

IN THE MATTER OF
REGINALD BIGGS, M.D.

Respondent

License Number: D54306

*** BEFORE THE**
*** MARYLAND STATE**
*** BOARD OF PHYSICIANS**
*** Case Number: 7718-0078A**

* * * * *

CONSENT ORDER

On August 1, 2019, Disciplinary Panel A (“Panel A”) of the Maryland State Board of Physicians (the “Board”) charged **REGINALD BIGGS, M.D.** (the “Respondent”), License Number D54306, with violating the probationary conditions imposed under the Consent Order, dated January 5, 2018 (the “2018 Consent Order”) and with violating the Maryland Medical Practice Act (the “Act”), Md. Code Ann., Health Occ. (“Health Occ.”) §§ 14-101 *et seq.* (2014 Repl. Vol. & 2018 Supp.).

VIOLATION OF CONSENT ORDER

Panel A charged the Respondent with violating the following terms and conditions of the 2018 Consent Order:

Condition No. Four (4)

The Respondent shall implement the following practice changes:

- (a) The Respondent’s patient charts shall include a section for the performance of a mental status examination. The Respondent shall perform a mental status examination on each patient office visit;

- (b) The Respondent’s progress notes shall include a section for assessment of current medications and the rationale for

maintenance or adjustment of medications. The Respondent shall review medications at each patient office visit and shall document his rationale for maintenance or adjustment of medications; and

- (c) The Respondent shall perform complete psychiatric assessments annually for all patients.

Condition No. Six (6)

During the probationary period, the Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agents. An unsatisfactory chart and/or peer review will constitute a violation of probation[.]

Condition No. Seven (7)

The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. II § 14-101 – § 14-702, and all laws, statutes, and regulations governing the practice of medicine in Maryland.

VIOLATIONS OF HEALTH OCC. § 14-404

Panel A charged the Respondent with violating the following provisions of the Act under Health Occ. § 14-404:

- (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; [and/or]
 - (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On October 16, 2019 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/Disciplinary History

1. The Respondent was originally licensed to practice medicine in Maryland on January 12, 1999, under License Number D54306. The Respondent's medical license is active and current through September 30, 2020.

2. The Respondent is not board-certified in any medical specialty. The Respondent's self-designated specialty is psychiatry. The Respondent maintains a medical office at 3731 Branch Avenue, B-309, Temple Hills, Maryland 20748.

3. The Board initiated an investigation of the Respondent in 2016 after receiving a complaint from a registered nurse from an alcohol and drug treatment center who stated that a patient reported to the nurse that: the Respondent was engaging in "vast overprescribing" of multiple stimulants, benzodiazepines, Suboxone and muscle relaxants; the Respondent prescribed numerous controlled dangerous substances (“CDS”) to the patient upon his request; and the patient referred other drug users to the Respondent's clinic to obtain stimulants and benzodiazepines.

4. As part of its investigation, the Board ordered a practice review, which determined that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care.

5. After reviewing these findings, Panel A, on September 14, 2017, issued disciplinary charges against the Respondent under Case Number 2217-0001A.

6. The Respondent resolved Panel A's charges by entering into the Consent Order, dated January 5, 2018, in which Panel A found as a matter of law that the Respondent failed 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, in violation of Health Occ. § 14-404(a)(22).

7. Pursuant to the Consent Order, Panel A reprimanded the Respondent and placed him on probation for a minimum period of one year, subject to a series of probationary conditions, including the following:

Condition No. Four (4)

The Respondent shall implement the following practice changes:

- (a) The Respondent's patient charts shall include a section for the performance of a mental status examination. The Respondent shall perform a mental status examination on each patient office visit;
- (b) The Respondent's progress notes shall include a section for assessment of current medications and the rationale for maintenance or adjustment of medications. The Respondent shall review medications at each patient office visit and shall document his rationale for maintenance or adjustment of medications; and

- (c) The Respondent shall perform complete psychiatric assessments annually for all patients.

Condition No. Six (6)

During the probationary period, the Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agents. An unsatisfactory chart and/or peer review will constitute a violation of probation[.]

