IN THE MATTER OF	*	**BEFORE THE MARYLAND**
ERIC C. MARCALUS, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D58166	*	**Case Number: 2017-0339B**

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CONSENT ORDER

On July 18, 2018, the Maryland State Board of Physicians (the "Board") charged **ERIC C. MARCALUS, M.D.,** (the "Respondent"), License Number D58166 with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ."), §§ 14-101 et seq. (2014 Repl. Vol. & 2017 Supp.).

Disciplinary Panel B 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 is the licensee:
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> . . .
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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; [and]
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> . . .
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review [.]

FINDINGS OF FACT

The Board makes the following Findings of Fact:

I. BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed on November 27, 2001, under license number D58166. The Respondent's license is presently active and expires on September 30, 2019.
2. The Respondent is board-certified in internal medicine.
3. The Respondent is a solo-practitioner in Maryland and works for a concierge medicine network.[1]
4. On or about November 17, 2016, the Board received a complaint from a nurse manager at the Respondent's practice (the "Complainant"). The complaint alleged that the Respondent prescribed "Large doses of multiple classes of controlled substances. Klonopin, Oxymorphone, Oxycodone, Oxycodone ER, Phentermine, Valium, and Opana. Extreme doses and interactions without monitoring for abuse."
5. Based on the complaint, the Board initiated an investigation of the Respondent.

I. BOARD INVESTIGATION

[1] To ensure confidentiality and privacy, the names of individuals, patients, and institutions involved in this case are not disclosed in this document.

6. In furtherance of its investigation, the Board conducted a drug survey, subpoenaed ten patient medical records from the Respondent and obtained the Respondent's written response to the complaint.

7. Moreover, on or about June 8, 2017, Board investigators interviewed the Respondent at the Board's offices.

8. During the interview, the Respondent stated that he did not have any training in pain medicine. The Respondent stated that his practice consists of approximately 480 patients, with 20 – 30 of those patients being treated for chronic pain management. The Respondent indicates that he used drug contracts and urine screening for all pain management patients.

9. On or about July 28, 2017, the Board sent ten patient medical records and related investigative materials to a peer review entity for independent review by two board certified anesthesiologists with a sub-specialty certification in pain medicine.

10. Upon review of the records, the peer reviewers concurred that the Respondent failed to meet appropriate standards for the delivery of quality medical care with respect to ten of the ten patients. Additionally, the peer reviewers concurred that the Respondent failed to maintain adequate medical records in ten of the ten patients.

II. PATIENT-SPECIFIC ALLEGATIONS

PATIENT 1

11. Patient 1, a male born in the 1950's, began seeing the Respondent for treatment in 2008. Patient 1 presented with several medical issues including chronic lower-back pain, high blood pressure, chronic smoking, and an enlarged prostate. Patient 1 also demonstrated a history of alcohol abuse throughout the course of treatment.

12. The Respondent prescribed non-steroidal anti-inflammatory ("NSAID") medications to treat the back pain and saw Patient 1 repeatedly for follow-up visits in 2008, 2009, 2010, and 2011.

13. On or about February 6, 2012, Patient 1 reported reduced efficacy from the NSAID medicine, after which the Respondent prescribed hydrocodone[2] 7.5/500 mg, one tablet per day at bedtime (#30) with one refill.

14. From February 6, 2012, to April 13, 2017, the last CDS prescription the Respondent issued under review, the Respondent consistently maintained Patient 1 on hydrocodone/acetaminophen 7.5 mg to 10 mg. On or about July 17, 2013, the Respondent increased Patient 1's dosage from one tablet per day to one tablet every six hours. On or about April 9, 2014, the Respondent increased Patient 1's hydrocodone dosage from 7.5 mg to 10

[2] Hydrocodone acetaminophen is a Schedule II CDS, and an opioid analgesic used to treat moderate to severe pain and sold under the brand names Lortab, Norco and Vicodin inter alia.

mg. Patient 1's last CDS prescription during the review period was issued on April 13, 2017, for Norco 10/325 mg at one tablet every four to six hours. Throughout this period of time, the Respondent regularly provided Patient 1 with narcotic refill prescriptions without documenting the necessary support for the refills.

