IN THE MATTER OF	*	**BEFORE THE**
GARY J. SPROUSE, M.D.	*	**MARYLAND STATE BOARD**
Respondent	*	**OF PHYSICIANS**
License Number: D32036	*	**Case Number: 2221-0025A**

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FINAL DECISION AND ORDER

On April 7, 2023, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") issued charges against Respondent Gary J. Sprouse, M.D. ("Respondent" or "Dr. Sprouse"), for alleged violations of the Maryland Medical Practice Act. *See* Md. Code Ann., Health Occ. §§ 14-101—14-509, 14-601—14-702. Specifically, Dr. Sprouse was charged with violating the following grounds of § 14-404 of the Health Occupations Article:

> **Health Occ. § 14-404. Denials, reprimands, probations, suspensions, revocations – Grounds.**
>
> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
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> (3) Is guilty of:
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> (ii) Unprofessional conduct in the practice of medicine;
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> . . .
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> (11) Willfully makes or files a false report or record in the practice of medicine;
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> . . .
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> (17) Makes a willful misrepresentation in treatment; [and]
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> . . .
>
> (23) Willfully submit false statements to collect feeds for which services are not provided[.]

The case was delegated to the Office of Administrative Hearings for an evidentiary hearing and the issuance of a proposed decision with proposed findings of fact, proposed conclusions of law, and a proposed disposition.

An Administrative Law Judge ("ALJ") for the Office of Administrative Hearings held an evidentiary hearing on September 23 and 24, 2024, via the Webex videoconferencing platform. An Assistant Attorney General from the Health Occupations Prosecution and Litigation Unit ("HOPL") of the Office of the Attorney General presented the case for the State. The Respondent represented himself.

On December 16, 2024, the ALJ who presided over the evidentiary hearing issued a proposed decision. Based on the proposed findings of fact, the ALJ proposed that the charges be upheld, concluding that Dr. Sprouse violated the grounds charged: Health Occ. § 14-404(a)(3)(ii), (11), (17), and (23). As a sanction, the ALJ proposed that Dr. Spouse be reprimanded, his license to practice medicine in Maryland be suspended for six months, he take a course in ethics, and he pay a fine of $35,000.

Dr. Sprouse filed exceptions to the ALJ's proposed decision, and the Administrative Prosecutor filed a response. On March 26, 2025, an exceptions hearing was held before Disciplinary Panel B ("Panel B" or the "Panel") of the Board. At the exceptions hearing, an Administrative Prosecutor from HOPL, was present and represented the State, and the Respondent was present and represented himself.

FINDINGS OF FACT

Panel B finds that the following facts were proved by the preponderance of evidence:

1. At all relevant times to the charges in this matter, the Respondent was licensed to practice medicine in Maryland.

2. The Respondent was originally licensed to practice medicine in Maryland on March 8, 1985.

3. The Respondent currently has no board certifications.

4. In 2020, the Respondent worked for Facility A,[1] a long-term care and subacute rehabilitation facility, in Maryland, until his termination in July 2020.

5. On March 5, 2020, a state of emergency and a catastrophic health emergency were declared in the State of Maryland in relation to the COVID-19 Pandemic.

6. On April 28, 2020; April 29, 2020; May 27, 2020; May 29, 2020; June 6, 2020; and June 16, 2020, the Respondent documented and billed for six medical assessments and/or evaluations of five Facility A patients that he did not perform. The patients were not present in Facility A at the time the Respondent documented he performed the medical assessments/evaluations. Those patients had been discharged or hospitalized at the times the Respondent claimed he had performed the medical assessments/evaluations at Facility A.

7. During this time period in the course of the COVID-19 Pandemic, there were not shortages of personal protective equipment ("PPE") at Facility A, but PPE was rationed to ensure a consistent supply.

8. During this time period in the course of the COVID-19 Pandemic, Facility A housed approximately 60 patients.

9. Also, during this time of the COVID-19 Pandemic at Facility A, the workload increased significantly, as each patient had to be screened for COVID-19 on a daily basis, many patients became sick and had to be quarantined, PPE needed to be changed between each patient

[1] For privacy and confidentiality, this final decision and order does not use the actual name of the facility or the actual names of the patients and instead uses generic terms.

visit, and many patients lost their lives. There was not a staffing issue that Facility A management considered a "shortage"; nonetheless, many third-party agency nurses or travelling nurses were brought in who were unfamiliar with the patients, and the overall workload had increased.