Condition No. Seven (7)

The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. II § 14-101 – § 14-702, and all laws and regulations governing the practice of medicine in Maryland.

8. Prior to the signing of this Consent Order, the Respondent remained on probation with the Board.

II. Current Findings

9. Pursuant to Condition No. Six (6) of the Consent Order, the Board obtained ten patient records and supporting materials from the Respondent and ordered a practice review. The practice review was performed by two physicians who are board-certified in psychiatry and neurology. The reviewers evaluated the treatment the Respondent provided to patients after May 6, 2018.

10. The peer reviewers submitted their findings in or around May 2019. The peer reviewers jointly concluded that in eight of the ten cases reviewed ("Patients 2-6 and 8-10"),¹ the Respondent failed to meet appropriate standards for the delivery of quality

medical care; and that in nine of the ten cases reviewed (“Patients 1-6 and 8-10), the Respondent failed to keep adequate medical records.

11. Examples of these deficiencies are set forth in the following patient summaries.

Patient 1

12. Patient 1 is an 18-year-old male patient who has been in treatment with the Respondent since 2016 (when the patient was 16 years old). Patient 1 was previously in treatment with another psychiatrist for attention deficit hyperactivity disorder (“ADHD”). The Respondent diagnosed Patient 1 with ADHD and Adjustment Disorder with anxiety. The Respondent maintained Patient 1 on various ADHD medications including Vyvanse and Ritalin. The Respondent saw Patient 1 on nine occasions between May 6, 2018 and February 2019.

13. The Respondent failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to Patient 1, for reasons including:

- (a) The Respondent failed to document that he performed a complete psychiatric assessment annually;
- (b) the Respondent’s mental status examination (“MSE”) is too brief and fails to document an adequate assessment of safety including suicidal and homicidal ideation;

1 For confidentiality purposes, the names of patients have not been identified in this document. The Respondent is aware of the identity of all patients referenced herein.

- (c) the Respondent's progress notes contain inadequate documentation regarding his formulation of his ADHD diagnosis;
- (d) the Respondent failed to document adequate information about possible alcohol or substance abuse, given Patient 1's endorsement of marijuana on self-questionnaire and family history of substance abuse;
- (e) the Respondent's treatment records fail to contain documentation of rating scales/collateral history from teachers, given that Patient 1 was in a specialized school during part of his treatment; and
- (f) the Respondent failed to document Patient 1's other non-psychiatric medications, if any, to ensure no adverse drug interactions.

Patient 2

14. Patient 2 is a 36-year-old male patient who has been in treatment with the Respondent since 2013. The Respondent documented an updated psychiatric assessment in November 2018 where he noted that Patient 2 had a long history of mood disorder, predominately depression but with a history of mood swings when younger; anxiety with panic attacks; and ADHD. The Respondent provided medication management that included selective serotonin reuptake inhibitors ("SSRIs"); stimulants; and benzodiazepines. The Respondent saw Patient 2 on six occasions between May 6, 2018 and February 2019.

15. 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), with respect to Patient 2, for reasons including:

- (a) the Respondent failed to appropriately document or assess Patient 2 for suicide risk in his treatment notes;
- (b) the Respondent failed to appropriately document or establish his diagnosis of Bipolar II Disorder;
- (c) the Respondent failed to appropriately document or establish his diagnosis of Panic Disorder;
- (d) the Respondent failed to appropriately document or establish his diagnosis of ADHD;
- (e) the Respondent failed to prescribe a mood stabilizer or atypical antipsychotic;
- (f) the Respondent prescribed high dosages of benzodiazepines (alprazolam 2 mg, three times per day, as needed), without appropriate documentation or assessment;
- (g) the Respondent failed to address positive toxicology findings for methadone, a drug the Respondent was not prescribing;
- (h) the Respondent failed to alter or consider alteration of use of alprazolam in view of Patient 2's positive toxicology findings for opioids;
- (i) the Respondent failed to document or perform a substance abuse evaluation in view of positive toxicology findings; and
- (j) the Respondent failed to maintain a medication log.