15. On or about April 13, 2017, the Respondent and Patient 1 entered into a contract for use of controlled medications with regards to hydrocodone. Prior to this date the Respondent had not required Patient 1 to enter any such agreement.

16. Since February 2012 when the Respondent began prescribing hydrocodone to Patient 1 to the end of the review period in April 2017, the Respondent never once ordered any urine drug screens to monitor Patient 1's opioid usage, and failed to order updated imaging studies to address Patient 1's complaints of pain.

17. Since on or about June 12, 2015, the Respondent continued to prescribe Norco 10/325 mg to Patient 1 on a regular basis without documenting any patient visit or progress notes.

18. The Respondent failed to meet appropriate standards for the delivery of quality medical care, and failed to keep adequate medical records with respect to Patient 1, in violation of Health Occ. §14-404 (a) (22), and (40), for reasons including:

a. Failing to order updated imaging studies, such as radiographs, and MRI;

b. Failing to make a referral to psychiatry, psychology, or rehabilitation when Patient 1 continued concomitant use of alcohol and opiates;

c. Failing to employ appropriate patient monitoring, including but not limited to urine drug screening;

d. Failing to adequately document his reasoning for medications and dosages sufficient to allow another clinician to understand the rationale for refilling CDS prescriptions; and

e. Failing to document progress notes subsequent to May 27, 2015, despite continuing to issue narcotic prescriptions.

PATIENT 2

19. Patient 2, a female born in the 1960's, initially sought treatment from the Respondent in 2005 for chronic ankle pain following multiple surgeries. Patient 2's medical history included depression, anxiety, insomnia and smoking. Patient 2 was previously referred to a psychiatrist.

20. On or about April 28, 2005, the Respondent began pharmacological treatment of Patient 2's pain by prescribing Vicodin[3] (30 tablets) taken

[3] Vicodin is a brand name for hydrocodone acetaminophen. It is a combination medication prescribed for pain and is classified as a Schedule II CDS.

every four hours as needed for pain. The Respondent failed to document the medical reasoning for prescribing Vicodin to Patient 2.

21. For approximately the next 12 years from April 28, 2005, to March 31, 2017, the Respondent maintained Patient 2 on high-dosages of short and long acting opioid medications in various combinations that included: Vicodin, Dilaudid 2mg to 4mg, Opana 40mg, OxyContin 30mg to 60mg (two to three tablets per day), MS Contin 60mg (two tablets per day) and oxycodone 30mg (one tablet every three to six hours).

22. Concurrently, the Respondent added Xanax .5mg to Patient 2's medication regimen on or about June 13, 2006, and Valium 10mg (three tablets per day) on or about June 24, 2015.

23. At one point in time, on or about December 15, 2009, the Respondent prescribed two long-acting opioids, Opana ER 40mg, and Dilaudid 4mg, at the same time. Approximately one week later, on or about December 22, 2009, the Respondent added oxycodone 30mg (#60).

24. On or about March 10, 2011, Patient 2 contacted the Respondent to inform him that she took one tablet of MS Contin and began to experience a breakout. Patient 2 was asked to bring the bottle in for a pill count at which point it was discovered that only 28 of the 60 tablets remained in the bottle. On or about March 11, 2011, the Respondent sent Patient 2 a letter discharging her from the practice. After a telephone conversation with Patient 2 during which she stated that her husband had flushed some

of the MS Contin tablets down the toilet, the Respondent prescribed oxycodone 40mg (#60).

25. From on or about October 20, 2017, to March 31, 2017, the Respondent maintained Patient 2 on oxycodone 30mg (once every three to four hours). During that time period, Patient 2 was returning for follow-up visits every two or three weeks for renewed prescriptions, which meant that Patient 2 was on seven to eleven tablets of oxycodone 30mg per day.

26. Based on Patient 2's medical record, throughout the more than twelve year period during which the Respondent treated Patient 2, only one urine drug screen ("UDS") was performed, on or about July 21, 2014. The results of this test indicated that Patient 2 was positive for prescribed oxycodone, benzodiazepines, and barbiturates. Patient 2 was also positive for non-prescribed hydromorphone, and hydrocodone. The Respondent did not address this abnormality.

