IN THE MATTER OF	*	**BEFORE THE**
NORMAN B. ROSEN, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D11985		**Case Number: 2016-0856B**

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

CONSENT ORDER

On November 13, 2017, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged **NORMAN B. ROSEN, M.D.**, (the "Respondent"), License Number D11985, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II §§ 14-101 *et seq.* (2014 Repl. Vol.).

The pertinent provisions of the Act under Health Occ. II § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* 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:
>
> ...
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;
>
> ...
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

Subsequent to the issuance of Charges Under the Maryland Medical Practice Act, the Respondent agreed to enter into the following Consent Order, consisting of Findings of Fact, Conclusions of Law, Order and Consent.

FINDINGS OF FACT

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on May 21, 1971. His license is scheduled to expire on September 30, 2019. The Respondent holds an inactive license in Pennsylvania.

2. The Respondent is board-certified in physical medicine and rehabilitation.

3. The Respondent is the medical director of a group pain management practice ("the Practice")[1] in Towson, Maryland.

4. The Board initiated an investigation of the Respondent after receiving a complaint dated April 27, 2016, from a family member of a patient (identified as Patient 1 herein) of the Respondent who reported concerns about the quantity of opioids the Respondent and another Practice physician ("Physician A"[2]) were prescribing to the patient.

5. In furtherance of its investigation, the Board obtained ten patient records from the Respondent for review. The Board referred the patient charts and related materials to a peer review entity for review. The peer reviewers found deficiencies in the Respondent's prescribing practices and recordkeeping.

[1] In order to maintain confidentiality, patient, employee and location names are not used in this document.
[2] Disciplinary Panel B has charged Physician A with violations of the Act.

6. In furtherance of the Board's investigation, the Respondent was interviewed under oath by Board staff. During the interview, the Respondent acknowledged that he oversees patient care, stating, "all care that is done in the office is my responsibility." He further stated that he consults with Practice practitioners and "[t]he only patients I'll see and take on myself are the most complicated ones."

7. In a statement to the Board, the Respondent noted that he had 42 years of experience in the areas of pain management, rehabilitation, sports and multi-disciplinary management. He stated that he was considered to be a "thought-leader in the past."

8. The Respondent submitted to the Board a response to the reports of the peer reviewers. The Respondent stated in part that he did not agree with the findings of the peer reviewers as well as his belief that he meets the standard of care from a "multi-disciplinary perspective." The Respondent also stated that "[t]he medical documentation in all cases supports this component of the standard of care was met based on 'universal precautions'..."

9. The peer reviewers noted the following general deficiencies with regard to the Respondent's prescribing practices:

   a. The Respondent consistently prescribed excessively high dosages of highly addictive short-acting opioids and long-acting opioids over prolonged periods of time in the absence of clinical evidence to support the dosages prescribed (Patients 1 – 10);

b. The Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management (Patients 1 – 10);

c. The Respondent maintained patients on excessively high levels of opioids for months and even years despite lack of improvement of functionality or pain control (Patients 1 – 10);

d. The Respondent failed to adequately monitor patients for the potential risk of diversion or addiction (Patients 1 -10);

e. The Respondent failed to significantly modify his treatment plan when patients demonstrated aberrant behavior including inconsistent urine drug tests ("UDTs"). Inconsistent results include positive results for drugs not prescribed, or illicit drugs or negative tests for drugs that were prescribed, which would raise concern for diversion (Patients 3, 4, 6 7 and 8);

f. The Respondent failed to obtain updated imaging studies or other objective clinical indications of a patient's pain (Patients 5, 6 and 8);

g. The Respondent consistently failed to check patients' past and ongoing medication histories with the Chesapeake Regional Information System for our Patients ("CRISP") or the Maryland Prescription Drug Monitoring Program ("PDMP") (Patients 1 -10);

h. The Respondent failed to taper or wean patients from excessive dosages of opioids in spite of the lack of functional improvement or pain control over extended periods of time (Patients 1 -10);

i. The Respondent failed to refer patients for appropriate consultations, including interventional pain management, for non-opioid-based treatment (Patients 2, 6 and 10); and

j. The Respondent continued to maintain or escalate opioid doses in spite of patient behavior indicating opioid use disorder where an addiction consult would be more appropriate (Patients 2 and 10).