Patient 3

16. Patient 3 is a 63-year-old female patient who has been in treatment with the Respondent since 2012. The Respondent had diagnosed Patient 3 with major depression and post traumatic stress disorder (“PTSD”). The Respondent recorded an updated psychiatric assessment in November 2018. The Respondent changed Patient 3’s diagnoses to Bipolar II Disorder, PTSD, ADHD and anxiety disorder. The Respondent prescribed three CDS (Vyvanse, alprazolam, zolpidem) and several prescription-only medications, including fluoxetine, bupropion, naltrexone and aripiprazole. The Respondent saw Patient 3 on six occasions between May 6, 2018 and February 2019. During the course of treatment, the Respondent ordered toxicology screenings for Patient 3 that were positive for cocaine on multiple occasions during 2018-2019.

17. 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), with respect to Patient 3, for reasons including:

- (a) the Respondent failed to appropriately document or establish his diagnosis of ADHD;
- (b) the Respondent failed to appropriately document or establish his diagnosis of PTSD;
- (c) the Respondent failed to appropriately document or assess Patient 3 for suicide risk in his ongoing medication management notes;

- (d) the Respondent documented progress notes that referenced treatment of another family member;
- (e) the Respondent failed to appropriately address Patient 3's positive toxicology screenings for cocaine;
- (f) the Respondent failed to document or consider alteration in treatment with respect to prescribing CDS (Vyvanse, alprazolam, zolpidem) in view of Patient 3's multiple positive toxicology screening findings for illicit CDS;
- (g) the Respondent inappropriately prescribed alprazolam on an as needed basis; and
- (h) the Respondent failed to appropriately address Patient 3's complaints of insomnia.

Patient 4

18. Patient 4 is a 37-year-old male patient who has been in treatment with the Respondent since September 2016. The Respondent originally diagnosed Patient 4 with Major Depressive Disorder ("MDD") (moderate severity, single episode); Panic Disorder (without agoraphobia); and ADHD (predominately inattention). At that time, the Respondent restarted Patient 4 on Wellbutrin, which the patient reported was effective in the past, along with Klonopin 2 mg, twice per day ("BID"); and Vyvanse 60 mg, every morning. Patient 4 continued to see the Respondent until February 2017, when he left treatment for about one year. Patient 4 returned for treatment in February 2018.

19. When Patient 4 did return for treatment, the Respondent did not document a new history but continued to record with a progress note. The Respondent did not take a

new history or record an MSE on this occasion. The Respondent saw Patient 4 on eight occasions between May 6, 2018 and January 2019. All of the Respondent's post-May 2018 progress notes contain brief MSEs but none specifically contain a suicide risk assessment. The Respondent noted that Patient 4 had pain complaints and was apparently under the care of a primary care physician for these complaints. The Respondent ordered a series of toxicology screenings that were at times negative for amphetamine and uniformly positive for alprazolam, both of which the Respondent was prescribing. Patient 4's toxicology screens were also positive for various opioids, buprenorphine and/or tramadol. The Respondent also prescribed omeprazole for "stomach upset."

20. 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), with respect to Patient 4, for reasons including:

- (a) the Respondent failed to document or take a full history or MSE upon Patient 4's return to treatment;
- (b) the Respondent failed to appropriately document or assess Patient 4 for suicide risk;
- (c) the Respondent failed to appropriately address Patient 4's inconsistent toxicology screens;
- (d) the Respondent failed to address his prescribing of CDS (*e.g.*, Vyvanse) in view of Patient 4's inconsistent toxicology screen results, or alter his treatment in response to these findings;

- (e) the Respondent inappropriately prescribed alprazolam (which he prescribed on an as-needed basis) in view of Patient 4's positive toxicology findings;
- (f) the Respondent failed to coordinate his care with Patient 4's primary care physician, who was apparently prescribing CDS;
- (g) the Respondent inappropriately prescribed omeprazole for Patient 4;
- (h) the Respondent failed to order pre-treatment or concurrent laboratory testing when prescribing divalproex (Depakote); and
- (i) the Respondent failed to document or engage in patient education with Patient 4 regarding the risks associated with combinations of benzodiazepines and opioids.