10. Facility A had protocols for indicating when a patient had been discharged or left the facility, and their bed remained on hold. These protocols were in place during the relevant time period in this matter, the COVID-19 Pandemic.

11. During the relevant time period in this matter during the COVID-19 Pandemic, Facility A utilized the Point Click Care ("PCC") electronic medical records system, which is utilized by eighty percent of long-term care facilities in the United States.

12. When a patient is discharged from Facility A, the PCC clearly indicates this, because the patient's record is no longer active. The default setting in the PCC is to only show active patients. To see discharged patients, a PCC user would have to widen a filter to include discharged patients. Once a patient has been discharged, PCC lists their date and time of discharge.

13. In addition, after a patient has been discharged, or has left the facility with their bed remaining on hold, going forward, there would be no vital signs for the patient, nursing progress notes, or active medicine list. Such information would not be present unless and until the patient eventually returned to Facility A.

14. If a patient left Facility A with their bed remaining on hold, the home page for that patient in the PCC would indicate the patient left the facility for another location and the date the patient left Facility A.

15. Facility A maintains a census, which lists its active present patients.

16. Facility A maintains a chart rack with the patients' physical medical charts. When a patient left the facility with their bed remaining on hold, their physical medical chart would be turned upside down on the chart rack to indicate they were not at the facility.

17. When a patient was discharged from Facility A, their physical medical chart would be removed from the chart rack, potentially be temporarily placed at the nursing station, and ultimately be placed on the desk of the medical records administrator in the medical records department.

18. During the relevant time at issue of the COVID-19 Pandemic, the Respondent, in addition to working at Facility A, maintained a private practice and performed services at other facilities.

19. In November of 2019, before the COVID-19 Pandemic, the Respondent billed for 207 visits at Facility A. In May of 2020, at the height of the pandemic, the Respondent billed for 1,162 visits at Facility A.

20. The Respondent submitted two Daily Evaluation for COVID-19 form assessments of Patient 1 purportedly performed in-person at Facility A on April 28 and 29, 2020. In those assessments, the Respondent noted the patient had no fever and no signs or symptoms of COVID-19, and in both assessments noted the patient had a clear chest.

21. The Respondent did not see Patient 1 or perform assessments on those dates.

22. Patient 1 was moved from Facility A to another facility, a hospital, for gastrointestinal treatment, on April 25, 2020. She returned to Facility A, on May 1, 2020.

23. The Respondent billed the Maryland Department of Health and Novitas Solutions for the two assessments of Patient 1. On October 4, 2020, shortly after the Respondent was notified that he was under investigation by the Board, the Respondent told the Maryland Department of

Health that the bills were submitted in error and no payment for the bills had been received. That same date, he returned to Novitas Solutions a total of $68.10, which the Respondent had received for the two assessments.

24. The Respondent completed a Daily Evaluation of COVID-19 form for Patient 2, indicating that he had evaluated Patient 2 on May 27, 2020, at Facility A. The form indicated, among other things, that the patient had no fever, coughing or wheezing.

25. The Respondent did not see or evaluate Patient 2 on May 27, 2020.

26. Patient 2 was discharged from Facility A on May 27, 2020, at 12:20 p.m. The Respondent arrived at Facility A, on May 27, 2020, to conduct evaluations after Patient 2 had been discharged.

27. The Respondent billed United Healthcare and Novitas Solutions for the evaluation of Patient 2. On October 4, 2020, the Respondent returned to United Healthcare and Novitas Solutions $9.14 and $34.05, respectively, that he had been paid by each for the assessment.

28. The Respondent created an Office Visit SOAP [Subjective, Objective, Assessment, Plan] Note indicating that he had seen Patient 3 on May 29, 2020, at Facility A and, among other things, indicated that he evaluated Patient 3's wounds, eating habits and appetite, COVID symptoms, and mental status.

29. The Respondent did not see or evaluate Patient 3 on May 29, 2020.

30. On May 28, 2020, at approximately 10:15 a.m., Patient 3 was discharged from Facility A and was not present to be examined by the Respondent on May 29, 2020.

31. The Respondent billed Bankers Life and Casualty Co. and Novitas Solutions for the assessment of Patient 3. On October 4, 2020, the Respondent returned to Casualty Co. and Novitas Solutions $18.95 and $71.99, respectively, which they had paid him for the assessment.

