IN THE MATTER OF	*	**BEFORE THE**
EBENEZER K. QUAINOO, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D61765	*	**Case Number: 2217-0007A**

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CONSENT ORDER

On April 23, 2019, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **EBENEZER K. QUAINOO, M.D.** (the "Respondent"), License Number D61765, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. and 2018 Supp.).

The pertinent provisions of the Act provide:

> (a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; [and]
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review.

On August 14, 2019, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of the

DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

Panel A finds:

I. BACKGROUND

1. At all times relevant, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. The Respondent was initially licensed in Maryland on May 21, 2004. The Respondent's license is presently active and is scheduled for renewal on September 30, 2019.

2. The Respondent was formerly board-certified in internal medicine. The Respondent's board-certification lapsed in or around 2014.

3. At all times relevant to the charges, the Respondent practiced medicine at Baltimore HealthCare PC, located at 3350 Wilkens Avenue, Suite 307, Baltimore, Maryland 21229.

II. THE COMPLAINT

4. The Board initiated an investigation of the Respondent after reviewing a complaint, dated November 16, 2016, from a relative of a patient, who raised concerns about the Respondent's management of the patient's pain medications and treatment.

III. BOARD INVESTIGATIVE FINDINGS

5. In furtherance of its investigation, the Board interviewed the Respondent and subpoenaed the medical records of ten patients ("Patients 1-10")[1] to whom the Respondent provided medical care that included his prescribing of controlled dangerous substances ("CDS").

6. The Board then referred this matter to two physicians who are board-certified in anesthesiology with subspecialty certifications in pain medicine for a practice review to determine if the Respondent complied with appropriate standards for the delivery of quality medical care and kept adequate medical records.

7. The two physician peer reviewers determined that 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 all 10 patients.

8. Examples of the above violations are set forth in the following patient-specific summaries.

Patient 1

9. The Respondent began providing medical care to Patient 1, a woman then in her 50s, in or around 2016. Patient 1's medical history included positive HIV status, morbid obesity (body mass index of 46), diabetes, hypertension, chronic obstructive

[1] For confidentiality reasons, the names of patients or other individuals will not be disclosed in this document. The Respondent may obtain the identity of any patient or individual referenced herein by contacting the assigned administrative prosecutor.

pulmonary disease, depression and chronic back pain. Patient 1 signed a pain management agreement on intake.

10. During the course of treatment, the Respondent placed Patient 1 on a variety of opioid and non-opioid prescription medications and in 2016, administered a series of trigger point injections.

11. The Respondent prescribed Patient 1 oxycodone 10 mg, four times per day, or QID, beginning in or around early 2016. The Respondent documented a physical examination and interval patient history at each visit but failed to document physical findings in the medical record to support prescribing opioids. The Respondent's clinical records indicate that Patient 1 received early oxycodone prescription refills on two occasions in late 2016.

12. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or 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 prescribed opioids for Patient 1 without documenting or establishing sufficient physical findings in the record to support such prescribing;
(b) the Respondent failed to appropriately monitor Patient 1 for drug abuse and/or diversion;
(c) Patient 1 underwent toxicology screening and tested positive for non-prescribed medications and/or illicit drugs (*i.e.*, marijuana, buprenorphine[2]) on more than one occasion. The Respondent failed to document or address these inconsistent findings in his progress notes and continued to prescribe high-dose opioids without an alteration in treatment;

[2] Buprenorphine is an opioid medication and Schedule III CDS that is used to treat opioid addiction.

(d) the Respondent provided early prescription refills of opioid prescriptions without documenting a reason for the early prescriptions;

(e) the Respondent's progress notes contain inconsistencies with respect to medications prescribed. For example, the Respondent inconsistently noted the strength/dosage of gabapentin[3] or misidentified the dosage strength of the medication. In other entries, the Respondent failed to consistently document medication dosages, *i.e.*, in August 2016, the Respondent switched Patient 1 from gabapentin to pregabalin[4] 75 mg three times per day, or TID, but in a subsequent note recorded that Patient 1 was on gabapentin 10 mg;

(f) the Respondent inappropriately copied components of his progress notes (*e.g.*, history of present illness, physical examination findings, medication prescriptions) from previous entries;

(g) the Respondent failed to document or establish an adequate justification for filling or refilling CDS;

(h) the Respondent's documentation was brief and frequently failed to include detailed descriptions of Patient 1's medical problems, summaries of laboratory and imaging findings, and referrals to specialists and consultation findings; and

(i) the Respondent's records failed to include a reasonable assessment of medical issues or a plan of care.

Patient 2

13. The Respondent began providing medical care to Patient 2, a woman then in her 50s, in or around 2012. Patient 2's medical history included morbid obesity, diabetes, hypertension, knee osteoarthritis, and low back pain.