Patient 5

21. Patient 5 is a 33-year-old female patient who has been in treatment with the Respondent since February 2015, at which time he diagnosed her with Bipolar II Disorder; ADHD (predominately inattention); and Anxiety Disorder NOS (not otherwise specified). The Respondent placed Patient 5 on Vyvanse 70 mg, every morning, with Adderall 20 mg, every evening for ADHD; Wellbutrin SR 200 mg, BID, for depression; Lamictal 100 mg daily, for mood stabilization; Xanax 0.5 mg, two times daily, as needed; and Ambien 10 mg at bedtime, as needed.

22. The Respondent saw Patient 5 on several occasions between May 2018 and November 2018, when he documented an updated psychiatric assessment. In that assessment, the Respondent noted that in March 2018, Patient 5 attempted suicide by overdosing on alprazolam and zolpidem but did not report the incident to him until July

2018. Despite this disclosure, the Respondent continued to prescribe these medications on an as needed basis.

23. In 2018, the Respondent also maintained Patient 5 on Vyvanse, Wellbutrin SR and Lamictal. In addition, the Respondent treated Patient 5 with psychotherapeutic concepts and encouraged Patient 5 to further explore issues with her therapist. In October 2018, the Respondent reported that Patient 5's mood was better and that she was on about ten medications for her asthma. In April 2018, the Respondent ordered a toxicology screen that was positive for cocaine and negative for amphetamine.

24. 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), with respect to Patient 5, for reasons including:

- (a) the Respondent failed to appropriately document or assess Patient 5 for suicide risk;
- (b) the Respondent failed to recognize or consider a diagnosis of personality disorder;
- (c) the Respondent failed to appropriately address a toxicology screen that was positive for cocaine;
- (d) the Respondent inappropriately prescribed "as needed" prescriptions for alprazolam and zolpidem, without determining Patient 5's actual use of these medications, and despite her prior attempted suicide through using these medications;

- (e) the Respondent failed to document or discuss with Patient 5 the potential risks of the various medications he was prescribing or obtain her informed consent for their use;
- (f) the Respondent failed to document or assess Patient 5's alcohol or drug use in view of her positive toxicology screen result for an illicit CDS;
- (g) the Respondent failed to appropriately substantiate his diagnosis of ADHD;
- (h) the Respondent continued to prescribe Vyvanse in view of Patient 5's positive toxicology screen for illicit CDS or consider alteration in treatment in response to that finding;
- (i) the Respondent failed to document or inquire into Patient 5's self-reported use of multiple asthma medications to ensure no adverse drug interactions;
- (j) the Respondent failed to document any counseling of Patient 5 regarding the use of benzodiazepines with asthma medications;
- (k) the Respondent failed to explore other diagnoses to Bipolar II Disorder in view of Patient 5's psychiatric and behavioral history;
- (l) the Respondent failed to document or consider use of an SSRI in view of Patient 5's substance abuse history; and
- (m) the Respondent failed to appropriately assess and attempt alternative treatments for Patient 5's self-report of insomnia, other than prescribing a sedative-hypnotic.

Patient 6

25. Patient 6 is a 44-year-old female patient who initially saw the Respondent from 2009 but then discontinued treatment in 2011. Patient 6 returned for treatment in August 2017. Patient 6 had a history of back pain and in the past, had been on various psychiatric medications. The Respondent diagnosed Patient 6 with MDD, Anxiety Disorder and ADHD.

26. When Patient 6 returned for treatment in 2017, the Respondent gave her the same diagnoses as in 2009. At this time, Patient 6's anxiety was significantly better but her depression was much worse. The Respondent placed Patient 6 on Mydayis for ADHD; Trintellix; and Halcion at bedtime. At this time, the Respondent assessed Patient 6 for suicide risk, but did not do so in subsequent treatment notes.