10. The peer reviewers concurred that the Respondent failed to maintain adequate medical records for Patients 2, 3, 4, 5, 7 and 8. Specifically, the peer reviewers noted that the Respondent failed to document adequately and clearly treatment rationale and medical decision-making. In addition, hand-written notes by multiple providers, including the Respondent, were at times difficult to read.

11. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and/or failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), for reasons outlined above and including those set forth in the following patient summaries.

PATIENT-SPECIFIC FINDINGS OF FACT

In addition to the general practice deficiencies, the peer reviewers found the patent-specific practice deficiencies that include those set forth below.

Patient 1

12. Patient 1, a male in his mid-50s, began seeing the Respondent in or around August 2015 for low back and bilateral knee pain. Patient 1 had been discharged

by his previous pain management physician because of non-compliance, specifically, UDTs that were positive for non-prescribed oxycodone.

13. Patient 1 was identified as a "medium-high risk" patient when he sought treatment at the Practice.

14. Physician A provided the majority of Patient A's care. On those occasions that the Respondent treated Patient 1, he continued high dosages of short-acting and long-acting opioids: Dilaudid 4 mg (hydromorphone)[3] TID (three times a day) and Exalgo 12 mg (extended release hydromorphone) BID (twice a day). The Respondent maintained Patient 1 on these medications for months.

15. The Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records with respect to Patient 1. He inappropriately prescribed high dosages of short-acting opioids for prolonged periods of time.

Patient 2

16. Patient 2, a female then in her early forties, was initially seen at the Practice in 2007 with complaints of low back pain and work-related right wrist pain. Patient 2 later developed more generalized pain and a probable diagnosis of Relapsing Polychondritis, an auto-immune disease characterized by recurrent episodes of inflammation of cartilage.

17. The Respondent began prescribing two oxycodone 5 mg (12 tablets a day). As Patient 2 complained of increased pain, the Respondent continued to escalate her dosage of oxycodone. At the end of the review period, June 2016, the

[3] All medications are Schedule II Controlled Dangerous Substances ("CDS") unless otherwise indicated.

Respondent was prescribing oxycodone 15 mg one to two tablets every two to three hours, a dosage that equaled over 200 mg/day.

18. The Respondent continued to escalate Patient 2's oxycodone dosage despite her lack of functional improvement.

19. The Respondent failed to consider other non-opioid treatment options.

20. In his summary of Patient 2's care, the Respondent failed to accurately report Patient 2's oxycodone dosage.

21. The Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records with respect to Patient 2. He inappropriately prescribed high dosages of short-acting opioids for prolonged periods of time.

Patient 3

22. Patient 3, a male then in his late twenties, was initially seen at the Practice in 2007. He presented with chronic pain from multiple gunshot wounds status post craniotomy and his medical history included traumatic brain injury, pancreatitis, shoulder pain and low back pain. He was a high-risk patient with a history of tobacco, alcohol and illicit drug abuse.

23. Patient 3's previous physician had discharged him after Patient 3 had tested positive for cocaine and admitted to taking medications from the mother of his child.

24. Other practitioners at the Practice frequently treated Patient 3; however, the Respondent monitored his overall care, counseled him, authorized changes in medications and communicated with referring physicians.

25. The Respondent initially prescribed morphine 30 mg two to three tablets every two hours (maximum 8/day), oxycodone 30 mg one to two tablets BID (twice a day) and a benzodiazepine, Valium 10 mg one to two tablets at bedtime.

26. For the last several years of the review period, the Respondent and other practitioners prescribed a regimen that included morphine sulfate extended release 15 mg TID, oxycodone 50 mg five or six/day and a benzodiazepine, Xanax.

27. Over the review period, through mid-July 2016, the Respondent prescribed or authorized changes in Patient 3's opioid dosages.

28. Throughout the review period, Patient 3 tested positive on numerous UDTs for various non-prescribed substances including codeine, fentanyl, hydrocodone, heroin and most frequently, alcohol.

29. The Respondent continued to prescribe high dosages on opioids in conjunction with benzodiazepines to Patient 3 in spite of frequent inconsistent UDTs and Patient 3's use of illicit drugs.