32. On June 6, 2020, the Respondent created a follow-up assessment note indicating that he conducted an evaluation of Patient 4 at Facility A. Among other things, the follow-up assessment indicated the patient did not have a fever, coughing, or headache and that his left leg was normal.

33. The Respondent did not see Patient 4 on June 6, 2020.

34. Patient 4 was discharged from Facility A, on June 6, 2020, at approximately 11:30 a.m. The Respondent arrived at Facility A, at 5:00 p.m., on June 6, 2020, five-and-a-half hours after Patient 4 had been discharged.

35. The Respondent billed United Healthcare for the follow-up assessment of Patient 4. On October 4, 2020, the Respondent returned to United Healthcare the $94.73 he had been paid for the follow-up assessment.

36. The Respondent completed and submitted a COVID-19 Daily Evaluation form indicating that he had evaluated Patient 5 in person at Facility A on June 16, 2020, and that Patient 5 was negative for signs of COVID-19, including having no fever, coughing, or headache.

37. The Respondent did not see Patient 5 or conduct an assessment on June 16, 2020.

38. Patient 5 was not at Facility A on June 16, 2020. Patient 5 was taken by ambulance from Facility A to a hospital for emergency treatment on June 15, 2020. Patient 5 returned to Facility A on June 22, 2020.

39. In his written statement to the Board and during his interview conducted by the Board, the Respondent admitted that he completed the medical documentation discussed above, despite that he had not seen or evaluated the patients on the days he claimed he had seen and evaluated the patients.

40. The Respondent submitted bills and was reimbursed for all but one of the falsely documented evaluations. By October 4, 2020, shortly after he had been notified of the Board's investigation, the Respondent had returned all of those funds.

41. When it was mandated that patients in long-term care facilities receive daily COVID-19 evaluations, there was no requirement for those evaluations to be performed by a physician. In most facilities, those evaluations were performed by nurses. The Respondent volunteered to perform COVID-19 evaluations at Facility A.

42. No patient was harmed as a result of the Respondent's actions.

43. When the Respondent documented and billed for the six medical assessments and/or evaluations of the five Facility A patients discussed above, wherein he did not actual perform those assessments/evaluations because the patients were not present at that facility, he performed those actions intentionally and not by accident, and he did not perform those actions as a result of an honest mistake.

44. The Respondent has a significant prior disciplinary history with the Board.

45. On June 26, 1996, the Respondent entered into a Consent Order with the Board wherein he was reprimanded and ordered to pay a $5,000 fine for practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine.

46. The Respondent has permitted a registered nurse who he employed in his medical office to act as a nurse practitioner, including issuing prescriptions the Respondent had pre-signed, even though she was not certified as a nurse practitioner.

47. On July 22, 2013, after a hearing before an administrative law judge, the Board issued a Final Decision and Order, concluding that the Respondent was responsible for deceptive use of his license, unprofessional conduct in the practice of medicine, making a false report in the

practice of medicine, failing to meet standards of quality medical care, and inadequate documentation.

48. The Final Decision and Order, in 2013, was the result of the Respondent signing a Certificate of Merit in a medical malpractice action without first reviewing the medical records, falsifying a progress note in a patient's medical record, inappropriately prescribing opioid medications by increasing dosages of opioids, failing to reduce dosages of opioids, failing to address addictions, and failing to refer patients to pain medicine specialists.

49. The Board suspended the Respondent's medical license until he completed Board-approved courses in pain management, medical ethics, and medical record-keeping.

50. On September 10, 2013, after the Respondent completed the required courses, the Board issued an Order Terminating Suspension and Imposing Probation ("Probation Order"). The Respondent was placed on probation for a minimum of three years under the condition that his practice be subject to peer and/or chart review and that he comply with the Maryland Medical Practice Act.

51. On July 30, 2014, after a hearing before an ALJ, the Board issued a Final Decision and Order, concluding the Respondent had failed to meet standards of quality medical care based on his improper prescribing of opioids and his treatment of a patient with suicidal depression. The Respondent was still on probation to address the issues in the 2013 case. The Board reprimanded the Respondent.

52. On July 11, 2016, after a hearing before an ALJ, the Disciplinary Panel A of the Board issued an Amended Final Decision and Order, concluding the Respondent violated the September 10, 2013 Probation Order and failed to meet standards of quality care based on his failure to provide safe and effective treatment for chronic pain.