27. After reinitiating treatment, the Respondent altered Patient 6's pharmacologic regimen. As of May 2018, the Respondent was prescribing Adderall XR 30 gm, daily; Trintellix 20 mg, daily; Ambien CR 12.5 mg, at bedtime as needed; Phentermine 37.5 mg, daily as needed for weight gain; Xanax 1 mg, three times per day, as needed; and Abilify 5 mg, daily. The Respondent completed an updated psychiatric assessment in August 2018.

28. In October 2018, the Respondent increased Patient 6's Adderall XR to 40 gm and changed her Ambien to Lunesta due to the Ambien losing its efficacy. In December 2018, the Respondent noted that Patient 6 was generally doing better, and in January 2019, the Respondent made no changes to her medication regimen and noted that Patient 6's mood was generally good.

29. 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), with respect to Patient 6, for reasons including:

- (a) the Respondent failed to appropriately document or assess Patient 6 for suicide risk in notes subsequent to his 2017 initial assessment;
- (b) the Respondent failed to appropriately document or establish his diagnosis of adult ADHD, or that he considered other diagnoses;
- (c) the Respondent inappropriately prescribed Phentermine without performing periodic weight measurements, other bariatric surveillance or obtaining appropriate informed consent;
- (d) the Respondent failed to order laboratory studies or monitor for neurologic or metabolic changes when prescribing antipsychotic medications;
- (e) the Respondent inappropriately increased Patient 6's ADHD medications prior to exploring other causes for Patient 6's change in symptoms;
- (f) the Respondent failed to appropriately document or explore Patient 6's self-endorsement of marijuana and how it may have affected Patient 6's mental health issues;
- (g) the Respondent failed to appropriately document or assess Patient 6 for alcohol or substance use in view of Patient 6's self-endorsement of marijuana use; and

- (h) the Respondent inadequately managed his prescribing of alprazolam, which he prescribed on an “as needed” basis. The Respondent did not record Patient 6’s actual use of the medication.

Patient 8

30. Patient 8 is a 34-year-old female patient who has been in treatment with the Respondent since 2014. Patient 8 developed PTSD after a serious automobile accident in which she was reportedly unconscious for “a couple of days.” The Respondent diagnosed Patient 8 with PTSD; MDD; Panic Disorder; and ADHD (predominately inattention). Patient 8 experienced further emotional distress after a series of individuals who were close to her died. The Respondent initially treated Patient 8 with Zoloft but then switched her to Brintellix (now called Trintellix). The Respondent also treated Patient 8 for panic attacks with alprazolam.

31. On a visit dated June 20, 2018, the Respondent prescribed the following medications: Adderall 30 mg, BID; Brintellix 20 mg, daily; Ambien 10 mg, at bedtime as needed; alprazolam 2 mg, three times per day, as needed; and Provigil 100 mg, daily. In a note dated August 15, 2018, the Respondent noted that Patient 8 was taking chemotherapy medication for an abdominal mass but did not note which medications she was taking. The Respondent maintained Patient 8 on the same medication regimen through his last recorded note of January 30, 2019.

32. 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), with respect to Patient 8, for reasons including:

- (a) the Respondent failed to appropriately document or assess Patient 8 for suicide risk;
- (b) the Respondent failed to appropriately establish his diagnosis of ADHD;
- (c) the Respondent inappropriately maintained Patient 8 on alprazolam, particularly in view of Patient 8's self-report of BID Vicodin use;
- (d) the Respondent failed to provide appropriate justification for his prescribing of zolpidem;
- (e) the Respondent failed to order psychotherapy to address Patient 8's anxiety;
- (f) the Respondent failed to document or consider the impact his prescribing regimen was having on Patient 8's sleep impairment;
- (g) the Respondent failed to document or obtain appropriate informed consent regarding the medications he was prescribing;
- (h) the Respondent failed to monitor the frequency of actual usage of CDS medications he was prescribing (*e.g.*, alprazolam and zolpidem, both of which were prescribed on an "as needed" basis); and
- (i) the Respondent failed to document an updated psychiatric assessment since 2014.