27. The Respondent failed to meet appropriate standards for the delivery of quality medical care, and failed to keep adequate medical records regarding Patient 2, in violation of Health Occ. §14-404 (a) (22), and (40), for reasons including:

a. Failing to employ appropriate patient monitoring including but not limited to periodic urine drug screening, pill count, or pharmacy survey;

b. Maintaining Patient 2 on high amounts of two long-acting opioid medications without adequate documentation, evaluations, reviews and/or monitoring;

c. Maintaining Patient 2 on two benzodiazepines concurrently without adequate documentation, or referral to psychiatry or behavioral health for evaluation and treatment as warranted;

d. Failing to address aberrant behaviors such as urine drug screening results which revealed the presence of unprescribed hydrocodone and hydromorphone, and Patient 2's frequent early return for renewed opioid prescriptions;

e. Failing to adequately document his reasoning for medications and dosages sufficient to allow another clinician to understand the treatment rationale to refill controlled substances; and

f. Failing to document progress notes subsequent to June 8, 2015, despite continuing to issue narcotic prescriptions;

PATIENT 3

28. Patient 3 is a male born in the 1960's who began seeing the Respondent for treatment in 2008. Patient 3 presented to the Respondent with a sore throat, and a history of neck pains believed to be associated with a

herniated disc. In addition, Patient 3 had a history of hypertension, diabetes, depression, and peripheral nerve disease.

29. On or about May 8, 2009, Patient 3 sought treatment from the Respondent due to additional problems with his pre-existing chronic neck pain. Patient 3 indicated that he was previously diagnosed with Torticollis which was being treated by another doctor. The Respondent began prescribing 30 tablets of Percocet[4] 5/325mg.

30. From May of 2009, through April 2017, Patient 3 sought treatment from the Respondent due to additional problems with his pre-existing chronic neck pain. Patient 3 indicated that he was previously diagnosed with Torticollis which was being treated by another doctor. The Respondent began prescribing 30 tablets of Percocet 5/325mg.

31. During the course of Patient 3's ten-year treatment period, the Respondent performed only one urine drug screen, on or about May 20, 2014. The results of which were positive for prescribed benzodiazepines and oxycodone, as well as unprescribed morphine. This abnormality was not addressed by the Respondent.

32. Patient 3's medical records reveal that the Respondent did not require Patient 3 to sign a pain management or opioid agreement.

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[4] Oxycodone acetaminophen is sold under the brand name Percocet. Oxycodone is classified as a Schedule II opioid analgesic, and is used in combination with acetaminophen for moderate to severe pain relief.

33. The Respondent failed to meet appropriate standards for the delivery of quality medical care, and failed to keep adequate medical records with respect to Patient 3, in violation of Health Occ. §14-404 (a) (22), and (40), for reasons including:

a. Maintaining Patient 3 on excessively high dosages of narcotics and benzodiazepines without adequate evaluations, reviews and/or monitoring;

b. Continuing to prescribe oxycodone to Patient 3 after urine drug screening revealed the presence of unprescribed morphine, without an addiction or behavioral therapy referral;

c. Failing to adequately document his reasoning and the necessity behind prescriptions and dosages sufficient to allow another physician to understand;

d. Failing to consider alternative modalities to minimize the use of excess narcotics;

e. Failing employ appropriate patient monitoring including but not limited to periodic urine drug screening, pill count or pharmacy survey; and

f. Failing to document progress notes subsequent to June 8, 2015, despite continuing to issue narcotic prescriptions.

PATIENT 4

34. Patient 4, a male born in the 1960's, sought treatment from the Respondent in 2003 due to recurrent ear infections and high blood pressure. In or around June 2004, Patient 4 was injured in a motor vehicle accident and suffered severe injuries to his right leg. Patient 4 underwent multiple surgeries as a result of the accident which left him in chronic pain for which he sought treatment from various physicians.

