IN THE MATTER OF	*	**BEFORE THE**
RAM KUMAR RASTOGI, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D17737	*	**Case Number: 2220-0172B**

* *

CONSENT ORDER

On October 1, 2021, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged **RAM KUMAR RASTOGI, M.D.** (the "Respondent"), License Number **D17737**, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. & 2020 Supp.). Panel B charged the Respondent with violating the following provision of the Act:

> **Health Occ. § 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[.]

On December 15, 2021, Panel B 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, and Order.

FINDINGS OF FACT

Panel B finds:

I. BACKGROUND

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 January 16, 1975, under License Number D17737. The Respondent's license is currently active and scheduled to expire on September 30, 2023.

2. The Respondent is not board-certified in any medical specialty.

3. At all times relevant hereto, the Respondent was employed part-time as a primary care physician at a medical group (the "Group")[1] located in Maryland.

II. THE COMPLAINT

4. On or about November 25, 2019, the Board received a complaint from the OB/GYN (the "Complainant") of one of the Respondent's patients ("Patient 1") who raised concerns about the large amount of opioids the Respondent prescribed to Patient 1.

[1] For confidentiality and privacy purposes, the names of individuals and health care facilities involved in this case are not disclosed in this Consent Order.

I. BOARD INVESTIGATION

5. After reviewing the above complaint, the Board initiated an investigation of the Respondent. As part of its investigation, the Board obtained a series of patient records, interviewed the Respondent, and obtained a peer review of his practice.

Patient Records

6. By letter dated January 27, 2020, the Board notified the Respondent that it had opened a full investigation of the matter and provided him with a copy of the Complaint. The Board directed the Respondent to provide a written response to the allegations within ten (10) business days. The Board also issued a Subpoena Duces Tecum that directed the Respondent to transmit to the Board within ten (10) business days "a complete copy of any and all medical records for [Patients 1-10]."

7. On or about February 18, 2020, the Respondent transmitted to the Board medical records, a signed certificate of medical records, and a summary of patient care for each of the ten (10) patients.[2]

Written Response

8. By letter dated February 17, 2020, the Respondent provided a written response to the allegations. The Respondent explained that many of his patients "come from poor socioeconomic backgrounds with little or no family support or encouragement . . . It is hard work in many cases to properly screen and even rely upon a patient's stated history."

[2] The Respondent addressed the medical care he provided to Patient 1 in his written response, and thus, did not submit a separate summary of care for that patient.

9. The Respondent admitted that he prescribed Patient 1 opioids without physically observing Patient 1. The Respondent stated that he relied on the verbal assessment provided by the patient's sister when informed that the patient was unable to attend the office visit.

Interview

10. As part of the Board's investigation, the Respondent was interviewed under oath on May 14, 2020. As part of that interview, the Respondent provided the following:

a. He has been working with the Group since 1976. His practice is office-based and he currently sees patients on an appointment and walk-in basis.

b. He has not taken any coursework or professional training in pain management.

c. Chronic pain management patients make up approximately five (5) percent of his practice while acute pain management patients make up another five (5) percent of his practice.

d. He does not utilize Opioid and/or Pain Management Treatment Contracts with his patients.

e. He admitted that some of his patients need prescriptions for both opioids and benzodiazepines in order to treat both their pain and their mental illness.

f. He noted that he explains to patients that he is only a primary care physician and not a specialist but many of his patients do not want to see a specialist.

Peer Review

11. In furtherance of its investigation, the Board submitted the ten (10) patient records (referenced *supra* as "Patients 1-10") and related materials to a peer review entity for a practice review to determine if the Respondent complied with appropriate standards

for the delivery of quality medical care and kept adequate medical records. Two peer reviewers, each board-certified in pain management ("Peer Reviewer 1" and "Peer Reviewer 2" respectively), independently reviewed the materials and submitted their reports to the Board.

12. In their reports, the two physician peer reviewers concurred that the Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), for ten (10) out of ten (10) patients. The peer reviewers further concurred that the Respondent failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), for ten (10) out of ten (10) patients.