53. Disciplinary Panel A of the Board found that the Respondent prescribed excessively high dosages of opioids, failed to sufficiently describe the pain complaints to justify prescribing opioids, inappropriately simultaneously prescribed benzodiazepines and opioids, and failed to refer patients to a pain management specialist.

54. Disciplinary Panel A of the Board reprimanded the Respondent and placed him on probation for eighteen months under the condition that his practice be overseen by two supervisors, a specialist in pain and a specialist in psychiatry with experience treating psychiatric conditions that coincide with pain conditions.

55. On August 12, 2019, Disciplinary Panel A of the Board issued a Cease and Desist Order, ordering the Respondent to stop prescribing or dispensing opioids in Maryland, finding that he posed a serious risk to the health, safety, and welfare of patients and noted that the Respondent had dangerous prescribing habits and should not be allowed to treat pain patients using controlled dangerous substances.

56. On March 11, 2020, the Respondent entered into a Consent Order with the Disciplinary A of the Board for failing to meet the standards of quality medical care, failing to keep adequate records, and violating the July 11, 2016 Amended Final Decision and Order.

57. Pursuant to that Consent Order, in 2020, the Respondent was reprimanded, permanently prohibited from prescribing and dispensing all controlled dangerous substances, permanently prohibited from delegating to physician assistants the prescribing or dispensing of controlled dangerous substances, permanently prohibited from certifying patients for the medical use of cannabis, ordered to surrender his controlled dangerous substances registration to the Office of Controlled Substances Administration, and fined $15,000.

DISCUSSION OF CHARGES

The Respondent filed exceptions to the ALJ's proposed decision, arguing that the ALJ made erroneous findings or determinations on the following issues: (1) willfulness; (2) the scope of immunity for health care practitioners during the COVID-19 Pandemic; and (3) the proposed sanction.[2]

I. Willfulness

The Respondent was charged with four grounds under § 14-404(a) of the Health Occupations Article. Three of the four grounds have a willfulness element. Those three grounds are:

(11) Willfully makes or files a false report or record in the practice of medicine;

(17) Makes a willful misrepresentation in treatment; [and]

(23) Willfully submits false statements to collect fees for which services are not provided[.]

The ALJ addressed the requirements of the willfulness element contained in § 14-404(a)(11), (17), and (23) of the Health Occupations Article.[3] The ALJ thoroughly reviewed *Kim v. Maryland State Board of Physicians,* 423 Md. 523 (2011), which concerns the meaning of willfulness in the context of § 14-404(a). The ALJ explained that *Kim* ruled that, in grounds with a willfulness element in § 14-404(a), a finding of willfulness does not require proof of an intent to deceive or a malicious intent. Instead, the ALJ found that, in the § 14-404(a) grounds containing the willfulness element, there must be proof that the conduct was committed intentionally.

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[2] Discussion of the Respondent's exceptions concerning the proposed sanction is in the Sanction section.

[3] All references to § 14-404(a) in this final decision and order concern § 14-404(a) of the Health Occupations Article.

According to the ALJ, there must be an intent to commit the act, but it does not require knowledge that the act will cause an illegal result.

The ALJ then addressed the Respondent's claim that his actions were accidental. The ALJ found that the Respondent's claim that his actions were merely accidental was "illogical and unconvincing." The ALJ addressed the Respondent's position that he checked the facility's census in the morning and would partially fill out assessments. The ALJ did not accept that the Respondent's actions were accidental or an honest mistake.

The ALJ explained in detail why he did not accept the Respondent's claim that the false records were accidental or the result of honest mistakes. The ALJ found that assessments partially completed before he left for work, as a witness for the Respondent testified, would not account for the records at issue, which were fully completed. The ALJ found that to properly fully complete the assessments would require the practitioner assessing a patient's condition to be in the presence of the patient being assessed. The ALJ also based his determination on the layers of processes that are available to ensure that a physician would know that a patient was no longer at the facility, including the PCC and the physical chart. The Respondent failed to consult these processes. The ALJ found that the Respondent's claim—that because he checked the facility's census before patients were discharged on that day caused the false records—unconvincing. The ALJ noted that only two of the six records at issue involved patients who left the facility on the same day as the purported assessment, thus the Respondent's reliance on viewing the census does not account for the other four records. The ALJ, moreover, relied on healthcare professionals who testified, including those who the Respondent presented as witnesses, that they were unaware of a similar occurrence (although one witness who testified was aware of a similar occurrence through perusing publications on physician discipline). And one witness of the Respondent, a nurse practitioner,

whom the ALJ found very credible in both demeanor and knowledge of the subject matter, testified that she would go to where the patient is located and, if the patient were not there, she would ask the nurse where the patient was, then look for the patient's medical record, which would indicate whether the patient was no longer at the facility.