Patient 9

33. Patient 9 is a 28-year-old female patient who has been in treatment with the Respondent since 2015. Patient 9 reportedly saw another psychiatrist for two years prior

to seeking treatment from the Respondent. Patient 9 reported that she was previously treated with medications for ADHD since elementary school. Patient 9 also reported depressive symptoms and panic attacks. The Respondent diagnosed Patient 9 with ADHD; MDD; and Panic Disorder. The Respondent's treatment notes do not contain prior treatment records from other providers.

34. The Respondent placed Patient 9 on a trial of Mydayis but it seriously increased her anxiety. On May 10, 2018, the Respondent placed Patient 9 back on Adderall. In the past, the Respondent had switched Patient 9 from Ambien 10 mg to Klonopin 2 mg, at bedtime, as needed.

35. As of May 10, 2018, the Respondent's medication regimen for Patient 9 consisted of: Adderall 30 mg, BID; Xanax 2 mg, BID, as needed; Paxil 10 mg, daily; and Klonopin 2 mg, at bedtime, as needed.

36. Patient 9 reported that she was off her medications for a month in October 2018, at which point the Respondent restarted her medications. The Respondent saw Patient 9 on four occasions between May 6, 2018 and January 2019.

37. During the course of treatment after May 6, 2018, the Respondent ordered a toxicology screening that was positive for amphetamine, which he was prescribing, and negative for benzodiazepine, which he was also prescribing. Prior toxicology screening also noted this inconsistency as well as a positive finding for marijuana. The Respondent did not appropriately address these inconsistencies in his treatment notes, or alter his prescribing regimen for alprazolam, which he prescribed on an "as needed" basis.

38. 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), with respect to Patient 9, for reasons including:

- (a) the Respondent failed to appropriately establish his diagnosis of ADHD;
- (b) the Respondent failed to document or address whether Patient 9's concentration difficulties were due to ADHD versus anxiety and/or depression;
- (c) the Respondent failed to document, investigate or address Patient 9's negative toxicology results with respect to alprazolam, or alter or consider altering Patient 9's treatment due to this finding;
- (d) the Respondent did not attempt to increase Patient 9's SSRI and reduce her benzodiazepine;
- (e) the Respondent prescribed an inappropriate initial dosage of Klonopin when treating Patient 9's sleep disturbances;
- (f) the Respondent did not attempt behavioral treatments for Patient 9's sleep disturbances; and
- (g) the Respondent failed to document on a periodic basis or assess Patient 9 for suicide risk.

Patient 10

39. Patient 10 is a 52-year-old female patient who has been in treatment with the Respondent since 2010. In a summary of care, the Respondent stated that Patient 10

was “very challenging,” and as having undergone numerous medication trials. Patient 10 reportedly demonstrated significant irritability even in the Respondent’s office, such that office staff scheduled her either at the end or beginning of the day. The Respondent diagnosed Patient 10 with Bipolar II Disorder and ADHD.

40. The Respondent completed two psychiatric assessments of Patient 10, in 2010 on intake, and one in 2012. Throughout his treatment of Patient 10, the Respondent made numerous changes to her medication regimen, such as discontinuation of modafinil and the addition of phentermine on August 14, 2018.

41. As of May 9, 2018, the Respondent had Patient 10 on the following medications: Cymbalta 120 mg, daily; Abilify 15 mg, daily; Adderall XR 60 mg, every morning; Mydayis 50 mg, every morning; Wellbutrin XL 300 mg, daily; Topamax 25 mg, BID; Ambien 10 mg, at bedtime, as needed; Phentermine 37.5 mg, daily; Latuda 60 mg, at bedtime; Cyproheptadine 4 mg, daily, as needed. The Respondent streamlined Patient 10’s medication regimen on August 4, 2018, as follows: Cymbalta 120 mg, daily; Abilify 15 mg, daily; Adderall XR 60 mg, every morning; Mydayis 50 mg, every morning; Ambien 10 mg, at bedtime; and Cyproheptadine 4 mg, daily, as needed.