35. In or around the latter part of 2008, the Respondent began prescribing narcotic medications to Patient 4 to treat his chronic pain. On or about August 13, 2008, the Respondent prescribed Percocet 10/325mg at one or two tablets every four to six hours.

36. During the next approximately eight years and eight months, from August 2008 to April 2017, the Respondent maintained Patient 4 on long and short acting opioid medications in various combinations that included Percocet 10/325mg, Opana ER 20mg, Duragesic Patch 25mcg, MS Contin 100mg, and Oxycodone 30mg. The Respondent substantially escalated Patient 4's narcotic dosage without documenting the medical reasoning or necessity for such escalation. By April 12, 2017, the Respondent had already maintained Patient 4 on oxycodone 30mg at one tablet every three hours (#240), and MS Contin 100mg at one tablet every eight hours (#90) for approximately five and a half years. Moreover, Patient 4 routinely received renewed prescriptions every three weeks for a one month supply.

37. On or about March 27, 2014, a urine drug screen was performed on Patient 4 which was positive for morphine, hydromorphone, and fentanyl, however the test was negative for prescribed Oxycodone.

38. On or about August 11, 2015 Patient 4 tested positive for hydromorphone, codeine, hydrocodone, morphine, oxycodone, and oxymorphone. The Respondent took no action to address those test results which were abnormal, and continued Patient 4 on high-dose narcotic therapy with morphine and oxycodone.

39. The Respondent failed to meet appropriate standards for the delivery of quality medical care, and failed to keep adequate medical records with respect to Patient 4, in violation of Health Occ. §14-404 (a)(22), and (40) for reasons including:

a. Failing to attempt low-dose narcotic therapy before progressing toward high-dose narcotic therapy with regards to the prescribed opioids;

b. Failing to monitor the use of controlled substances with urine drug screens conducted at appropriate intervals;

c. Failing to address abnormal results of urine drug screenings;

d. Failing to address red flags such as Patient 4's consistent early return for renewed narcotic prescriptions;

e. Failing to document his justification for ultra-high dose opiate therapy and the impact the medications have on function and quality of life;

f. Failing to document medical reasoning and justification for renewing narcotic prescriptions; and

g. Failing to document progress notes subsequent to May 19, 2015, despite continuing to issue narcotic prescriptions.

PATIENT 5

40. Patient 5, a male born in the 1970's, initially sought treatment from the Respondent around May 2014 for multiple medical issues including lower back pain from an accident approximately 20 years prior. Patient 5 also reported anaphylaxis, pain in the shoulder and knee areas, and carpal tunnel syndrome.

41. On or about May 6, 2014, the Respondent began prescribing MS Contin 100mg one tablet every eight hours (#90), and oxycodone 30mg one tablet every four hours as needed (#180). The Respondent maintained Patient 5 on this regimen approximately every three weeks with the last prescription noted in Patient 5's records on March 20, 2017.

42. On or about May 13, 2015, Patient 5 completed a UDS, the results of which were positive for prescribed drugs as well as an unprescribed drug,

hydromorphone. The Respondent took no action to address this abnormality.

43. The Respondent failed to meet appropriate standards for the delivery of quality medical care, and failed to keep adequate medical records with respect to Patient 5, in violation of Health Occ. § 14-404(a) (22) and (40), for reasons including:

a. Failing to attempt low-dose narcotic therapy before progressing toward high-dose narcotic therapy with regards to the prescribed opioids;

b. Failing to consider multimodal approaches such as formal pain rehabilitation program or referral to appropriate providers such as a back surgeon to minimize the utilization of opiate therapy;

c. Failure to order urine drug screens at an appropriate frequency over the duration of treatment;

d. Failure to take remedial action as a result of abnormal findings on the only urine drug screen completed during the course of treatment;

e. Having Patient 5 return for appointments at irregular intervals prior to the previous month's prescriptions having been exhausted, resulting in large quantities of extra medication;

f. Failing to document medical reasoning and justification for renewing narcotic prescriptions;

g. Failing to document his reasoning for utilization of high-dose opiate therapy in the absence of lower dosages being attempted first; and

h. Failing to order imaging of shoulder and knee areas to assess pathology.