The Respondent argues on exceptions that his actions can only be found willful if there is proof that he acted with an intent to deceive. According to the Respondent, fraud requires an intent to deceive. The Respondent also argues that his errors were an honest mistake, inadvertent, or accidental. According to the Respondent, the "State cannot rely on negligence, oversight, or administrative errors to meet the threshold for fraud."

Panel B accepts the ALJ's findings. The *Kim* case, which governs this issue, explains the requirements of willful conduct in the context of § 14-404(a) of the Health Occupations Article. In this context, *Kim* does not require proof of an intent to deceive or to commit fraud. As stated in *Kim,* "'Willful,' for purposes of § 14-404, requires proof that the conduct at issue was done intentionally, not that it was committed with an intent to deceive or with malice." *Kim,* 423 Md. at 546. The Panel does not accept the Respondent's contention that the willful element in the § 14-404 provisions require a showing of an intent to deceive or to commit fraud. And the Panel further finds that the Respondent's acts with respect to the conduct at issue were intentional and voluntary. The Respondent's conduct was not accidental, was not inadvertent, and was not the result of honest mistakes. The Panel adopts the ALJ's reasoning on this issue.

The evidence demonstrates that to complete the medical assessments properly would require meeting with the patient. There is no dispute that the records of medical assessments that did not take place at issue were completed without the Respondent meeting with the patients. The Respondent intentionally recorded medical information of patients' conditions for medical

assessments that he did not perform, and he intentionally billed for these medical assessments that he did not perform. The Respondent did not record medical information at issue about the patients' conditions accidentally. The medical records at issue purposely indicated that he medically evaluated the patients on days when he did not evaluate those patients. As correctly stated by the ALJ, "all six assessments were documents completely – not partially – meaning that at some point in the day he intentionally completed documentation for examinations he never performed." (PD at 23.) If he could not locate a patient for an assessment, there were many avenues available to the Respondent to determine whether the patients were at the facility. Yet the Respondent still completed medical forms indicating that the patients at issue had been at the facility and underwent medical assessments or examinations by him, when the patients were not present at the facility, and the Respondent did not assess or examine the patients as he indicated on these forms. The Respondent's failure to use the available resources to attempt to determine the patients' locations, when he did not meet with the patients, indicates an intent on the Respondent's part to document medical assessments that did not take place. It shows his intent was not to record accurate medical information, but instead to complete assessment forms and bill for medical acts he did not perform.

The Panel does not find that the Respondent acted in good faith or inadvertently with respect to the conduct at issue. Certainly, medical records sometimes contain honest mistakes, but these are not those records. This is not a situation in which a health care professional absentmindedly wrote an incorrect date, measurement, or observation on a form. To explain how the false records were produced, the Respondent relies on the challenges he faced by the COVID-19 Pandemic. The Panel does not find, though, that the circumstances of the COVID-19 Pandemic indicate that the Respondent's actions were unintentional. The evidence included testimony from other healthcare professionals who worked during the COVID-19 Pandemic, and who (except for

the witness familiar with this type of misconduct through professional disciplinary publications) were unfamiliar with the type of false records produced by the Respondent here. And Patient 3's record at issue and Patient 4's record at issue were not merely daily COVID-19 evaluations. In particular, the record at issue concerning Patient 3 is a detailed SOAP Note for a supposed May 29, 2020, follow-up evaluation. The note contains purported details of the patient's medical condition as if the Respondent thoroughly examined the patient on May 29, 2020, and, in fact, states, at one point, "Pt is seen for a follow-up. Pt is seen in the room." But this evaluation did not take place.

Nor does the Panel find that the Respondent's contention that he quickly returned payments to the insurance companies after he was notified the Board was investigating him evinces an honest mistake. Rather, the Panel finds that the repayments demonstrate an effort to diminish or quell focus on his actions.

The Panel finds the Respondent's conduct at issue willful and denies his exceptions on this issue. The Panel finds that the Respondent willfully made or filed false reports or records in the practice of medicine, made willful representations in treatment, and willfully submitted false statements to collect feeds for which services were not provided, in violation of Health Occ. § 14-404(a)(11), (17), and (23).