42. The Respondent’s chart for Patient 10 contains extensive notes from Patient 10’s primary care provider. The primary care provider noted in a progress note dated July 24, 2018, that Patient 10 was taking two caffeine pills BID, which the primary care physician recommended Patient 10 discontinue taking. The Respondent did not address this in his treatment notes, despite prescribing high doses of stimulants (Mydayis 50 mg, Adderall XR 60 mg) and a sleep medication.

43. The Respondent also has a note from a cardiologist from May 11, 2018, where the cardiologist discontinued Patient 10's Adderall XR 30 mg BID. The Respondent's notes stated that Patient 10 was continuing to take both Adderall and Mydayis after this visit, however. Although the Respondent discussed Patient 10's use of stimulants, he did not follow the cardiologist's recommendation.

44. 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), with respect to Patient 10, for reasons including:

- (a) the Respondent failed to document or consider a diagnosis of personality disorder;
- (b) the Respondent maintained Patient 10 on an excessive dosage of Cymbalta, with no further benefit warranting its continuation at this dosage;
- (c) the Respondent continued Patient 10 on redundant stimulants after Patient 10's cardiologist discontinued her Adderall;
- (d) the Respondent did not document or address Patient 10's use of caffeine pills;
- (e) the Respondent maintained Patient 10 on excessive doses of stimulants after Patient 10 reported palpitations to her cardiologist, who recommended discontinuation of Adderall;
- (f) the Respondent did not document or undertake metabolic monitoring when prescribing an antipsychotic (Abilify); and

- (g) the Respondent failed to document or undertake a periodic assessment of suicide risk.

Supplemental response

45. The Respondent submitted a written supplemental response to the Board, dated May 24, 2019, in which he addressed the peer reviewers' findings. The Respondent stated that he was "dismayed by [his] performance," but was "determined to have a practice that is commensurate with the Board's expectations." The Respondent acknowledged some of the deficiencies the reviewers noted, such as: his failure to obtain laboratory testing for some of the psychotropic medications that he routinely prescribes, and his failure to undertake other forms of monitoring when prescribing these medications; the lack of comprehensiveness of his MSEs; and his failure to specifically note a suicide assessment in his treatment notes. The Respondent acknowledged that it would be beneficial for him to consult with a supervisor to address these deficiencies. The Respondent stated, "I need to gain greater familiarity with treatment guidelines for the various disorders I treat."

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent's actions constitute a violation of the following provisions of the Act under Health Occ. § 14-404(a): (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; and (40) Fails to keep adequate medical records as determined by appropriate peer

review. Additionally, the Respondent's actions constitute a violation of Conditions Nos. Four (4), Six (6) and Seven (7) of the Consent Order, dated January 5, 2018.

ORDER

It is thus by Disciplinary Panel A of the Board, hereby:

ORDERED that the **REPRIMAND**, imposed by the January 5, 2018 Consent Order remains in effect; and it is further

ORDERED that the Probation and probationary terms and conditions of the January 5, 2018 Consent Order are **TERMINATED**; and it is further

ORDERED that Respondent's license to practice medicine in Maryland is **SUSPENDED**. The suspension goes into effect 60 days from the date of execution of this Order, to give Respondent time to transition his patients to other providers;² and it is further

ORDERED that during the period of suspension, Respondent shall establish and implement a procedure by which Respondent's patients may obtain their medical records without undue burden and notify all patients of that procedure; and it is further

² If Respondent's license expires during the period of suspension, and Respondent fails to renew his license:

- (i) the failure to renew the license does not remove the suspension from the Respondent's disciplinary record during the period of non-renewal;
- (ii) the time of suspension will be tolled until Respondent's license to practice medicine in this state is reinstated or until Respondent again possesses a license;
- (iii) the condition precedent to terminating a suspension is tolled until Respondent's license to practice medicine in this State is reinstated or Respondent again possesses a license.