14. The Respondent placed Patient 2 on an opioid medication regimen for chronic pain, which included: MS Contin[5] 15 mg, two times per day, or BID; oxycodone

[3] Gabapentin is a neuropathic medication used to treat peripheral neuropathy, chronic pain and other conditions.

[4] Pregabalin is a prescription-only medication used to treat neuropathic pain.

[5] Morphine Sulfate ((MS) Contin) is an opioid medication and Schedule II CDS.

15 mg QID; and intermittent prescriptions of methadone[6] 5 mg at bedtime, or QHS. The Respondent also prescribed tizanidine;[7] topiramate[8] BID, and gabapentin 300 mg TID.

15. Patient 2 had an MRI[9] of both shoulders in October 2014, which showed mild degenerative changes but no significant physical findings to support opioid prescribing.

16. Patient 2 complained of ongoing pain in her low back, knees and shoulder. The Respondent prescribed increasing doses of opioids for many months with no objective findings to support such prescribing.

17. The Respondent did not have Patient 2 execute a pain management agreement until two years after he initiated prescribing opioid medications for her. The Respondent ordered toxicology screening that at times was negative for morphine, negative for all substances and/or positive for marijuana. The Respondent failed to address these findings in his progress notes or alter his treatment plan despite these inconsistencies.

18. The Respondent also prescribed a benzodiazepine, alprazolam[10] 0.25 mg BID, with no clear indication in his progress notes.

19. The Respondent's office notes contain inconsistent references to his prescribing of opioid medications. For example, the Respondent intermittently

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[6] Methadone is an opioid medication used for opioid maintenance therapy and to treat pain. Methadone is a Schedule II CDS.
[7] Tizanidine is a muscle relaxant and prescription-only medication.
[8] Topiramate is a prescription-only medication used to treat nerve pain and other conditions.
[9] Magnetic Resonance Imaging (MRI) is a medical imaging technique used in radiology to form pictures of the anatomy and physiological processes of the body to diagnose diseases and medical conditions.
[10] Alprazolam is a benzodiazepine and Schedule IV CDS.

documented that Patient 2's opioid history included OxyContin 10 mg BID, and sometimes methadone 5 mg QHS. The Respondent did not adequately document Patient 2's medication changes, benefits of such changes, or whether he in fact changed Patient 2's medications.

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/or 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 prescribed escalating dosages of opioid medications for Patient 2 in the absence of objective findings or appropriate indications to support such prescribing;
(b) the Respondent failed to perform an opioid risk assessment to assess Patient 2's risk for opioid misuse/abuse/diversion prior to prescribing opioids;
(c) the Respondent failed to appropriately monitor Patient 2 for drug abuse and/or diversion, including the use of urine drug screenings, blood toxicology tests, pill counts or pharmacy checks;
(d) the Respondent failed to document or address Patient 2's toxicology screening findings that at times were positive for illicit substances and negative for prescribed opioids. The Respondent failed to alter his prescribing of opioid medications despite this inconsistency.
(e) the Respondent failed to document in his progress notes that he considered relating Patient 2's mental health issues to her chronic pain complaints;
(f) the Respondent prescribed a benzodiazepine without clear indication;
(g) the Respondent inappropriately prescribed opiates with benzodiazepines;
(h) the Respondent's medical records are inadequate in that they appear to be copied from prior visits, which made it difficult to follow his opioid prescribing history. The Respondent failed to clearly document the medications he prescribed for

Patient 2 or medication changes he made to his prescribing regimen; and

(i) the Respondent failed to document or substantiate in his progress notes his rationale for changing medications and/or dosage amounts.

Patient 3

21. The Respondent began providing medical care to Patient 3, a man then in his 30s, in or around 2015. Patient 3's medical history included smoking, depression, anxiety disorder, hypertension, chronic low back pain and lumbar spine surgery. The Respondent continued to provide medical care to Patient 3 until he discharged him in March 2017.

22. The Respondent prescribed medications to Patient 3 including duloxetine,[11] lisinopril,[12] Wellbutrin,[13] methadone 5 mg BID and oxycodone 5-10 mg TID. The Respondent also administered lumbar trigger point injections.

23. Although Patient 3 complained of pain, muscle spasm and tightness in his back, his physical examinations were largely normal. The Respondent did not establish that Patient 3 needed to be prescribed opioids.

24. Patient 3 signed a pain management agreement on intake that included toxicology screening. The Respondent performed toxicology screening in October 2015 that was negative for opiates. The Respondent ordered toxicology screening on March 1, 2017, which was positive for prescribed medications and buprenorphine, a medication the

[11] Duloxetine is a prescription-only anti-depressant medication used to treat various conditions including depression, anxiety and neuropathic pain.
[12] Lisinopril is used to treat high blood pressure and heart failure.
[13] Wellbutrin (Bupropion) is a medication used to treat depression.