Unprofessional Conduct

The ALJ relied upon *Cornfeld v. State Bd. of Physicians,* 174 Md. App. 456, 479 (2007), to find that the Respondent engaged in unprofessional conduct in the practice of medicine. As explained by the ALJ, in *Cornfeld,* the Appellate Court of Maryland (the Court of Special Appeals at the time of the *Cornfeld* decision) held that the physician's false statements to a hospital review investigator and to the Board regarding treatment he had provided constituted unprofessional

conduct in the practice of medicine. The ALJ found, "[h]ere, the Respondent's willfully false record-making, misrepresentations in treatment and in billing constitute unprofessional conduct in the practice of medicine." Panel B accepts the ALJ's determination. The Panel finds the Respondent guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

II. Issue of Immunity based on COVID-19 Catastrophic Health Emergency

The Respondent had entered into evidence two documents signed by the Maryland Governor, at the time of the events at issue, concerning the COVID-19 Pandemic: the Order of the Governor of the State of Maryland, Amending and Restating the Order Dated April 5, 2020 Authorizing Various Actions related to Nursing Homes and Other Health Facilities, dated April 29, 2020 (Order of the Governor); and the State of Maryland Renewal of Declaration of State of Emergency and Existence of Catastrophic Health Emergency – COVID-19, dated July 30, 2020[4] (Renewal of Declaration). It appears the Respondent presented these documents as part of his argument that he is entitled to immunity from the administrative action against him.

In the proceeding at OAH, the Respondent cited two statutory provisions: Md. Code Ann., Pub. Safety § 14-3A-06 and Md. Code Ann., Health-Gen. § 18-907(d). Section 14-3A-06 of the Public Safety Article states, "A health care provider is immune from civil or criminal liability if the health care provider acts in good faith and under a catastrophic health emergency proclamation." Section 18-907(d) of the Health-General Article states, "A health care provider acting in good faith and in accordance with a catastrophic health emergency disease surveillance

[4] As noted by the ALJ, this second document was issued after the Respondent had completed the six assessments at issue.

and response program is immune from civil or criminal liability related to those actions, unless the health care provider acts with willful misconduct."

The ALJ found that neither statute applies to the Respondent's circumstances in this administrative action. First, the ALJ determined that both statutes apply to "civil or criminal liability," not to administrative actions. *See, e.g., Matter of Cricket Wireless, LLC,* 259 Md. App. 44, 68 (2023) (an administrative action against a professional license "is neither civil nor criminal in nature"). Second, the ALJ did not accept that the Respondent acted with an honest intention and thus did not act in good faith. *See* 374 Md. 665, 681 (2003).[5] Third, the ALJ also found that the Respondent failed to establish that the Respondent's actions with respect to the six assessments at issue were "under" or "in accordance with" the proclamation or a disease surveillance and response program. The ALJ did not accept that "documenting and billing for patient examinations that he never performed" were in conformity with any order or proclamation issued the governor or Secretary of Health. The orders and directives at issue were to ensure that each resident was evaluated at least daily for a possible COVID-19 infection. For the six assessments at issue, the Respondent did not evaluate the patients, despite documenting that he did. The ALJ thus did not find that the Respondent is immune from administrative sanctions in this case.

On exceptions, the Respondent relies upon an Opinion of the Attorney General, dated December 28, 2015, to argue that physicians are entitled to immunity in administrative actions. The Respondent contends that immunity excluding administrative acts and applying to only civil and criminal acts is a "narrow interpretation [that] contradicts the intent of the emergency proclamation and legal guidance provided by the Attorney General's office." But the Attorney General Opinion the Respondent relies upon states, "Based on this plain language, it is our view

[5] The ALJ had already determined that the Respondent's offenses were willful.

that health care providers are immune from civil or criminal liability. . ." 100 Op. Att'y at 188. It does not indicate physicians are immune from administrative sanctions. The statutes the Respondent relies upon afford immunity in civil and criminal cases, but not in administrative actions.

The Respondent also relies upon the "good faith" requirement included in each statute, contending that his errors were unintentional. But as already explained, the Respondent's conduct at issue was neither in good faith nor unintentional. Panel B finds that the Respondent did not act in good faith and finds that he acted with willful misconduct. The statutory protection for acts made in good faith does not apply to the Respondent with respect to the six assessments at issue.