30. When communicating with other physicians, the Respondent at times provided inaccurate and misleading information. For example, in July 2016, the Respondent wrote to a physician at an addiction treatment center who had agreed to see Patient 3 that Patient 3 "did not have any drug aberrancy that we were aware of until 2 months ago when we started to noticing needle marks on his extremities which got worse over the course of the last week..."

31. Also in July 2016, the Respondent transmitted to the Board a summary of his care of Patient 3. His summary states in pertinent part: "[Patient 3's] prior urines had never shown misuse of any substances except for alcohol."

32. The Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records with respect to Patient 3. He inappropriately prescribed high dosages of opioids in conjunction with benzodiazepines for prolonged periods of time. The Respondent failed to alter significantly Patient 3's medication regimen despite frequent UDTs that were positive for illicit drugs and alcohol. The Respondent failed to document his treatment rationale in a clear manner. His communications with other physicians and the Board regarding Patient 3's treatment were at times inaccurate and misleading.

Patient 4

33. Patient 4, a male then in his thirties, was initially seen at the Practice in October 2011 for chronic back and leg pain resulting from a 2004 work-related injury. Patient 4 had undergone multiple spine surgeries. He is a smoker with a significant psychiatric history. Patient 4 previously had been treated for three years at a pain management practice but was discharged for non-compliance, including self-escalation of doses, running out of medication early and refusing UDTs.

34. Prior to presenting to the Practice, recommendations for his treatment included outpatient and inpatient weaning of opioids.

35. Prior to seeing the Respondent, Patient 4's medication regimen included morphine 150 mg daily.

36. During the review period, the Respondent maintained Patient 4 on high dosages of opioids including: MS Contin 60 mg one tablet BID up to TID; oxycodone 30 mg one tablet TID up to QID (four times a day); Soma[4] one to two tablets at bedtime and Elavil.[5]

37. Patient 4 had multiple inconsistent UDTs. Some were positive for alcohol, and some were negative for oxycodone. The Respondent maintained Patient 4 on high levels of opioids despite Patient 4's inconsistent UDTs and did not alter his medication regimen significantly subsequent to an inconsistent UDT.

38. In his July 2016 summary of Patient 4's care that he transmitted to the Board, the Respondent referred to the report of a 2012 Independent Medical Examination of the Respondent in which the examiner recommended a weaning goal that would reduce Patient 4's morphine equivalents from 300 mg a day to "no more than approximately 120 mg morphine equivalents a day." In the summary, the Respondent noted that the examiner felt Patient 4 "could be adequately managed on 150 mg of morphine a day. When the patient came to us in 2011, he was started on 60 mg of MS Contin twice a day (120 mg) which then was increased over the next year or two, 120 mg twice a day. He currently is on 60 mg three times a day (180 mg)."

39. The Respondent's statement to the Board is inaccurate and misleading. At the time of the summary, the Respondent was prescribing to Patient 4 a daily dose of

[4] A CDS Schedule IV muscle relaxant.
[5] An anti-depressant.

180 mg of morphine, but also a daily dose of 210 mg of oxycodone, or approximately 495 morphine equivalents per day.

40. The Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records with respect to Patient 4. Patient 4's condition warranted opioid management; however, the Respondent's escalation of dosages for years despite multiple inconsistent UDTs was inappropriate. The Respondent failed to alter significantly Patient 4's medication regimen despite frequent UDTs that were positive for illicit drugs and alcohol. The Respondent failed to document his treatment rationale in a clear manner. His communications with the Board regarding Patient 4's treatment were at times inaccurate and misleading.

Patient 5

41. Patient 5, in his fifties, initially presented to the Practice in 2003 with complaints of knee, ankle and foot pain. Patient 5's diagnoses included: peripheral neuropathy secondary to diabetes; obesity; deconditioning and mechanical low back pain.

42. Patient 5 reported that his prior medication regimen included OxyContin 80 mg QID and Roxicodone 30 mg six times/day for a daily oxycodone dose of 500 mg.

43. During the review period, the Respondent prescribed to Patient 5 two long-acting opioids (OxyContin and Opana) and two short-acting opioids (Roxicodone 15 mg and Roxicodone 30 mg) simultaneously and in conjunction with a benzodiazepine (Xanax).