Respondent did not prescribe.[14] Despite these inconsistent findings, the Respondent continued Patient 3 on opioid medications (oxycodone 10 mg TID, methadone 5 mg BID) without an alteration in prescribing. The Respondent ordered repeat testing a second time in March 2017, which was positive for non-prescribed substances (buprenorphine, cocaine), after which he reportedly discharged Patient 3.

25. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or 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 prescribed opioids for Patient 3 but failed to document or establish physical findings to support such prescribing;
(b) the Respondent failed to perform an opioid risk assessment to assess Patient 3's risk for opioid misuse/abuse/diversion prior to prescribing opioids;
(c) the Respondent failed to appropriately monitor Patient 3 for drug abuse and/or diversion;
(d) the Respondent failed to appropriately follow up with Patient 3 after Patient 3 tested positive for non-prescribed and/or illicit drugs;
(e) the Respondent's progress notes are inadequate in that they appear to have multiple sections that are copied from previous notes, such as history of present illness, physical examination and assessments;
(f) the Respondent's progress notes contain inconsistent notations about medications prescribed; and
(g) one of the Respondent's progress notes for Patient 3 contains other irregularities, including a history of present illness for a 48-year old woman, despite the fact that Patient 3 was a male in his 30s.

[14]The Respondent submitted a Supplemental Response, dated December 27, 2017, in which he provided a document that states that Patient 3 underwent toxicology screening on August 17, 2016 and tested positive for cocaine. The chart the Respondent submitted to the Board, however, does not contain this laboratory finding, and his progress notes do not document this positive toxicology finding.

Patient 4

26. The Respondent began providing medical care for Patient 4, a woman then in her 20s, in or around March 2012. Patient 4's medical history included bipolar disorder, seizure disorder, migraine headache, chronic low back pain reportedly from multiple motor vehicle accidents, and asthma. Patient 4 also had a history of post-traumatic stress disorder, for which she was being followed by a psychiatrist.

27. Patient 4's imaging studies showed no sign of fracture or lumbar disc disease. Despite negative imaging studies, the Respondent placed Patient 4 on oxycodone 15 mg TID and alprazolam 0.5 mg BID. In 2014, the Respondent added MS Contin 15 mg BID to her oxycodone and alprazolam regimen, without appropriate indication. In 2014, the Respondent administered bilateral knee injections. In 2015, the Respondent switched Patient 4's MS Contin to methadone 5 mg BID without indication or documented rationale for why he switched the medication.

28. During the course of treatment, Patient 4 underwent periodic toxicology screening that at times was either positive for illicit drugs (heroin, marijuana) or negative for prescribed opioids and/or benzodiazepines. The Respondent did not document or address these inconsistent findings in subsequent progress notes.

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/or 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 establish a basis to prescribe opioid medications. The Respondent's physical examination findings failed to establish an appropriate basis for opioid prescribing. The physical examinations in each clinical note remains unchanged, and lumbar spine and knee x-rays performed did not demonstrate significant abnormalities. Despite this, the Respondent placed Patient 4 on opioid and benzodiazepine therapy;

(b) the Respondent failed to perform an opioid risk assessment to assess Patient 4's risk for opioid misuse/abuse/diversion prior to prescribing opioids;

(c) the Respondent inappropriately prescribed opioids for Patient 4 while she was also receiving benzodiazepine prescriptions from another practitioner;

(d) the Respondent inappropriately escalated his prescribing of high-dose opioid medications without appropriate indication;

(e) the Respondent inappropriately prescribed high-dose opioid medications in combination with benzodiazepines;

(f) the Respondent failed to address Patient 4's multiple inconsistent toxicology screenings for illicit and/or prescribed opioid medications. Despite these inconsistencies, the Respondent failed to address these findings in his progress notes and continued prescribing opioid medications without an alteration in treatment;

(g) the Respondent's progress notes are unclear in that multiple sections appear to be copied from previous notes. In many of the record entries the chief complaint, history of present illness, review of systems, physical examination and assessment remain unchanged in subsequent office notes. In the entries, the Respondent listed Patient 4's age as 27 years old during a multi-year time span;

(h) the Respondent failed to contact or document contacting Patient 4's psychiatrist, even though Patient 4 was being treated for mental health issues and chronic pain, and was being prescribed opioids and benzodiazepines; and

(i) the Respondent documented a history of drug withdrawal seizures from the January 2015 clinic visit to March 2017 but failed to document or undertake an objective work-up for the seizures and failed to document or undertake a follow-up on the patient's mental health history.

