IN THE MATTER OF	*	**BEFORE THE**
GARY J. SPROUSE, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D32036	*	**Case Number: 2218-0276 A**

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

ORDER TO CEASE AND DESIST

Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board"), pursuant to Md. Code Ann., Health Occ. § 14-206(e)(2), hereby orders **GARY J. SPROUSE, M.D.** (the "Respondent") to immediately **CEASE AND DESIST** from prescribing opioids in the State of Maryland. Panel A has determined that, with respect to Respondent's prescribing of opioids, there is a preponderance of evidence of grounds for discipline under § 14-404 of the Health Occupations Article and there poses a serious risk to the health, safety, and welfare of patients. *See* Health Occ. § 14-206(e)(2). Panel A's determinations are based upon the following findings of fact:[1]

1. Respondent is licensed to practice medicine in the State of Maryland. Respondent was initially licensed to practice medicine in Maryland on March 8, 1985. The Respondent's license is active through September 30, 2019.

2. Respondent is board-certified in internal medicine having been granted lifetime certification in 1985.

[1] The statements regarding Panel A's findings are intended to provide Respondent with notice of the basis of the cease and desist order. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against Respondent, if necessary, in connection with this matter.

3. Respondent maintains two medical offices in Maryland. In one office, Respondent practices internal medicine and pain medicine. In his other office, Respondent practices addiction medicine. Respondent is the sole physician in these offices, although he supervises a physician assistant in one these offices.

4. Respondent does not hold any hospital privileges. Respondent does have privileges at multiple nursing homes in Maryland.

5. Respondent holds a waiver issued by the Substance Abuse and Mental Health Services Administration ("SAMHSA"), Center for Substance Abuse Treatment ("CSAT") of the U.S. Department of Health and Human Services ("HHS"), to practice opioid dependency treatment with approved buprenorphine[2] medications, for up to 275 patients.

6. Respondent has a lengthy disciplinary history with the Board. There have been three orders since 2013, including a violation of a Board Order, which all pertain to his inappropriate and dangerous prescribing of CDS for the treatment of chronic pain, including his prescribing of high dosages of opioids and his prescribing of opioids in conjunction with benzodiazepines, as well as his inappropriate prescribing of CDS for patients' psychiatric conditions and patients with dual diagnoses.

7. Respondent has been under the Board's supervision continuously since July 22, 2013. His most current probationary period began on July 11, 2016.

8. Beginning in March 2018, the Board has received complaints from

[2] Buprenorphine, an opioid, is used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates, such as pain relievers like morphine.

physicians, pharmacists, and friends of patients and has received reports from State oversight agencies about Respondent's prescribing of CDS.

9. On March 12, 2018, the Board received a written complaint from the friend of a deceased patient of Respondent's, Patient 1[3], "an active alcoholic with liver failure." The complainant stated that in late 2016, Respondent started prescribing Oxycontin, which Respondent continued to increase, and then started prescribing Ambien, Xanax, and Methadone.

10. On June 28, 2018, the Board received a report, dated June 14, 2018, from a Pharmacy Claims Investigator, a licensed pharmacist ("Pharmacist A") for Maryland Medicaid recipients, who had reviewed prescription claims from Medicaid recipients from January 2016 through March 2018. For the 28 patients that Respondent treated with chronic opioids, Pharmacist A reported:

> ...the doses and quantities were usually excessive. It was common for patients to be prescribed Methadone 10 mg, Hydromorphone 8 mg, and Oxycodone 15 mg and 30 mg at quantities of #100 to #150. These same patients usually received high dose, high quantity benzodiazepines, such as Alprazolam 2 mg and Clonazepam 2 mg concurrently.

11. On June 26, 2018, the Board received a complaint from an anonymous health care provider. The complainant stated that he has seen a patient who was on chronic opioids and benzodiazepines.[4] The complainant referred the patient to pain management, but the patient continued to present requesting high doses of benzodiazepines. The complainant started to taper the patient, but the patient called and

[3] Respondent's care of Patient 1 was peer reviewed.
[4] Respondent subsequently identified this individual, based on information in the complaint, as Patient 2. Respondent's care of Patient 2 was peer reviewed.

stated, "I found someone who will write me for what I want" and gave the name of the new provider as Respondent. In addition, the complainant referred to a second patient[5] in the practice who is filling "high doses of opiates and benzodiazepine and paying cash for the prescriptions." The complainant identified the provider as Respondent.

