IN THE MATTER OF	*	**BEFORE THE**
Peter Chiang, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D43472	*	**Case Number: 2218-0001A**

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CONSENT ORDER

On July 19, 2018, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged Peter Chiang, M.D. (the "Respondent"), License Number D43472, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-401 *et seq.* (2014 Repl. Vol. & 2017 Supp.).

The pertinent provisions of the Act under Health Occ. § 14-404 provide:

> (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[.]

CDC[1] GUIDELINES

The pertinent provisions of the CDC guidelines provide:

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

...

5. When opioids are started, clinicians should prescribe the lowest effective dosage.

6. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should

[1] Centers for Disease Control and Prevention ("CDC").

optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

On December 5, 2018, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

Panel A finds:

I. BACKGROUND

1. At all times relevant to these charges, the Respondent was a physician licensed to practice medicine in the State of Maryland. He was initially licensed in Maryland on July 2, 1992, and is presently licensed through September 30, 2018.

2. The Respondent is not board-certified in any specialty. The Respondent is an approved buprenorphine prescriber for substance abuse.

3. The Respondent was working as a *locum tenens* physician for pain management at a Health and Wellness center ("Facility A"),[2] located in Clinton, Maryland, from June 14, 2015 through August 16, 2017, when he resigned. At all times relevant to these charges, the Respondent was a general practitioner at a Medical Center ("Facility B"), located in Baltimore, Maryland.

4. On or about July 5, 2017, the Board received a report from the Maryland Office of the Inspector General ("OIG") noting unusual prescribing practices by the Respondent. OIG's pharmacy investigator ("OIG Investigator") noticed the Respondent was prescribing high amounts of oxycodone to at least two patients who had a history of past substance abuse or past criminal charges of controlled dangerous substance ("CDS") possession, distribution, and forgery. The OIG Investigator's report included a spreadsheet of patient prescriptions, including the prescriptions the Respondent had written and which pharmacy had filled them.

5. On receipt of the complaint, the Board initiated an investigation which included subpoenaing ten patient medical records from the prescription drug monitoring program ("PDMP") report the OIG Investigator had provided to the Board.

6. On August 22, 2017, the Board notified the Respondent of the complaint filed and requested a written response.

7. The Respondent provided the medical records and a summary of care for each of the ten patients requested.

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[2] To ensure confidentiality, the names of individuals, patients, and institutions involved in this case are not disclosed in this document. The Respondent may obtain the identity of all individuals, patients, and institutions referenced in this document by contacting the administrative prosecutor.

8. On January 16, 2018, Board staff transmitted the ten patient records, summaries of care, and relevant investigative documents to two peer reviewers board-certified in pain medicine for the purpose of conducting a peer review.

9. On or about May 7, 2018, the Board received the peer review report regarding the Respondent's care and treatment of Patients 1-10. The results of the peer review are set forth below.

10. On or about May 7, 2018, the Board sent the peer review reports to the Respondent.

11. On May 22, 2018, the Respondent submitted a supplemental response to the Board regarding the peer reviews.

INTERVIEW OF RESPONDENT

12. On December 12, 2017, Board staff interviewed the Respondent under oath.

13. During the interview, the Respondent said that he was the only provider at Facility A and saw approximately 30 patients every Saturday, all for chronic pain management. He also stated, however, that he spent about 30 minutes with each patient and worked for 6 hours between 9:00 am and 3:00 pm.

14. When asked details about his time seeing patients at Facility A, the Respondent said, "I don't keep numbers." He also stated that during an exam he routinely took a complete history and reviewed patient records to evaluate prior treatment. The Respondent further stated that he conducted urine drug screening to ensure patient compliance. The Respondent acknowledged that he resigned from Facility A as a result of

receiving a notice of investigation from the Board. He stated he no longer treats patients for pain management.

II. PATIENT-RELATED FINDINGS

STANDARD OF CARE VIOLATIONS

15. The peer reviewers concurred that the Respondent did not meet the standard of quality medical care in all ten patient records reviewed for reasons in whole or in part as follows:

- The Respondent failed to adequately assess the patients for the purpose of commencing opioid treatment because in whole or in part he failed to elicit a comprehensive history, failed to conduct an adequate physical examination, and failed to obtain prior medical records (Patients 1-10);[3]
- The Respondent made non-specific referrals for alternative treatment such as neurosurgery and physical therapy, but failed to provide a specific physician or practice and did not document whether the patient complied with his referral recommendation (Patients 1-10);
- The Respondent failed to discuss or apply the CDC standard of prescribing less than 90 MME/day (Patients 1-10);
- The Respondent consistently failed to check patients' past and ongoing medication history with the PDMP (Patients 1-10);
- The Respondent failed to provide adequate re-assessments to determine whether there was a necessity to continue opioid therapy (Patients 1-10);
- The Respondent consistently maintained the patient on high doses of highly addictive opioids which placed the patient at a higher risk for adverse events of fatal or non-fatal overdoses, and an increased risk for opioid dependence (Patients 4, 5, 6, 8, 9 and 10);

[3] The Respondent obtained prior hospital records for Patient 5 but failed to reference the visits in his notes to confirm he had reviewed the records.