The Panel further agrees with the ALJ that the Respondent's documentation and billing for assessments that he did not perform are not consistent with acting "in accordance with" a catastrophic health emergency disease surveillance and response program or "under" a catastrophic health emergency proclamation. The catastrophic health emergency directives concerned providing patients with examinations or assessments to protect against the spread of COVID-19. Documenting and billing for assessments that did not take place does not align with the catastrophic health emergency programs and proclamations. The Panel finds that the Respondent is not entitled to immunity and denies the Respondent's exception.

CONCLUSIONS OF LAW

Based upon the findings of fact and as explained above, Panel B concludes that the Respondent: is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); willfully made or filed a false report or record in the practice of medicine, in violation of Health Occ. § 14-404(a)(11); made a willful misrepresentation in treatment, in

violation of Health Occ. § 14-404(a)(17); and willfully submitted false statements to collect feeds for which services were not provided, in violation of Health Occ. § 14-404(a)(23).

SANCTION

Under the sanctioning guidelines, COMAR 10.32.02.10, a violation of Health Occ. § 14-404(a)(3)(ii), unprofessional conduct in the practice of medicine that is not sexual in nature, has a minimum sanction of a reprimand and a maximum sanction of revocation, with a minimum fine of $10,000, and a maximum fine of $25,000. *See* COMAR 10.32.02.10B(3)(e). A violation of Health Occ. § 14-404(a)(11), willfully making or filing a false report or record in the practice of medicine, has a minimum sanction of a reprimand and a maximum sanction of revocation, with a minimum fine of $10,000 and a maximum fine of $50,000. *See* COMAR 10.32.02.10B(11). A violation of Health Occ. § 14-404(a)(17), making a willful misrepresentation in treatment, has a minimum sanction of a reprimand and a maximum sanction of revocation, and a minimum fine of $10,000, and a maximum fine of $50,000. *See* COMAR 10.32.02.10B(17). And a violation of Health Occ. 14-404(a)(23), willfully submitting false statements to collect fees for which services were not provided, has a minimum sanction of a reprimand and a maximum sanction of revocation, and a minimum fine of $10,000 and a maximum fine of $50,000. *See* COMAR 10.32.02.10B(23).

"The disciplinary panel "may impose more than one sanction, provided the most severe sanction neither exceeds the maximum nor less than the minimum permitted under the sanctioning guidelines." COMAR 10.32.02.09A(4). "If a licensee has violated more than one ground for discipline as set forth in the sanctioning guidelines: (a) The sanction with the highest severity ranking should be used to determine which ground will be used in developing a sanction; and (b) The disciplinary panel may impose concurrent sanctions based on other grounds violated." COMAR 10.32.02.09A(6).

The ALJ proposed a reprimand, a six-month suspension of the Respondent's license, a $35,000 fine, and a course in ethics. The ALJ emphasized the Respondent's extensive disciplinary history with the Board and that the Respondent "committed these acts deliberately, i.e., willfully." While the evidence does not show that the Respondent caused patient harm, the ALJ found there was potential to cause significant patient harm. The ALJ further noted that the conduct at issue, occurring six times over three months, demonstrates a pattern of detrimental conduct and further noted that the Respondent pursued financial gain over the welfare of his patients. The ALJ also mentioned that the patients at issue were especially vulnerable, being elderly and residing in a long-term care facility during the COVID-19 Pandemic. The ALJ also relied on the unsuccessful previous attempts at rehabilitation, mentioning that the Respondent had previously been disciplined for conduct related creating a false medical record.

The Respondent took exception to the ALJ's analysis concerning the factors taken into account in arriving at the proposed sanction. The Respondent contends that the ALJ erred by finding that his conduct was deliberate, arguing that his actions were not premeditated. The Respondent further asks for credit for being cooperative with the Board's investigation, noting that he voluntarily admitted the misconduct. Unlike the ALJ's finding of a detrimental pattern, the Respondent categorizes his conduct as an isolated matter. The Respondent also argues that the ALJ should not have found a lack of rehabilitative potential. According to the Respondent, in a previous disciplinary action against him, where he "had entered a false note for a hospital patient, the Respondent did intentionally write a false note. . . This case is completely different. The Respondent had no inkling that an error had occurred until July. There was no intention of filing a false note." The Respondent also takes issue with the ALJ's finding that he was motivated by financial gain: "This money was promptly returned when the billing errors were discovered." The

Respondent also claims the ALJ erred in finding that his actions had the potential to cause significant patient harm. The Respondent notes that false medical records concerning patients' COVID-19 symptoms filed while the patients were not staying at the nursing facility could not have been relied upon to cause patient harm, because the patients' COVID-19 status where the patients were at the time would not have depended upon the Respondent's false assessments.