12. On July 18, 2018, the Board received a written complaint from a pharmacist ("Pharmacist B") at a pharmacy on the Eastern Shore of Maryland, who noted "an unusual prescribing pattern for oxycodone at large quantities and high doses" and that Respondent "frequently writes for multiple controlled substances at once."

13. On February 8, 2019, the Board transmitted the pertinent investigative materials, including patient medical records and Respondent's response to the complaints, to an independent peer review entity for review by two physicians, both who are board-certified in Pain Medicine.

14. On March 26, and April 4, 2019, respectively, the two peer reviewers submitted their reports to the Board which found that in ten of the ten patient records reviewed, Respondent failed to meet standards of quality medical care. See Health Occ.§ 14-404(a)(22).

15. Panel A's findings include the following regarding the ten patients:[6]

a. Patient 1- Respondent prescribed high doses of opioids (500 MME/day) to Patient 1 who had liver cirrhosis from alcohol abuse. Respondent did not adjust Patient 1's doses to take into account the altered metabolism based on liver impairment. Respondent prescribed Methadone chronically for Patient 1 but failed to check a

[5] Respondent subsequently identified this individual, based on information in the complaint, as Patient 3. Respondent's care of Patient 3 was peer reviewed.

[6] Respondent's treatment of these patients are more fully set forth in the two peer review reports which have been reviewed by Panel A and previously provided to Respondent.

12 lead EKG for the risk of Qtc prolongation, which could lead to a fatal arrhythmia while using Methadone. Respondent did not have a strategy to deal with Patient 1's development of opoiod tolerance, such as rotating to another opioid. Respondent provided limited discussion of Patient 1's reported chronic pain syndrome, but no comprehensive patient evaluation, treatment plan, or ongoing assessments. Respondent obtained only limited drug screens;

b. Patient 2 - Respondent concomitantly prescribed Oxycodone and benzodiazepines to Patient 2 but failed to justify why the benefit outweighed the risk nor did he try safer alternatives. Although he was aware that Patient 2 was cutting his medications in half and was satisfactory, Respondent did not reduce either the opioid or the benzodiazepine. Patient had groin pain from a previous hernia repair, but Respondent failed to do a workup or a referral to a general surgeon for evaluation of post-operative pathology. Respondent only obtained one urine drug screen and no pill counts; and continued high dose opioid medication although Patient 2 did not show any significant improvement;

c. Patient 3- Patient 3 sought care from Respondent after a pain specialist had decreased Patient 3's opioid regimen. Respondent failed to contact the prior treating pain specialist or obtain medical records to understand why the prior physician made the adjustment. Respondent treated Patient 3 with high dose Methadone but failed to obtain a 12 lead EKG to assess the risk of prolonged QTc and failed to obtain the result of a prior EKG. Respondent stated he intended to reduce Patient 3's pain medications but instead he increased pain medication. Respondent prescribed benzodiazepines chronically even though an anxiety assessment tool noted that Patient 3 had minimal anxiety. Respondent failed to justify why the benefit of concomitant prescribing of opioids and benzodiazepines outweighed the risk nor did he try safer alternatives;

d. Patient 4 - Patient 4 reportedly has been on pain medications for 21 years, off and on, and although Respondent decreased Patient 4's medication, Patient 4 remained on 420 MME/day at the time of the review. Respondent chronically prescribed benzodiazepines and while he noted Patient 4's side effects from SSRI medications used for anxiety, he failed to refer Patient 4 to a psychiatrist for treatment of his panic attacks. Respondent also failed to refer Patient 4 to a spine specialist. Respondent used Methadone to treat Patient 4's chronic pain but failed to obtain a 12 lead EKG to assess the risk of

prolonged QTc. Respondent continued to prescribe daily Klonopin even though Patient 4's urine was negative for Klonopin and Patient 4 reported was using Klonopin as a "prn" medication; and Respondent failed to address the presence of a marijuana metabolite in Patient 4's urine in multiple drug tests. Respondent did not justify why he prescribed opioids and benzodiazepines concurrently;