44. In 2015, the Respondent regularly prescribed to Patient 5 opioids that exceeded 1800 mg morphine equivalents/day.

45. In 2016, the Respondent prescribed to Patient 5 opioids that exceeded 800 mg morphine equivalents/day, noting that Patient 5 was not doing well due to the decreased medications.

46. The Respondent failed to obtain any nerve conduction studies during the review period although much of his treatment was focused on Patient 5's diabetic neuropathy.

47. The Respondent conducted only one UDT, which was consistent, over a 12-year period of treatment.

48. The Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records with respect to Patient 5. He inappropriately prescribed extremely high dosages of opioids in conjunction with benzodiazepines for prolonged periods of time. The Respondent failed to perform regular UDTs.

Patient 6

49. Patient 6, a male in his forties, was seen for much of his care by a Practice physician other than the Respondent, Physician A for neck and back pain starting in January 2008.

50. In a statement to the Board, the Respondent stated that he supervised Physician A's treatment of Patient 6.

51. In 2008, a physician other than Physician A began prescribing oxycodone 30 mg to Patient 6, documenting decreased range of motion of his cervical and lumbar spine.

52. Physician A began treating Patient 6 in December 2009. Physician A maintained Patient 6 on oxycodone 30 mg prescribing up to two tablets every four to six hours.

53. In June 2010, a practitioner other than Physician A documented in Patient 6's record: "Do not prescribe this patient any opioids, had 2 overdoses." At the next visit, Physician A prescribed to Patient 6 the same quantity of oxycodone 30 mg as previously.

54. Physician A prescribed Patient 6 on oxycodone 30 mg, albeit with a slight decrease in the quantity of pills prescribed despite Patient 6's multiple inconsistent UDTs that were positive for marijuana and hydrocodone, the latter of which was not prescribed, and an inconsistent UDT that was negative for oxycodone but positive for morphine and Soma, neither of which had been prescribed.

55. The Respondent, in his capacity of Physician A's supervisor, failed to meet appropriate standards for the delivery of quality medical services with regard to Patient 6. The Respondent permitted Physician A to prescribe high dosages of short-acting opioids over several years without appropriate pathology or findings on physical examination, without a plan to transition Patient 6 off oxycodone 30 mg, a highly addictive opioid, and despite multiple inconsistent UDTs and information that Patient 6 had overdosed in the past. The Respondent failed to

require Physician A to obtain updated radiological studies and did not refer Patient 6 to physical therapy until 2014. The Respondent failed to require Physician A to refer Patient 6 for a interventional pain management consultation. Despite Patient 6's multiple violations of the Medication Agreement, the Respondent permitted Physician A to prescribe high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management.

Patient 7

56. Patient 7, a male then in his mid-thirties, initially presented at the Practice in 2008 with a history of back pain. When Patient 7 was referred to the Practice, it was noted that Patient 7 was on an extremely high dosage opioid regimen including: (OxyContin 80 mg 12 tablets/day; OxyContin 60 mg 12 tablets/day; oxycodone 30 mg 12 tablets/day; Percocet 10/325 12 tablets/day; Dilaudid 8 mg 9 tablets/day, Valium 10 mg BID and Adderall 30 mg daily.

57. The Respondent discontinued some of the opioids and decreased the dosage of others through June 2016; however, at the end of the review period, the Respondent continued to prescribe high opioid dosages to Patient 7 (OxyContin 80 mg 6 tablets/daily, OxyContin 40 mg 2 tablets/day and oxycodone 30 mg 6-9 tablets daily).

58. At various times during the review period, the Respondent prescribed benzodiazepines in conjunction with high dosages of opioids.

59. In 2014, Patient 7 was seen by an addiction specialist who reported, "[s]econdary to [Patient 7's] opiate dosage, inconsistencies of story, as well as most likely

comorbid mental illness, legal history of violence x3 and DUI x2, loss of parent before adolescence, I consider him at this time until further information is obtained to be at least moderate risk of medication misuse, abuse of diversion." The specialist recommended "frequent quantitative analysis of opiate blood levels to assure patient is taking medication as prescribed."[6]

60. The Respondent failed to order UDTs regularly and consistently both before and after the addiction specialist's report despite several red flags including Patient 7's reports of running out of medication early and his 2014 drug-related arrest. In addition, some of the UDTs that were performed were positive for drugs not prescribed or negative for drugs that were prescribed.

