IN THE MATTER OF	*	**BEFORE THE MARYLAND**
DANIEL B. LEVY, M.D.	*	**STATE BOARD**
RESPONDENT	*	**OF PHYSICIANS**
LICENSE NO.: D57169	*	**CASE NO.: 7716-0087 A**

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CONSENT ORDER

On January 26, 2018, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **Daniel B. Levy, M.D.** (the "Respondent"), License No. D57169, under 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 provision of Health Occ. §14-404 under which Panel A charged Respondent provides the following:

> (a) 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 licensee if the licensee:
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> (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[.]

In addition, Panel A charged Respondent with violating the following terms and conditions of the Consent Order between the Board and Respondent, dated May 23, 2016 (the "Consent Order"):

> 6. During the probationary period, 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; and
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> 7. Respondent shall comply with the Maryland Medical Practice Act, Md.

Code Ann., Health Occ. §§ 14-101- 14-702, and all laws and regulations governing the practice of medicine in Maryland[.]

On April 11, 2018, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring because of the DCCR, Respondent agreed to enter this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Panel A makes the following findings of fact:

I. License and Medical Background

1. At all times relevant hereto, Respondent was, and is, licensed to practice medicine in Maryland. Respondent was originally licensed to practice medicine in Maryland on March 2, 2001, under license number D57169. Respondent last renewed his license in or about September 2016, which will expire on September 30, 2018.

2. Respondent is board-certified in Internal Medicine, having been originally certified in 1998 and recertified in March 2009. Respondent has a sub-certification in infectious disease, having been originally sub-certified in November 2000 and re-certified in October 2010.

3. Respondent holds hospital privileges at a hospital in the greater metropolitan Baltimore area.

4. Respondent practices internal medicine in a multi-specialty group practice in Baltimore County.

II. Background of Investigation

5. On or about May 23, 2016, Respondent entered a Consent Order with the Board as a resolution of disciplinary charges of failing to meet standards of quality

medical care regarding ten out of ten of Respondent's patients. Respondent's pain management care had been peer-reviewed by two independent physicians who were board-certified in pain medicine.

6. Under the terms of the Consent Order, Respondent agreed to comply with certain terms and conditions. One of the conditions was that Respondent was subject to a subsequent peer review by an agent of the Board.

III. Board Investigation

7. On April 28, 2017, Board staff sent correspondence to Respondent, notifying him of the initiation of the peer review. The Board issued a subpoena to Respondent for a complete copy of the medical records for ten patients, who were selected by Board staff from the Maryland Prescription Drug Monitoring Program ("PDMP") printouts; and, requested that Respondent provide a summary of care for each patient listed in the subpoena.

8. On May 12, 2017, Respondent submitted to the Board the ten subpoenaed medical records and the summaries of care.

9. On May 17, 2017, the Board referred the case to an independent peer review agency, requesting independent peer review by two physicians who are board-certified in pain medicine.

10. On August 8, 2017, the Board received the peer review reports. The peer reviewers concurred that regarding nine of the ten patients reviewed, Respondent failed to meet appropriate standards for the delivery of quality medical care, after October 16, 2016.[1]

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[1] October 16, 2016 is the date of the beginning of the peer review period.

11. On August 10, 2017, the Board sent copies of the peer review reports to Respondent with the names of the reviewers redacted requesting Respondent to provide a Supplemental Response.

12. On August 28, 2017, the Board received Respondent's Supplemental Response, which was subsequently reviewed by the two peer reviewers, prior to the issuance of Charges.