e. Patient 5 - Respondent rapidly escalated Patient 5's opioids over the course of seven to eight months, starting a 150 MME and escalating to greater than 800 MME/day instead of the standard of starting low and titrating slowly. Patient 5 reportedly had been doubling his medication and using his sister's Valium to achieve pain control, but Respondent failed to counsel Patient 5 about the risks and proceeded to increase Patient 5's pain medication dose. Respondent failed to check a 12 lead EKG prior to starting Methadone. Respondent documented only limited monitoring and Respondent failed to respond to a urine drug screen which showed non-prescribed illicit drug use. Respondent did not justify why he prescribed opioids and benzodiazepines concurrently;

f. Patient 6 - Respondent prescribed an exceedingly high opioid regimen to Patient 6 by combining Fentanyl and Oxycodone 30 mg, dispensing 300 tablets a month for a total of 1170 MME/day. Respondent failed to refer Patient 6 to a pain management specialist early in the treatment course because Patient 6's medical conditions and treatment needs, such as a pain pump, were highly complex. When Respondent finally did refer Patient 6 for an evaluation, Respondent failed to ensure and insist that Patient 6 follow through.

g. Patient 7- Respondent treated Patient 7 with high dose opioids, including Methadone, equivalent to 500 MME/day, in combination with a benzodiazepine, but failed to justify why the benefit outweighed the risk nor did he try safer alternatives. Respondent failed to obtain a 12 lead EKG to assess the risk of prolonged QTc;

h. Patient 8 -Respondent treated Patient 8 with high dose opioids, including Methadone, equivalent to 1500 MME/day by July 2018. Respondent failed to obtain a 12 lead EKG to assess the risk of prolonged QTc. Respondent only obtained one urine drug screen on Patient 8 during the review period, which was negative for prescribed oxycodone. Respondent failed to respond to this result;

i. Patient 9 - Respondent prescribed Oxycodone and Klonopin concomitantly to Patient 9, as well as an additional prescription for Xanax because of "multiple stressors" but failed to justify why the benefit outweighed the risk nor did he try safer alternatives, nor did he alter the regimen when Patient 9 used more Klonopin than prescribed. Respondent failed to document that Patient 9 failed a drug test and thereafter, failed to order enough random drug tests. Respondent failed to ensure that Patient 9 followed through with his referral to a Rheumatologist. Patient 9 could have benefited from disease modifying anti-rheumatic drugs which potentially could have reduced Patient 9's opioid load and failed to use non-opioids to treat her Fibromyalgia syndrome which potentially could reduce her opioid load; and

j. Patient 10 - Respondent failed to request and review Patient 10's past medical records, such as imaging studies or notes from a neurologist who diagnosed Trigeminal Neuralgia, to corroborate Patient 10's reports. Respondent started Patient 10 on an opioid regimen and quickly escalated the dose going from 30 MME/day to 500 MME/day, without any objective evidence of significant pathology, new trauma, or new pathology findings. Respondent failed to appropriately respond to drug test inconsistencies and failed to obtain frequent random drug tests based on prior insistencies, over taking prescription opioids outside of Respondent's instructions, running out of medication early and her reported history of smoking marijuana.

16. On April 17, 2019, the Board received a complaint from a pharmacist ("Pharmacist C") with Office of Controlled Substances Administration ("OCSA") of the Maryland Department of Health. Pharmacist C cited the results of OCSA inspections of pharmacies, which were identified to have multiple "red flags," such as patients under the age of 40 who travel long distances to see Respondent and opioid prescriptions being written by Respondent in high strength and large quantities and in combination with either benzodiazepine or a stimulant and complaints from two pharmacists, one of whom stating that Respondent gives patients his cell phone number in case they have problems

getting their prescriptions filled and that, when the pharmacist calls, Respondent will approve the prescription. The other pharmacist stated that young patients travel long distances between their homes, Respondent, and the pharmacy.

17. On April 26, 2019, based on the high volume of credible complaints and the serious concerns raised by the peer reviewers, the Board asked a medical expert who is board-certified in Pain Medicine and board-certified in Physical Medicine and Rehabilitation, to provide an opinion on whether Respondent is safe to treat patients with chronic pain or to be prescribing CDS.