61. In his July 2016 summary of care, the Respondent misstated Patient 7's opioid dosage. The Respondent reported that Patient 7 was then being prescribed oxycodone 720 mg/day. Review of the record revealed that the Respondent in fact was prescribing 920 mg/day.

62. The Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records with respect to Patient 7. He inappropriately prescribed extremely high dosages of opioids for prolonged periods of time. At various times, the Respondent also prescribed benzodiazepines in conjunction with high dosages of opioids. The Respondent failed to perform regular UDTs.

Patient 8

[6] Although Patient 7 was to follow-up with the addiction specialist he later declined to do so.

63. Patient 8, a male then in his late- thirties, initially presented to the Respondent in 2009 with complaints including chronic back pain, bilateral knee pain and bilateral hand pain.

64. Patient 8's medication regimen when he was seen by the Respondent included methadone 10 mg 12 tablets/day and Percocet 10/325 one tablet BID. The Respondent failed to confirm Patient 8's regimen nor did the Respondent order a baseline UDT.

65. The Respondent continued Patient 8's regimen until May 2012 when it was discovered that Patient 8 was being prescribed methadone and oxycodone by another physician. The Respondent then continued Patient 8's methadone and started oxycodone 15 mg maximum 5 tablets/day.

66. The Respondent decreased Patient 8's methadone dosage to 10 mg 5 tablets/day, but doubled his oxycodone dosage despite having documented that Patient 8 was tolerating the lower dose of methadone.

67. The Respondent prescribed various benzodiazepines to Patient 8 during the review period.

68. The Respondent failed to obtain an MRI for Patient 8 at any time during the review period.

69. Patient 8 demonstrated aberrant behavior throughout the review period including multiple and consecutive inconsistent UDTs, many for illicit drugs such as cocaine and heroin, others for nonprescribed drugs such as fentanyl, codeine and benzodiazepines. Patient 8 also frequently ran out of his medications early. The Respondent continued to prescribe the same dosages of opioids despite the

frequent inconsistent UDTs. He required Patient 8 to be seen more frequently, but took no other action in response to the inconsistent UDTs.

70. When communicating with Patient 8's other treating physician, the Respondent failed to report Patient 8's multiple inconsistent UDTs.

71. The Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records with respect to Patient 8. He inappropriately prescribed extremely high dosages of opioids for prolonged periods of time. At various times, the Respondent also prescribed benzodiazepines in conjunction with high dosages of opioids. The Respondent failed to address inconsistent UDTs in an appropriate manner. The Respondent's communications with other physicians were at times inaccurate and misleading.

Patient 9

72. Patient 9, a male then in his early twenties, was initially seen by the Respondent in August 2007 with complaints of low back and knee pain.[7]

73. Patient 9 had been discharged from his previous pain management practice because of medication misuse.

74. Patient 9's medication regimen when he presented to Practice A included Roxicodone 40 mg QID. The former physician noted that he discontinued a prescription for MS Contin 30 mg because Patient 9 had not filled a prescription for it. The former physician reported that he had prescribed several different opioids to Patient 9, but that Patient 9 stated that none controlled his pain.

[7] Patient 9 was treated by the Respondent and other practitioners at Practice A.

75. During the review period, the Respondent doubled Patient 9's dosage of Roxicodone and added methadone with no clear improvement in Patient 9's function.

76. Although Patient 9's MRI findings were relatively mild, the Respondent failed to order any type of diagnostic testing to determine a clear etiology of Patient 9's pain or to justify the increase in opioid dosages.

77. During the review period, the Respondent documented frequent episodes of Patient 9's aberrant behavior. Patient 9 had many inconsistent UDTs, testing positive on multiple occasions for nonprescribed fentanyl, heroin, morphine, codeine and hydrocodone. Patient 9 frequently ran out of medications early. In 2008, Patient 9 was arrested for altering prescriptions.

78. The Respondent typically addressed Patient 9's aberrant behavior by temporarily increasing the frequency of Patient 9's visits and decreasing slightly his opioid dosages. When Patient 9 produced a consistent UDT, the Respondent increased the dosages and Patient 9's visit intervals.