PATIENT 6

44. Patient 6, a female born in the 1970's, presented to the Respondent in October 2013. Patient 6 came to the Respondent with a complex medical history including obesity, depression, anxiety, nicotine dependence, and neck and back problems. Patient 6 had undergone various surgeries including cervical fusion in 2005, and lumbar fusion in 2009, prior to seeing the Respondent.

45. On or about October 22, 2013 the Respondent began prescribing MS Contin 100mg, one tablet every eight hours (#90), and oxycodone 30mg one tablet every four hours (#180). The Respondent continued Patient 6 on this medication regimen approximately every three weeks through December 21, 2015.

46. On or about July 7, 2014 the Respondent placed Patient 6 on additional Morphine Sulfate Extended Release (MSER)[5] 30mg at 90 tablets, along

[5] Morphine Sulfate Extended Release (MSER) is a strong prescription pain medicine that contains morphine, a Schedule II CDS. It is marketed under the brand name MS Contin.

with 90 tablets of MS Contin 100mg, and 180 tablets of oxycodone 30mg approximately every three weeks through April 18, 2015.

47. On or about May 15, 2015, the Respondent prescribed 90 tablets of oxycodone 15mg, in conjunction with MSER 100mg at 90 tablets, and oxycodone 30mg at 180 tablets approximately every two or three weeks through April 12, 2016.

48. On or about May 10, 2016 through the end of the peer review period, the Respondent discontinued MSER, but instead, maintained Patient 6 on 90 tablets of OxyContin 80mg and 180 tablets of oxycodone 30mg approximately every three weeks with the last prescription occurring on April 11, 2017.

49. Throughout the entire treatment period, the Respondent ordered only one UDS on or about September 4, 2014, the results of which were abnormal in that they noted the presence of unprescribed codeine and hydromorphone. The Respondent failed to address this abnormality.

50. The Respondent failed to meet appropriate standards for the delivery of quality medical care, and failed to keep adequate medical records with respect to Patient 6, in violation of Health Occ. §14-404(a) (22) and (40) for reasons including:

a. Failing to attempt low-dose narcotic therapy before progressing toward high-dose narcotic therapy with regards to the prescribed opioids;

b. Failing to consider alternative medications or modalities to address Patient 6's reports of pain;

c. Failing to order urine drug screens at an appropriate frequency over the duration of treatment;

d. Having Patient 6 return for appointments at irregular intervals prior to the previous month's prescription having been exhausted, resulting in large quantities of extra medication;

e. Failing to note his justification for continued use of high-dose opiate therapy; and

f. Failing to note correlation between office visits and prescription refills.

PATIENT 7

51. Patient 7, a female born in the 1950's, initially sought treatment from the Respondent in October 2003. Patient 7 presented to the Respondent with several issues including her blood pressure and allergies. Patient 7 also had difficulties with neck pain for which she was receiving physical therapy, acupuncture, and various medications.

52. On or about July 2, 2010, an MRI was performed on Patient 7's lumbar region which showed disc protrusion and arthropathy from L4-S1.

53. On or about July 27, 2012, the Respondent began prescribing Vicoprofen[6] 7.5/200mg, one tablet every four hours (#90) after Patient 7 complained of a tailbone injury from a fall. The Respondent maintained Patient 7 on Vicoprofen 7.5/200mg (#90) on a monthly basis until mid-2013.

54. On or about May 3, 2013, Patient 7 complained of pain to her right thumb after pruning. In order to address this, the Respondent added oxycodone 10mg, one tablet twice per day (#60) to Patient 7's medication regimen. The Respondent increased the oxycodone dosage to 20mg on May 7, 2013.

55. On or about April 9, 2015, the Respondent increased the oxycodone quantity to 120 tablets in conjunction with Vicoprofen 7.5/200mg at 120 tablets. This combination was continued on an approximate monthly basis through the end of the peer review period.

56. Throughout the course of Respondent's treatment of Patient 7, diazepam 10mg at 120 tablets was also prescribed as needed.

57. Throughout the entire treatment period, the Respondent ordered only one UDS on or about September 9, 2016, the results of which were abnormal in that they noted the presence of unprescribed hydromorphone. The Respondent failed to address this abnormality.