18. On May 3, 2019, the Expert provided a report to the Board based on the Expert's review of Respondent's medical records of the ten patients. The Expert found that Respondent "has shown a proclivity for risky and possibly dangerous prescribing habits and he should not be allowed to treat pain patients using CDS's." In support of the Expert's opinion, the Expert stated:

> I found a disturbing pattern of prescribing opioids at significantly high dosage by Dr. Sprouse. One of the first patents' (sic) I reviewed was an alcoholic with liver cirrhosis being prescribed Methadone 40 mg per day along with Oxycodone 120 mg per day equating to a total of 500 MME/day.[7] There was no attempt to lower the dose despite the compromised hepatic function. He justified continuation of the high dose opioid regimen by noting the patient did not have signs or symptoms of respiratory distress. It appeared that Dr. Sprouse did not understand the significance of a compromised hepatic function as it pertain to opioid metabolism.
> ...
>
> Dr. Sprouse on many occasions concomitantly prescribed a benzodiazepine along with high dose prescription opioids.
> ...

[7] This individual is Patient 1.

> A review of the prescribing profile of the patients I reviewed indicate that Dr. Sprouse has a clear pattern of excessive opioid prescribing which is considerably higher than the current standard of care for safe opioid prescribing for chronic non-cancer pain of 90 MME/day. In addition to showing an unusual tolerance of the risk of concomitant use of Benzodiazepines with high dose prescription opioids as noted below.[8]
>
> . . .
>
> I have found that Dr. Sprouse who is an internist by training is not qualified by the spectrum of his training and evidence of his practice habits to treat pain related conditions or prescribe CDS's for patients who require chronic opioid therapy for treatment of chronic pain conditions.

CONCLUSIONS OF LAW

Based on the foregoing findings, Panel A concludes that there is a preponderance of evidence of grounds for discipline under § 14-404(a)(22) (failure to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care performed in this State) and that the Respondent's prescribing of opioids poses a serious risk to the health, safety, and welfare of patients, authorizing Panel A to issue, under Health Occ. § 14-206(e)(2), this Cease and Desist Order, which requires Respondent to cease and desist the prescribing and dispensing of all opioids and prohibiting the Respondent from delegating to a physician assistant the prescribing or dispensing of opioids.

ORDER

Based on the foregoing findings of fact and Conclusions of Law, and pursuant to § 14-206(e)(2) of the Health Occupations Article, it is, by Board Disciplinary Panel A,

[8] The expert specified nine of the ten patients that he reviewed who received over 180 MME per day of opioids, and five of whom received greater than 500 MME/day of opioids. In addition, four of the nine patients received a benzodiazepine in conjunction with high doses of opioids.

hereby

ORDERED that Respondent shall **CEASE and DESIST** from prescribing or dispensing opioids in the State of Maryland; and it is further

ORDERED that Respondent shall not delegate to any physician assistant the prescribing or dispensing of opioids; and it is further

ORDERED that this order is **EFFECTIVE IMMEDIATELY**, and it is further

ORDERED that this is an Order of Panel A, and, as such, is a **PUBLIC DOCUMENT.** See Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b) (2) and Md. Code Ann., Gen. Prov. § 4-333(b)(6).

Signature on File

08/12/2019
Date

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

NOTICE OF OPPORTUNITY FOR A HEARING

Respondent has the right to contest this order through a hearing. To obtain a hearing, Respondent shall file, within **30 days** of the date of this order, a written request for a hearing and a written opposition to the order. The written opposition shall state the Respondent's legal and factual grounds for opposing the order. The request for hearing and opposition shall be filed with: Christine A. Farrelly, Executive Director, Maryland State Board of Physicians, 4201 Patterson Avenue, 4th Floor, Baltimore, Maryland 21215, with copies mailed to Janet Klein Brown, Assistant Attorney General, Health Occupations Prosecution and Litigation Division, Office of the Attorney General, 300

West Preston Street, Suite 201, Baltimore, Maryland 21201. If the Respondent fails to timely file a request for a hearing, the Respondent waives his right to contest the order to cease and desist.