IV. Summary of Findings of Failing to Meet Standards of Quality Medical Care

13. In nine of the ten of the cases reviewed, the peer reviewers concurred that Respondent failed to meet standards for prescribing opioids after October 16, 2016, in that Respondent:

a. Failed to adequately see patients for follow-up visits to assess benefit of opioids or continued need for opioid medication;

b. Failed to adequately monitor patients who are on high doses of opioids by frequent visits, random urine screenings, and pill counts;[2]

c. Discussed patients' requests for opioid medications by telephone rather than in-office face-to-face visits;

d. Allowed patients or their relatives to pick up prescriptions for opioid medication, at times very high doses, at the office, without seeing the patients for an office visit;

e. Rarely sent patients who were receiving opioids for urine drug screens; and

f. In cases where a urine drug screen revealed "red flags" for diversion, failed to discharge the patients and send the patients to a drug rehabilitation facility but continued to prescribe opioids.

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[2] Since being placed on probation, Respondent regularly monitors his patients by obtaining PDMP reports, as required by one of the conditions of probation.

V. Patient Specific Standards of Care Allegations Pertaining to Patients 1, 3, 4, 5, and 6-10.[3]

Patient 1

14. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 1, after October 16, 2016, for reasons including but not limited to that he:

a. Failed to frequently follow-up to check for compliance with prescriptions for oxycodone. For example, he saw Patient 1 on August 5, 2016 and not again until March 24, 2017, seven months later; and he wrote 16 prescriptions for Patient 1, including an increase in the dose of opioids from 180 to 200 tablets, without a documented explanation, during this timeframe, and without an office visit, contrary to his written Opioid Agreement with Patient 1;

b. Failed to obtain random urine screens;[4] and

c. Failed to confirm that Patient 1 was receiving a functional benefit from the opioid medication.

Patient 2[5]

Patient 3

15. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 3, after October 16, 2016, for reasons including but not limited to that he:

a. Failed to frequently follow-up to check for compliance with prescriptions for oxycodone. For example, he saw Patient 3 on December 2, 2016 and not again until May 15, 2017, five and one-half months later;

b. Provided Patient 3 with nine prescriptions for oxycodone 30 mg, some of

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[3] The Peer Review reports contain a synopsis of the care provided by Respondent to each patient as understood by both reviewers from a review of Respondent's medical records. Respondent has been provided a copy of the peer review reports.

[4] On August 21, 2017, after the peer review concluded, Respondent obtained a urine toxicology drug screen.

[5] There were no charges regarding Patient 2.

which were paid for with cash (a "red flag"), between February 2, 2017, and April 3, 2017, without an office visit; and

c. Continued to prescribe opioids without Patient 3 obtaining any functional benefit, and while Patient 3's health appeared to be worsening.

Patient 4

16. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 4, after October 16, 2016, for reasons including but not limited to that he:

a. Failed to closely follow-up with Patient 4, who has a history of alcohol abuse, to monitor the effects of and compliance with high doses of opioid medications;

b. Wrote refills of prescriptions for opioids without seeing Patient 4 for office visits. For example, he saw Patient 4 on November 10, 2016, and not again until April 21, 2017, over five months later;

c. Failed to follow-up on a pain management consult regarding Patient 4;

d. Failed to have an opioid agreement;

e. Failed to obtain urine drug screens; and

f. Continued to prescribe opioids in rising doses for Patient 4 despite the lack of objective benefit and in the face of Patient 4's overall health worsening.

Patient 5

17. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 5 after October 16, 2016, for reasons including but not limited to he:

a. Failed to see Patient 5 for a face-to-face encounter after January 5, 2017, although he continued to write prescriptions for high doses of opioids until April 2017, at which time he referred Patient 5 to a physiatrist for pain management;

b. Permitted Patient 5's adult son to pick up her prescriptions for high dose, highly abusable pain medications, another "red flag;" instead of seeing Patient 5 in-person,

c. Failed to properly handle Patient 5's claim that her pain medication had been stolen by her daughter. For example, wrote prescriptions for replacement medications without an office visit and without a police report;

d. Failed to refer Patient 5 for an orthopedic consult;

e. Failed to obtain random urine drug screens even though Patient 5 was at high risk for diversion; and

f. Failed document his rationale for not having a signed opioid agreement with Patient 5.