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[6] Vicoprofen is a brand name for hydrocodone and ibuprofen. It is a combination medication used for short-term relief of moderate to severe pain. It contains hydrocodone, an opioid analgesic classified as a Schedule II CDS.

58. The Respondent failed to meet appropriate standards for the delivery of quality medical care, and failed to keep adequate medical records with respect to Patient 7, in violation of Health Occ. §14-404(a) (22) and (40), for reasons including:

a. Failing to attempt low-dose narcotic therapy before progressing toward high-dose narcotic therapy with regards to the prescribed opioids;

b. Failing to consider alternative medications or modalities to address Patient 7's reports of pain;

c. Having Patient 7 return for appointments at irregular intervals prior to the previous month's prescription having been exhausted, resulting in large quantities of extra medication.;

d. Failing to order urine drug screens at an appropriate frequency over the duration of treatment; and

e. Failing to note his justification for continued use of high-dose opiate therapy.

PATIENT 8

59. Patient 8, a female born in the 1930's, began seeing the Respondent for treatment on or about March 20, 2012. Patient 8 was suffering from chronic back pain, as well as anxiety disorder, and chronic obstructive

pulmonary disease when she initially presented to the Respondent after her previous physician retired.

60. During Patient 8's initial visit on or about March 20, 2012, she indicated to the Respondent that she had been taking pain medications for many years and required refills. The Respondent issued prescriptions for 150 tablets of Percocet 10/325mg, 60 tablets of Xanax .25mg, and 120 tablets of Opana 10mg. The Respondent's records do not indicate the use of any corroborative imaging studies.

61. For the next approximately five years, from March 2012 to March 2017, the Respondent maintained Patient 4 on long and short acting opioid medications in various combinations that included Percocet 10/325mg, Opana ER 20mg and oxycodone 10, 15, and 30mg, as well as benzodiazepines that included Xanax. The Respondent substantially escalated Patient 8's narcotic dosage without documenting the medical reasoning or necessity for such escalation. By April 14, 2015, the Respondent was maintaining Patient 8 on oxycodone 30mg at five tablets per day (#150), and oxycodone 15mg at five tablets per day (#150), along with Xanax .5mg twice per day, and Ritalin. Moreover, Patient 8 routinely received renewed prescriptions every three weeks for a one-month supply.

62. On or about March 16, 2017, Patient 8 was hospitalized for altered mental status due to acute renal failure and suspected opioid overuse which was

treated with hydration and Narcan[7]. Patient 8 was sent home on substantially reduced narcotic dosage and without benzodiazepines.

63. On or about April 12, 2017, the Respondent restarted oxycodone 30mg with a plan to increase slowly. Xanax was also restarted.

64. The Respondent failed to meet appropriate standards for the delivery of quality medical care, and failed to keep adequate medical records with respect to Patient 8, in violation of Health Occ. §14-404(a) (22), and (40), for reasons including:

a. Failing to order updated imaging studies such as radiographs, and MRI;

b. Failing to consider baseline and random urine drug screens;

c. Failing to consider alternative medications or modalities to address Patient 8's reports of pain;

d. Failing to attempt low-dose narcotic therapy before progressing toward high-dose narcotic therapy with regards to the prescribed opioids;

e. Having Patient 8 return for appointments at irregular intervals prior to the previous month's prescription having been exhausted, resulting in large quantities of extra medication;

[7] Narcan is a brand name for naloxone, an opioid antagonist.

f. Failing to order an appropriate frequency of urine drug screens over the duration of treatment; and

g. Failing to note his justification for continued use of high-dose opiate therapy, including the concurrent use of two short-acting opiates.

PATIENT 9

65. Patient 9, a female born in the 1960's, initially sought treatment from the Respondent in July, 2012. Patient 9 presented with a history of severe back pain following lumbar fusion surgery in 2005. Patient 9 was seen by various pain management doctors and attempted physical therapy but reported limited relief.

66. On or about July 16, 2012, the Respondent prescribed Percocet 5/325mg two tablets a day as needed (#45) along with Xanax 0.5mg for sleep.