13. Specifically, the peer reviewers found that for the ten (10) patients, the Respondent failed to meet the standard of quality medical care for reasons including but not limited to the following:

a. The Respondent failed to use Opioid Risk Assessment Screening Tools prior to prescribing opioids to determine whether patients were at risk for developing a substance use disorder. *See e.g.,* Patients 1-10.

b. The Respondent initiated opioid therapy without discussing the risks and benefits of prescription opioids. *See e.g.,* Patients 1-10.

c. The Respondent failed to discuss and have patients sign an Opioid and/or Pain Management Treatment Contract prior to starting or continuing opioid therapy. *See e.g.*, Patients 1-10.

d. The Respondent prescribed and maintained non-cancer patients on high doses of opioids over the recommended MME[3] per day. *See e.g.,* Patient 3 (270 MME/day) and Patient 8 (120 MME/day).

[3] Morphine Milligram Equivalence ("MME") is a value assigned to each opioid to represent its relative potency by using morphine as the standard comparison. The CDC Guideline for Prescribing Opioids for Chronic Pain (the "CDC Guideline") uses MME to establish a recommended opioid dosing and

e. The Respondent prescribed various combinations of controlled dangerous substances ("CDS"), such as benzodiazepines, opioids, and sedative-hypnotics to patients, and failed to document or disclose the risk for concomitant use of these medications. *See e.g.,* Patient 3 (Fentanyl, Morphine, Alprazolam, and Clonazepam); Patient 4 (Percocet and Xanax); Patient 5 (Oxycodone and Xanax); Patient 7 (Hydrocodone, Tramadol, and Clonazepam); Patient 8 (Tylenol #3 and Alprazolam); Patient 9 (Flexeril, Oxycodone, and Clonazepam); and Patient 10 (Tramadol, Soma, and Alprazolam).

f. The Respondent failed to prescribe Naloxone for prevention of unintentional opioid overdose for patients being treated with Chronic Opioid Therapy (COT) and educate the patient and family/friends on how to use it. *See e.g.,* Patients 1-9.

g. The Respondent failed to monitor patient compliance with opioid therapy by periodically checking the Prescription Drug Monitoring Program (PDMP); conducting routine, random urine toxicology screens; and conducting pill counts. *See e.g.,* Patients 1-10.

h. The Respondent prescribed/continued to prescribe opioids even though the patient had not been seen in the office. *See e.g.,* Patient 1.

14. The peer reviewers also independently concluded that the Respondent failed to keep adequate medical records in all ten (10) patients whose records were reviewed.

15. Both peer reviewers commented on the lack of readability of the Respondent's medical records. Peer Reviewer 2 added: "Adequate record keeping starts with the Respondent's own office notes and these are hand written and mostly barely legible."

16. The peer reviewers identified several areas of concern with respect to the Respondent's medical documentation, including but not limited to the following:

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recommends using precaution when prescribing opioid doses greater than or equal to 50 MME per day and avoiding or carefully justifying a decision to increase opioid doses greater than or equal to 90 MME per day.

a. The Respondent failed to document a comprehensive evaluation, including a detailed medical history and physical exam of patients' physical complaints prior to prescribing CDS. *See e.g.,* Patients 2, 3, 4, 5, 6, 7, 9.

b. The Respondent failed to provide enough information regarding reassessment for the continuation of chronic opioid therapy or the justification for maintaining the patient on the risky combination of high dose opioids and high dose benzodiazepines. *See e.g.,* Patients 3, 4, 5.

c. The Respondent failed to document efforts to monitor compliance. *See e.g.,* Patients 1-10.