ORDERED that during the period of suspension, Respondent shall not:

- (1) practice medicine;
- (2) take any actions after the effective date of this Order to hold himself out to the public as a current provider of medical services;
- (3) authorize, allow or condone the use of Respondent's name or provider number by any health care practice or any other licensee or health care provider;
- (4) function as a peer reviewer for the Board or for any hospital or other medical care facility in the state;
- (5) dispense medications; or
- (6) perform any other act that requires an active medical license; and it is further

ORDERED that during the period of suspension Respondent shall enroll in and undergo and complete a comprehensive evaluation by the Clinical Competence Assessment Program administered by the Center for Personalized Education for Professionals ("CPEP"); and it is further

ORDERED that Respondent shall fully and timely cooperate and comply with the assessment process established by CPEP, and shall fully participate and comply with all evaluations and screenings as directed by CPEP; and it is further

ORDERED that Respondent shall enroll in, and fully and timely cooperate and comply with any educational intervention recommended by CPEP; and it is further

ORDERED that Respondent's failure to comply with any the assessment process established by CPEP or any educational intervention recommended by CPEP, constitutes a violation of this Consent Order; and it is further

ORDERED that following the CPEP evaluation, CPEP shall produce written reports to Panel A and Respondent detailing the results of the evaluations and its

recommendation about whether Respondent's performance was satisfactory or unsatisfactory, and whether he is clinically competent and safe to return to practice of medicine; and it is further

ORDERED that after Panel A's receipt of the written reports, Respondent may petition Panel A to terminate his suspension. Disciplinary Panel A shall consider Respondent's disciplinary history and the CPEP report and determine whether Respondent is clinically competent and safe to return to the practice of medicine. If the Panel determines that Respondent is safe to practice, the Panel may terminate his suspension and may impose any terms and conditions it deems appropriate on Respondent's return to practice, including any educational intervention recommended by CPEP, probation, a requirement to work in a structured environment that includes supervision, a peer supervisor, chart review, peer review, and any other appropriate terms and conditions; and it is further

ORDERED that if Disciplinary Panel A determines that Respondent is not safe to return to the practice of medicine based on the CPEP report, Disciplinary Panel A may decline to terminate the suspension and may further require completion of any educational intervention recommended by CPEP. Upon completion of the educational intervention, Respondent may again apply for termination of his suspension under the same conditions described above; and it is further

ORDERED that if the CPEP evaluation, at any point, indicates that Respondent is incapable of practicing medicine safely and unlikely to improve, Disciplinary Panel A

may revoke Respondent's license in accordance with the procedures required by the Administrative Procedures Act; and it is further

ORDERED that, if Respondent allegedly fails to undergo and complete a comprehensive evaluation by the Clinical Competence Assessment program administered by CPEP or fails to complete any educational intervention recommended by CPEP, 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, Respondent shall be given a show cause hearing before the Board disciplinary panel; and it is further

ORDERED that, after the appropriate hearing, if the Board disciplinary panel determines that Respondent has failed to comply with these requirements of this Order, the Board disciplinary panel may reprimand Respondent, place Respondent on probation with appropriate terms and conditions, or suspend or revoke Respondent's license to practice medicine in Maryland. The Board disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon Respondent; and it is further

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

ORDERED that this 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) (2014 & Supp. 2018).

02/11/2020
Date

Signature on File

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

CONSENT

I, Reginald Biggs, 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

2-7-2020
Date

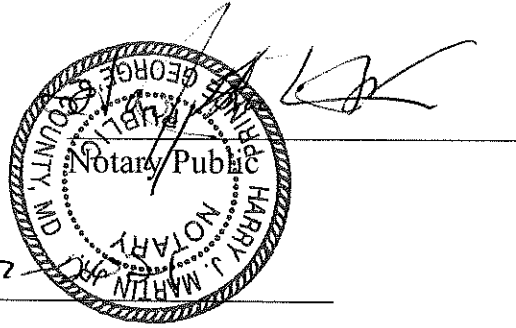
Reginald Biggs, M.D.

NOTARY

STATE OF Maryland
CITY/COUNTY OF Prince Georges

I HEREBY CERTIFY that on this 7 day of Feb ²⁰~~2019~~, before me, a Notary Public of the foregoing State and City/County, personally appeared Reginald Biggs, 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.



My Commission expires: 11-22-2021