67. On or about July 30, 2012, the Respondent added 60 tablets of MS Contin extended release 30mg, and increased Patient 9's Percocet dosage to 10/325mg (#90).

68. On or about September 10, 2012, Patient 9 was prescribed 90 tablets of Percocet 5/325mg, and 90 tablets of Percocet 10/325mg.

69. On or about November 19, 2012, the Respondent increased Percocet 10/325mg, and to 150 tablets along with 90 tablets of Xanax 0.5mg. This prescription regimen was continued until approximately April 24, 2013.

70. On or about January 31, 2013, a UDS was performed on Patient 9. The results of this screen were positive for benzodiazepines, oxycodone, ethanol, and tetrahydrocannabinol (THC)[8]. The Respondent did not address this abnormality.

71. On or about May 22, 2013, the Respondent switched Percocet to 150 tablets of oxycodone 15mg at five tabs per day and switched from Xanax to Clonazepam 0.5mg.

72. On or about August 12, 2013, the Respondent increased the oxycodone dose to 120 tablets at 20mg to be taken four times per day.

73. On or about October 10, 2013, the Respondent continued oxycodone 20mg, but added 30 tablets of oxycodone 10mg. No reason for the addition of oxycodone 10mg was made apparent.

74. On or about February 27, 2014, a UDS was completed for Patient 9. The results of this screening were positive for benzodiazepines, THC, cocaine, and oxycodone. The Respondent failed to address Patient 9's use of illicit drugs.

75. On or about May 9, 2014, oxycodone 10mg was increased to 90 tabs with continuation of oxycodone 20mg.

76. On or about June 19, 2014, the Respondent prescribed Fentanyl Patch 25mcg/hour every 72 hours in addition to the ongoing oxycodone

[8] Tetrahydrocannabinol (THC) is a cannabinoid, and the principal psychoactive constituent of cannabis, a Schedule I CDS.

regimen. There was an attempt to increase the Fentanyl Patch to 50mcg/hour, but this effort was discontinued on approximately September 25, 2014.

77. On or about January 29, 2015, oxycodone 10mg was increased to 20mg at 90 tablets, while oxycodone 30mg (#120) was continued.

78. On or about July 2, 2015, oxycodone 20mg was increased to 180 tablets. The Respondent continued Patient 9 on 90 tablets of Xanax 2mg, and added 30 tablets of lorazepam 2mg.

79. On or about October 27, 2015, the Respondent added 60 tablets of MSER 15mg to Patient 9's regimen, which continued on an approximate four to six week basis.

80. On or about March 2, 2016, another UDS was completed for Patient 9. The results of this screening were positive for lorazepam, alprozalam, and oxycodone. This test was negative for prescribed morphine.

81. The Respondent failed to meet appropriate standards for the delivery of quality medical care, and failed to keep adequate medical records with respect to Patient 9, in violation of Health Occ. §14-404(a) (22), and (40), for reasons including:

a. The repeated use of high doses of two separate short-acting narcotics without documented justification;

b. Failing to attempt low-dose narcotic therapy before progressing toward high-dose narcotic therapy with regards to the prescribed opioids;

c. Having Patient 9 return for appointments at irregular intervals prior to the previous month's prescription having been exhausted, resulting in large quantities of extra medication;

d. Failing to document his justification for the use of high dose opiate therapy and random increases in dosages;

e. Failing to document overall functioning and pain scores. Notes that are present do not allow another clinician to understand the treatment plan and rationale for prescription refills;

f. Failing to monitor patient compliance with UDS at appropriate frequency over the duration of treatment;

g. When UDS was ordered, failing to respond to abnormal results, including addressing Patient 9's use of illicit drugs;

h. Failing to refer Patient 9 to Addiction Medicine and Behavioral Management rather than continuing treatment with high-dose opiates and benzodiazepines; and

i. Failing to consider alternative medications or modalities to address Patient 9's reports of pain.