Respondent's Supplemental Written Response

17. The Board provided the Respondent with the peer reviewers' findings. By letter dated August 6, 2020, the Respondent submitted his response. The Respondent noted: "It appears that these peer reviews were performed to the standards and protocols used by Pain Management specialists. I am not a Pain Management specialist, but I have been in primary care medicine for 44 years." The Respondent added:

> As a result of this inquiry, I have now discharged or referred almost all of my chronic pain patients . . . Moving forward, the only prescriptions I am writing currently for narcotics are short term prescriptions until the patient can be seen by Pain Management, and I am trying to use NSAIDS, Physical Therapy, and other modalities rather than narcotics medication when I can. Also, I am now routinely checking PDMP and CRISP and conducting regular toxicology screenings[.]

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel B concludes as a matter of law that the Respondent failed to meet the 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 thus by Disciplinary Panel B of the Board, hereby:

ORDERED that the Respondent, Ram Kumar Rastogi, M.D., License No. D17737, is **REPRIMANDED**; and it is further

ORDERED that the Respondent is permanently prohibited from prescribing and dispensing all Controlled Dangerous Substances (CDS) under Criminal Law § 5-401 *et seq.*; and it is further

ORDERED that the Respondent agrees to surrender the Respondent's CDS Registration to the Office of Controlled Substances Administration; and it further

ORDERED that any delegation agreement entered into by Dr. Rastogi shall prohibit the Dr.Rastogi from supervising Physician Assistants in their prescribing of the CDS; and it is further

ORDERED that on every January 31st thereafter if the Respondent holds a Maryland medical license, the Respondent shall provide the Board with an affidavit verifying that the Respondent has not prescribed any of the prohibited CDS (or the specified subcategory of prohibited CDS) in the past year; and it is further

ORDERED that if the Respondent fails to provide the required annual verification of compliance with this condition:

(1) there is a presumption that the Respondent has violated the permanent condition; and
(2) the alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing; and it is further

ORDERED that the Respondent is permanently prohibited from certifying patients for the medical use of cannabis; and it is further

ORDERED that on every January 31st thereafter if the Respondent holds a Maryland medical license, the Respondent shall provide the Board with an affidavit verifying that the Respondent has not certified patients for the medical use of cannabis in the past year; and it is further

ORDERED that if the Respondent fails to provide the required annual verification of compliance with this condition:

(1) there is a presumption that the Respondent has violated the permanent condition; and
(2) the alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing.

ORDERED that the Respondent is placed on **PROBATION** until Dr. Rastogi completes the recordkeeping course condition of probation described below.[4] During probation, the Respondent shall comply with the following terms and conditions of probation:

Within six (6) months, the Respondent is required to take and successfully complete a course in **MEDICAL RECORDKEEPING**. 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) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

(c) the courses may not be used to fulfill the continuing medical education credits required for license renewal;

(d) the Respondent is responsible for the cost of the courses; and it is further

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

ORDERED that the prohibition on prescribing and certifying goes into effect **THIRTY (30)** calendar days after the effective date of this Consent Order; and it is further

ORDERED that the disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's CDS prescriptions. The administrative subpoenas will request the Respondent's CDS prescriptions from the beginning of each quarter; and it is further

ORDERED that, after the Respondent has complied with all terms and conditions of probation imposed by the Consent Order, the Respondent may submit a written petition for termination of probation. After consideration of the petition, the Respondent's probation may be administratively terminated through an order of the disciplinary panel if the Respondent has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and 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 or her designee. The Executive Director or her designee 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 radiography 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).

Signature On File

5/13/2022
Date

Ellen Douglas Smith
Deputy Director
Maryland State Board of Physicians

CONSENT

I, Ram Kumar Rastogi, M.D., 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. § 14-405 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

5-11-22

Date

Ram Kumar Rastogi, M.D.
License No. D17737

NOTARY

STATE OF Maryland

CITY / COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 11 day of May 2022, before me, a Notary Public of the foregoing State and City/County, personally appeared Ram Kumar Rastogi, 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.

Anita Dragan
Notary Public
Anne Arundel Co., MD
My Commission Exp. 2-8-24

Anita Dragan
Notary Public

My Commission expires: 2-8-2024