- The Respondent prescribed high dose opioids when alternative forms of treatment would have been more appropriate (Patients 2, 3, 7, 8, 9 and 10);

- The Respondent did not adequately address the patient's positive urine tests for illicit drugs or urine drug screening that was negative for prescribed opioids (Patients 1, 2, 3, 5, 9 and 10);

- The Respondent ignored red flags that would raise concern for diversion (Patients 3 and 9);

- The Respondent failed to initiate a patient on the lowest effective dose of oxycodone (Patient 2);

- The Respondent failed to prescribe naloxone[4] for prevention of suspected opioid overdose (Patient 2);

- The Respondent escalated the opioid dose without any documented rationale (Patient 3); and

- The Respondent failed to discuss with the patient the risk of taking benzodiazepines concomitantly with high dose opioids (Patients 5 and 10).

16. The Respondent's care as outlined above in whole or in part is evidence of the Respondent's failure to meet the standard of quality medical care in violation of Health Occ. § 14-404(a)(22).

INADEQUATE MEDICAL RECORDKEEPING

17. The peer reviewers concurred that the Respondent failed to maintain adequate medical records in all ten patient records reviewed for reasons in whole or in part as follows:

- The Respondent's documentation consisted primarily of a check-off system of prepopulated items. He routinely inadequately documented treatment plans and responses to treatment (Patients 1-10);

[4] Naloxone is a prescription medication that reverses the effects of an opioid overdose

- The Respondent's notes lacked details, were repetitive, and often illegible (Patients 1-10). For example, most notes document the same assessment and treatment: "exercise" or "diet and exercise";

- The Respondent routinely repeated the same examination findings for the neurological, extremities and back as "within normal limits" ("wnl") (Patients 1, 2, 3, 4, 5 and 6);

- The Respondent failed to adequately document follow-up notes (Patients 1, 2, 3, 5, 9 and 10). For example, the Respondent did not document treatment plans, specific responses to treatment;

- The Respondent failed to document that he adequately addressed with the patient inconsistent urine drug screens (Patients 1, 2, 3, 5, 9 and 10); and

- There was a continued discrepancy between the patient's recorded pain score and the pain score documented by the Respondent (Patients 1 and 5).

18. The Respondent's actions and inactions as outlined in pertinent part above in whole or in part is evidence of deficiencies in the Respondent's record keeping in violation of Health Occ. § 14-404(a)(40).

II. CONCLUSIONS OF LAW

Based on the Findings of Fact, Panel A concludes as a matter of law that the Respondent's actions as outlined in pertinent part above constitute a failure to meet appropriate standards as determined by appropriate peer review for the delivery of medical care in violation of Health Occ. § 14-404(a) (22); and failure to keep adequate medical records as determined by appropriate peer review in violation of Health Occ. § 14-404(a)(40).

III. ORDER

It is thus by Panel A, hereby:

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

ORDERED that except for buprenorphine prescribed for addiction, the Respondent is permanently prohibited from prescribing and dispensing all other Controlled Dangerous Substances (CDS); and it is further

ORDERED:

(a) 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 CDS (or the specified subcategory of CDS) in the past year;

(b) 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 the Respondent is placed on **PROBATION**[5] for a minimum period of **TWO (2) YEARS** to begin upon the effective date of this Consent Order, subject to the following probationary terms and conditions:

1. Within **SIX (6) MONTHS** of this Consent Order, the Respondent shall successfully complete an intensive Board disciplinary panel-approved course in medical documentation. The panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license

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

renewal. The Respondent shall provide documentation to the Board that the Respondent has successfully completed the course. The Respondent is responsible for the cost of the course;

2. The Panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program ("PDMP") on a quarterly basis for the Respondent's CDS prescriptions. The administrative subpoenas will request a review of the Respondent's CDS prescriptions from the beginning of each quarter;

3. Within five business days of the date of this Consent Order, the Respondent shall inform the Board in writing of his or her current employer or employers, the employer's or employers' address or addresses, and of all locations including hospitals at which the Respondent provides health care services. The Respondent shall keep the Board informed of any subsequent employment changes within five business days of the change;

4. The Respondent shall, within five business days of the effective date of this Order provide a copy of this Consent Order to the office of Controlled Substance Administration, the federal Drug Enforcement Administration, and provide documentary proof to the Board of the submission of these notices; and it is further

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

ORDERED after the Respondent has complied with all terms and conditions of probation and the minimum period of probation imposed by the Consent Order has passed:

The Respondent may submit a written petition for termination of probation. After consideration of the petition, the probation may be terminated through an order of the

disciplinary panel. The Respondent may be required to appear before the disciplinary panel to discuss his or her petition for termination. The disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel if there are no pending complaints relating to the charges; and it is further

ORDERED that a violation of probation constitutes a violation of the Consent Order; 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 a 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 the Board or a Disciplinary Panel; and it is further

ORDERED that, after the appropriate hearing, if the Board or Disciplinary Panel determines that the Respondent has failed to comply with any term or condition of this Consent Order, the Board or 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 Board or Disciplinary Panel may, in 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 all laws governing the practice of medicine under the Maryland Medical Practice Act, §§ 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. *See* Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

01/04/2019
Date

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

CONSENT

I, Peter P. Chiang, M.D., assert that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

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 notice of intent to deny. I waive these rights 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 their 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.

12/24/18
Date

Signature on File

Peter P. Chiang, M.D.

STATE/ DISTRICT OF Maryland

CITY/COUNTY OF:

I HEREBY CERTIFY that on this 22 day of December, 2018, before me, a Notary Public of the State/District and County aforesaid, personally appeared Peter P. Chiang, M.D., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires:

DENNES KIM
NOTARY PUBLIC STATE OF MARYLAND
COUNTY OF MONTGOMERY
My Commission Expires Nov. 9, 2019