PATIENT 10

82. Patient 10, a male born in the 1970's, was initially seen by the Respondent in or about May of 2012. Patient 10 presented to the Respondent with a history of chronic lower back pain as well as anxiety. An MRI of the lumbar spine from approximately July 2, 2010 showed significant pathology in the lumbar spine.

83. On or about May 28, 2012, the Respondent treated Patient 10 after having reviewed medical records from Patient 10's previous doctor. The Respondent continued Patient 10 on oxycodone 30mg, and oxycodone 15mg. Trigger point injections were also utilized intermittently.

84. On or about August 28, 2012, oxycodone 30mg was increased to seven tabs per day, and oxycodone 15mg was increased to three tabs per day.

85. On or about July 31, 2014, a UDS of Patient 10 revealed the presence of methadone. The Respondent did not address this abnormality.

86. The Respondent failed to meet appropriate standards for the delivery of quality medical care, and failed to keep adequate medical records with respect to Patient 10, in violation of Health Occ. §14-404(a) (22), and (40), for reasons including:

a. Failing to attempt low-dose narcotic therapy before progressing toward high-dose narcotic therapy with regards to the prescribed opioids;

b. Having Patient 10 return for appointments at irregular intervals prior to the previous month's prescription having been exhausted, resulting in large quantities of extra medication;

c. Failing to order UDS at appropriate frequency over the duration of treatment and failing to address abnormal results;

d. Failing to document his justification for the use of high dose opiate therapy and random increases in dosages. Reasons for increases in medications are also poorly documented; and

e. Failing to keep notes sufficient to allow another clinician to understand the treatment plan and rationale for refills.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's violated Health Occ. §14-404(a)(22) by failing 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 Health Occ. § 14-404(a)(40), by failing to keep adequate medical records as determined by appropriate peer review.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by a majority of the quorum of the Board considering this case:

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

ORDERED that the Respondent is placed on **PROBATION** for a minimum two (2) years. [9] During probation, the Respondent shall comply with the following terms and conditions of probation:

(A) The Respondent is required to take **TWO** courses. The first course shall be in the appropriate prescribing of opioid medications. A second course shall be in proper record-keeping practices. The following terms apply to each course:

1. It is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before they are begun;
2. The disciplinary panel will not accept courses taken over the internet;
3. The Respondent shall enroll in and successfully complete panel approved courses within six months;
4. The Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

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

5. The courses may not be used to fulfill the continuing medical education credits required for license renewal; and
6. The Respondent is responsible for the cost of the courses.

(B) During the probationary period the Respondent is prohibited from prescribing or dispensing:

1. All opioids;
2. In emergency cases, the Respondent may issue no more than one prescription for a drug listed above for each patient during the probationary period, but the prescription may not exceed the lowest effective dose and quantity needed for a duration of five days. The prescription may not be refilled, nor may it be renewed. The Respondent shall notify the Board within 24 hours of any prescription written as authorized by this paragraph;
3. The Respondent is prohibited from delegating to a Physician Assistant the prescribing of the above prohibited substances;
4. This prohibition on prescribing and dispensing goes into effect **60 DAYS** after the Consent Order effective date;
5. Respondent shall not accept new opioid patients during this 60-day transition period.

(C) During probation the Respondent is prohibited from certifying a patient for the medical use of cannabis.

(D) During probation the disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's Controlled Dangerous Substances ("CDS") prescriptions. The administrative subpoena will request the Respondent's CDS prescriptions from the beginning of each quarter.

(E) The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §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 shall not apply for early termination of probation; and it is further

ORDERED that 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 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 if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that a violation of probation constitutes a violation of the Consent Order; and it is further

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

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order and it is further;

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

ORDERED that 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).

01/07/2019
Date

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

CONSENT

I, Eric C. Marcalus, 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 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.

Signature on file

12/21/2018
Date

Eric Marcalus, M.D.
Respondent

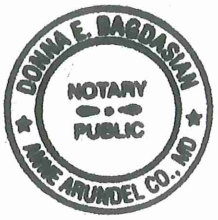
NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 21st day of December,

2018, before me, a Notary Public of the foregoing State and City/County personally appear Eric Marcalus, 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 notary seal.



Notary Public

My commission expires: 6/12/22