The Respondent's logic—that the false medical records he produced did not have the potential to cause patient harm because the assessments would not be relied upon as the result of the patients being in another location—does have merit. This point, however, is insufficient to impose a less severe sanction than the one the ALJ recommended. The Panel finds the ALJ's recommended sanction is appropriate and adopts it. The Respondent deliberately produced false medical records. While, under these peculiar circumstances, the patients' locations most likely prevented them, and others, from being harmed by the false records, the fact that the Respondent was willing to intentionally engage in falsifying medical records cannot be tolerated. Further, the Respondent's previous discipline involving intentionally falsifying a medical record indicates a lack of rehabilitative potential. The Panel does not find that the Respondent failed to cooperate with the Board's investigation, but the Panel does not accept the Respondent's claims that his conduct was a result of honest mistakes, a typical paperwork error, or an unintentional paperwork system flaw. The Respondent intentionally produced records that were deliberately false and intentionally billed for assessments that did not take place. The Respondent's conduct also does not indicate an isolated incident. The six assessments that the Respondent intentionally falsified occurred over a period of several weeks. The Panel also agrees with the ALJ's proposed findings that the Respondent was motivated by financial gain and that the Respondent has an extensive disciplinary history with the Board.

ORDER

It is, on the affirmative vote of a majority of the quorum of Panel B, hereby

ORDERED that Dr. Sprouse is **REPRIMANDED;** and it is further

ORDERED that the Respondent's license to practice medicine in Maryland is **SUSPENDED** for a minimum period of **SIX MONTHS.**[6] During the suspension period:

(1) The Respondent shall not:

(a) Practice medicine in Maryland;
(b) Take any actions to hold himself out to the public as a current provider of medical services;
(c) Authorize, allow, or condone the use of his name or provider number by any health care practice or any other licensee or health care provider;
(d) Function as a peer reviewer for the Board or for any hospital or other medical care facility in the State;
(e) Prescribe or dispense medications; or
(f) Perform any other act that requires an active medical license; and

(2) The Respondent is required to take and successfully complete a course in **ethics.** The following terms apply:

(a) It is the Respondent's responsibility to locate, enroll in, and obtain the Panel's approval of the course before the course begins;
(b) The Respondent must provide documentation to the Panel that the Respondent has completed the course;
(c) The course may not be used to fulfill the continuing medical education credits required for license renewal; and
(d) The Respondent is responsible for the cost of the course; and it is further

ORDERED that, within **ONE YEAR**, the Respondent shall pay a civil fine of **$35,000.** 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

[6] If the Respondent's license expires during the period of suspension, the suspension and any conditions of the suspension will be tolled.

renew or reinstate the Respondent's license if the Respondent fails to timely pay the fine to the Board;[7] and it is further

ORDERED that the Respondent shall not apply for early termination of suspension; and it is further

ORDERED that after the minimum period of suspension has passed and the Respondent has fully and satisfactorily complied with all terms and conditions of the suspension, the Respondent may submit to the Board a written petition for termination of suspension. After determining that the Respondent has complied with the relevant terms of the suspension, the disciplinary panel may administratively terminate the Respondent's suspension through an order of the disciplinary panel; and it is further

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

ORDERED that, if the Respondent allegedly fails to comply with any term or condition of the suspension, 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 of the suspension, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms

[7] The civil fine is not a condition of the suspension.

and conditions, further suspend 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 fine on the Respondent; and it is further

ORDERED that this Final Decision and Order goes into effect upon the signature of the Board's executive director or her designee. The executive director or her designee signs this Final Decision and Order on behalf of Panel B; and it is further

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

Signature On File

06/25/2025
Date

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Health Occ. § 14-408, the Respondent 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 the mailing of this Final Decision and Order. The cover letter accompanying this Final Decision and Order indicates the date Final Decision and Order 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 the Respondent 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, 4th Floor
Baltimore, Maryland 21215

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

David Wagner
Assistant Attorney General
Maryland Department of Health
300 West Preston Street, Suite 302
Baltimore, Maryland 21201