Patient 6

18. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 6, after October 16, 2016, for reasons including but not limited to that he:

a. Failed to see Patient 6 more frequently than every six months, even though he was prescribing hydrocodone and dextroamphetamine to Patient 6 on a monthly or more frequent basis;

b. Failed to refer Patient 6 for pain management;

c. Failed to obtain random urine drug screens;[6] and

d. Failed to obtain a signed opioid agreement.

Patients 7 through 10

19. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 7 through 10, after October 16, 2016, for reasons including but not limited to deficiencies similar to those described in Paragraphs 14 to 18 above. The patterns of deficiencies as described regarding Patients 1, and 3 through 6 were evident regarding Patients 7 through 10 as well.

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[6] On May 26, 2017, after Respondent sent the medical records to the Board for the peer review, Respondent ordered a urine drug screen on Patient 6.

VI. Summary of Findings

20. Respondent's failure to meet standards of quality medical care after October 16, 2016, constitutes evidence of violation of Health Occ. §14-404(a)(22).

21. Respondent's unsatisfactory peer review constitutes evidence of violation of Condition 6 of the conditions of probation as stated in the Consent Order.

22. Respondent unsatisfactory peer review regarding quality of medical care constitutes evidence of violation of Condition 7 of the conditions of probation as stated in the Consent Order.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel A of the Board concludes as a matter of law that Respondent violated Health Occ. § 14-404(a)(22)(fails to meet standards of quality medical care); and violated Conditions 6 and 7 of the Consent Order of May 23, 2016.

ORDER

It is, on the affirmative vote of a majority of the quorum of Disciplinary Panel A, hereby:

ORDERED that the probation and probationary conditions imposed by the May 23, 2016 Consent Order are **TERMINATED**; and it is further

ORDERED that Respondent is reprimanded; and it is further

ORDERED that Respondent shall cease the practice of chronic pain management. Respondent is permanently prohibited from prescribing any opioids to a patient for more than three days and only in an emergency. In emergency cases, the prescription may not exceed the lowest effective dose and quantity needed for a

duration of three days. The prescription may not be refilled, nor may it be renewed. Respondent shall notify the Board within 24 hours of any prescription written under the authority of this paragraph; and it is further

ORDERED that Respondent agrees that the Panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for Respondent's Controlled Dangerous Substances ("CDS") prescriptions to ensure that Respondent is in compliance with the terms and conditions of this Order; and it is further;

ORDERED that Respondent is placed on probation[7] for a minimum of eighteen (18) months with the following conditions:

1. Respondent shall not supervise a Physician Assistant for patients in which the treatment plan involves the prescribing of opioids for longer than three days;

2. Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, and all laws and regulations governing the practice of medicine in Maryland; and it is further

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

ORDERED that after a minimum of eighteen (18) months, Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Panel A. The Board or Panel A will terminate the probation if Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

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

ORDERED that if Respondent allegedly fails to comply with any term of probation or any other term imposed by this Consent Order, Respondent shall be given notice and an opportunity for a hearing. If there is a 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 there is no dispute as to a material fact, 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 Respondent has failed to comply with any term of probation or any other term imposed by this Consent Order, the 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 Panel may, in as addition to one or more of the sanctions set forth above, impose a civil monetary fine on 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 unless stated otherwise in the order, any time 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 A; and it is further

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4–101 et seq.

April 30, 2018
Date

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

CONSENT

I, Daniel B. Levy, M.D., License No. D57169, by affixing my signature hereto, acknowledge that:

I am represented by counsel, Janet A. Forero, Esquire, and have consulted with counsel before entering 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.

I acknowledge the validity of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I am waiving those procedural and substantive protections. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

April 24, 2019
Date

Signature on File
Daniel B. Levy, M.D., Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 24th day of April, 2018 before me, a Notary Public of the State and County aforesaid, personally appeared Daniel B. Levy, M.D., License number D57169, 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.

Janice D. Miller
Notary Public

My commission expires 11/13/2019