79. In 2014, the Respondent discontinued methadone and added Opana ER (extended release oxymorphone) 5 mg TID, quickly increasing the Opana dosage to 30 mg QID.

80. At the end of the review period, the Respondent was prescribing Roxicodone 30 mg one tablet every three to four hours and Opana 30 mg QID.

81. The Respondent failed to meet appropriate standards for the delivery of quality medical care with respect to Patient 9. He inappropriately prescribed extremely

high dosages of opioids for prolonged periods of time. The Respondent failed to address inconsistent UDTs in an appropriate manner.

Patient 10

82. Patient 10, a male in his late twenties, initially presented to the Practice in December 2015 and was briefly seen by a physician other than the Respondent.

83. Patient 10 presented with chronic low back pain and shoulder pain. Patient 9 was a heavy tobacco smoker and also smoked marijuana. His medical history included anxiety and depression and a family history of bipolar disorder. Patient 10 admitted to buying Suboxone from friends.

84. The Respondent began seeing Patient 10 in January 2016 and continued his medication regimen of Suboxone, Klonopin, Seroquel, Celebrex and Flexeril.

85. Patient 10 was a high-risk patient; however, the Respondent did not consider referring him for a psychiatric and/or addiction consultation before prescribing him opioids. The Respondent also did not discuss with Patient 10 spine interventions such as a selective nerve root block.

86. In February 2016, the Respondent discontinued Suboxone and started oxycodone 15 mg six tablets;/day and methadone 10 mg one tablet at bedtime.

87. Through April 2016, the end of the review period, the Respondent increased Patient 10's methadone dosage to 10 mg QID, but did not decrease the dosage of Patient 10's oxycodone.

88. The Respondent sometimes saw Patient 10 sooner than every two weeks and refilled his medications despite Patient 10's admission that he took more medications than had been prescribed.

89. In his summary of Patient 10's care, the Respondent reported that Patient 10 had not kept a follow-up appointment in April 2016 and that it was subsequently learned that Patient 10 may have overdosed on heroin.

90. The Respondent failed to meet appropriate standards for the delivery of quality medical care with respect to Patient 10. He inappropriately prescribed high dosages of opioids in conjunction with benzodiazepines for a prolonged period of time. The Respondent failed to consider non-opioid modes of treating Patient 10.

CONCLUSIONS OF LAW

Based on the forgoing Findings of Fact, Disciplinary Panel B of the Board concludes as a matter of law that the Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40).

ORDER

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

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

ORDERED that the Respondent is permanently prohibited from prescribing and dispensing all Controlled Dangerous Substances ("CDS"); and it is further

ORDERED that Disciplinary Panel B may routinely issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program ("PDMP") for the Respondent's prescription monitoring data; and it is further

ORDERED that the Respondent is placed on **PROBATION**[8] for a minimum period of **TWO (2) YEARS;** and it is further

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

ORDERED that, after a minimum of two years, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Panel B. The Respondent may be required to appear before the Board or Panel B to discuss his petition for termination. The Board or Panel B will grant the petition to terminate the probation if there are no pending complaints against the Respondent related to the charges; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition of this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings. If 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 a disciplinary panel determines that the Respondent has failed to comply with any term or condition of this Consent Order, a disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in

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[8] If the Respondent's license expires while the Respondent is on probation, the probationary period will be tolled.

addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that the Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101 – 14-702, and all federal and state laws and regulations governing the practice of medicine in Maryland; 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, unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of Panel B; and it is further.

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. Gen. Prov. §§ 4-333(b)(6) (2014 & Supp. 2017).

09/27/2018
Date

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

CONSENT

I, Norman B. Rosen, M.D., acknowledge that I was represented by counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I waive these substantive and procedural protections. I affirm that I am waiving my right to appeal any adverse ruling of a disciplinary panel of the Board that I might have filed after any such hearing. I acknowledge the legal authority and 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 sign this Consent Order voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

Signature on File

9-17-18
Date

Norman B. Rosen, M.D.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 17 day of September 2018, before me, a Notary Public of the foregoing State and City/County, personally appeared Norman B. Rosen, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

KIMBERLY BYRNES NOTARY PUBLIC CARROLL COUNTY, MD. COMMISSION EXPIRES MAY 17 2020

Notary Public

My commission expires: _____