delivery of quality medical care based on her treatment of Patient D for:

a) Failing to provide Patient D with Naloxone and educate her on its use;

b) Failing to require Patient D to enter into an opioid contract;

c) Prescribing high-dose opioids and carisoprodol knowing that Patient D was also taking multiple benzodiazepine from other providers; and

d) Providing two full 30-day prescriptions to Patient D despite her nearly monthly hospital admissions.

Patient E

24. Patient E, a female born in the 1970s, began treatment at the Pain Clinic in or around mid-2017 for pain secondary to cervical spondylosis, migraine, inflammatory arthritis of spine and joint and psoriatic arthritis. Patient E underwent a gender reassignment surgery on or about September 3, 2017. Prior to the surgery, Patient E was on morphine sulfate ER 15 mg once every eight hours, morphine IR 15 mg twice a day as needed, Lyrica 1000 mg three times daily, Cymbalta 60 mg once daily and marinol 5 mg three times daily. Subsequent to the surgery, the surgeon added Dilaudid 8 mg every three hours as needed for post-operative pain.

25. The Respondent saw Patient E 10 days after her surgery on or about September 13, 2017. At this visit, the Respondent discontinued Dilaudid and increased morphine sulfate ER to 100 mg twice daily and morphine IR 15 mg to three times daily. The Respondent also added diazepam 2 mg every 12 hours.

26. On or about October 25, 2017, Patient E underwent breast augmentation and was provided 80 tablets of Percocet by the surgeon. At a visit with the Respondent on or about November 14, 2017, the Respondent noted that Patient E only had three tablets of Percocet left. The Respondent changed Patient E's short-acting opioid to oxycodone 30 mg five times daily and increased Valium to 7.5 mg three times daily.

27. On or about March 7, 2018, following a revision surgery, the Respondent saw Patient E and increased Valium to 10 mg three times daily. Patient E stated at that

time that she was experimenting with medical cannabis. Subsequently, Patient E continued to visit the Pain Clinic once every one to two months for prescriptions at MME of 425 and chronic diazepam of 10 mg three times daily.

28. The Reviewer found the Respondent failed to meet appropriate standards for the delivery of quality medical care based on her treatment of Patient E for:

a) Significantly increasing and maintaining Patient E on high-dose opioids and valium following her gender reassignment surgeries; and

b) Failing to provide Naloxone and educate Patient E on its use.

Patient F

29. Patient F, a male born in the 1960s, began seeing the Respondent on or about July 17, 2017, for chronic opioid medication management for his lower back pain. The Respondent previously treated Patient F for cervical issues that did not include medication management. Patient F had a history of failed back syndrome and multiple lumbar surgeries as a result of work-related injuries.

30. Patient F began seeing the Respondent for low back pain on or about July 17, 2017, after Patient F's previous pain management provider retired. At this visit, the Respondent prescribed Valium 5 mg every bedtime and oxycodone 5 mg three times daily.

31. The Respondent saw Patient F a total of nine times between July 17, 2017, and July 18, 2018. Initially, the Respondent saw Patient F for follow up visits every month, but later on the frequency of visits changed to every two months with Patient F receiving two months-worth of prescriptions.

32. The Respondent did not have Patient F sign an opioid contract until nine months after she began treating Patient F for lower back pain and ordered only one urine toxicology screen, dated July 18, 2018, with a repeat toxicology screen on September 13, 2018, due to insufficient sample. The Respondent also did not prescribe Naloxone to Patient F.

33. The Reviewer found the Respondent failed to meet appropriate standards for the delivery of quality medical care based on her treatment of Patient F for:

a) Failing to require Patient F to enter into an opioid contract in a timely manner;

b) Failing to see Patient F on a more frequent basis for follow up (at least once every four weeks);

c) Failing to order urine toxicology screens in sufficient frequency to monitor Patient F; and

d) Failing to prescribe Naloxone to Patient F and educate him on its use.

CONCLUSION OF LAW

Based on the Findings of Fact, Disciplinary Panel A of the Board concludes as a matter of law that the Respondent failed to meet the standard of care for the delivery of quality medical care, in violation of Health Occ. § 15-314(a)(22).

ORDER

It is thus by an affirmative vote of a majority of a quorum of Disciplinary Panel A of the Board, hereby:

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

ORDERED that within **SIX MONTHS**, the Respondent is required to take and successfully complete a course in the controlled dangerous substances prescribing. The following terms apply:

(a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course is begun;
(b) due to the COVID-19 pandemic, the disciplinary panel will accept a course taken in person or over the internet;
(c) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the course;
(d) the course may not be used to fulfill the continuing medical education credits required for license renewal;
(e) the Respondent is responsible for the cost of the course; it is further

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board. The Executive Director signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; and it is further

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

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If the disciplinary panel determines there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if the disciplinary panel determines there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

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

01/06/2021
Date

Signature on File

Christine A. Farrelly, Executive Director

CONSENT

I, Kimberly M. Fern, PA-C, acknowledge that I have consulted with counsel before signing this document.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 15-315 and Md. Code Ann., State Gov't §§ 10-201 *et seq*. concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

Signature on File

12/18/20
Date

Kimberly M. Fern, PA-C

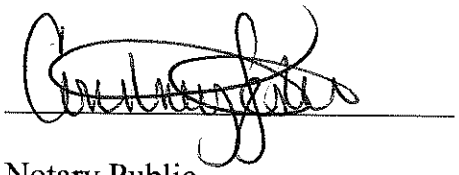
NOTARY

STATE OF Maryland

CITY/COUNTY OF Caroline

I HEREBY CERTIFY that on this 18th day of December 2020, before me, a Notary Public of the foregoing State and City/County, personally appeared Kimberly M. Fern, PA-C, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.



Notary Public

My Commission expires: July 22, 2023