Patient 5

30. The Respondent began providing medical care to Patient 5, a woman then in her late 40s, beginning in or around March 2015 and continuing until around January 2017. Patient 5's medical history included protein C and S deficiency, recurrent deep venous thrombosis, stroke and transient ischemic attack, migraine headaches, low back pain and chronic knee pain. Patient 5 signed a pain management agreement on intake. Patient 5 reported that she was on chronic opioid therapy including dilaudid, oxycodone and OxyContin.

31. Patient 5 underwent toxicology screening on intake, which was negative for all drugs, despite Patient 5's claim that she had been treated with chronic opioid therapy. Despite this inconsistent finding, the Respondent placed Patient 5 on an immediate and extended-relief opioid treatment regimen that included oxycodone 15 mg QID and OxyContin 20 mg BID.

32. The Respondent's physical examination findings do not support the prescribing of opioids.

33. During the course of treatment, Patient 5 underwent toxicology screening, with inconsistent results. Patient 5 tested positive for marijuana multiple times in 2016, in violation of her pain management agreement. Patient 5 also tested negative for opioid medications prescribed (August 2016). The Respondent failed to address Patient 5's noncompliance and/or document follow-up in his progress notes but continued to prescribe opioid medications for Patient 5, without an alteration in treatment.

34. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or 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 establish a basis to prescribe opioid medications. The Respondent's physical examination findings failed to establish a basis for opioid prescribing;
(b) the Respondent inappropriately initiated high-dose chronic opioid therapy in view of Patient 5's inconsistent toxicology screening on intake. In addition, the Respondent failed to obtain Patient 5's prior medical records or imaging studies prior to initiating such prescribing;
(c) the Respondent inappropriately increased the dosage of Patient 5's opioid treatment regimen without appropriate indication;
(d) the Respondent inappropriately placed Patient 5 on chronic opioid therapy in view of Patient 5's medical co-morbidities, which included a history of stroke and transient ischemic attack;
(e) the Respondent failed to appropriately address Patient 5's inconsistent toxicology screening results and continued to prescribe opioid medications without an alteration in treatment;
(f) the Respondent's progress notes are inadequate in that some of the progress notes consist of duplicate notes from one visit to the next;
(g) the Respondent failed to document in the record that he acknowledged and discussed the patient history with the patient; and
(h) the Respondent noted that Patient 5 needed to follow-up with a psychiatrist but failed to make a referral or confirm that Patient 5 was under psychiatric care.

Patient 6

35. The Respondent began providing medical care to Patient 6, a man then in his 60s, in January 2014. Patient 6's medical history included depression, hypertension,

coronary artery disease (with prior stent placement), and chronic knee pain (with prior left knee replacement and anticipated right knee replacement). Patient 6 signed a pain management agreement on intake.

36. The Respondent did not order toxicology screening on intake but began prescribing opioid medications including methadone 10 mg TID and gabapentin. The Respondent continued to prescribe this regimen until April 2014, when he increased Patient 6's methadone to 20 mg BID, reportedly when Patient 6 was diagnosed with sciatica and low back pain. The Respondent did not obtain hospital records to verify the diagnosis or obtain imaging studies prior to increasing Patient 6's methadone.

37. In September 2014, the Respondent added morphine sulfate extended release 15 mg BID to Patient 6's existing opioid regimen. The Respondent did not document a rationale for using two extended-release opioid medications. The Respondent continued this regimen into 2016. In June 2016, the Respondent reduced Patient 6's methadone, discontinued his morphine extended release and added oxycodone 5 mg BID. The Respondent continued prescribing methadone 10 mg TID and oxycodone 5 mg BID until Patient 6's last visit in January 2017.

38. A hospital admission record from January 2017 stated that Patient 6 was taking methadone and using heroin and cocaine.

39. During the treatment interval, the Respondent ordered toxicology screening for Patient 6. Some of those tests were positive for non-prescribed medications (benzodiazepines) and illegal substances (marijuana, cocaine), and negative for prescribed medications (methadone). Despite these findings, the Respondent did not alter

or taper Patient 6's opioid regimen.

40. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or 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 prescribed opioid medications for Patient 6 without documenting or establishing physical findings in the record to support such prescribing;
(b) the Respondent failed to order toxicology screening or undertake an opioid risk assessment prior to prescribing opioids;
(c) the Respondent failed to address Patient 6's positive toxicology screening results in a timely manner. Despite Patient 6's inconsistent toxicology findings, the Respondent continued to prescribe opioid medications including methadone, without an alteration in treatment;
(d) the Respondent continued to prescribe opioid medications for Patient 6, despite Patient 6's extensive substance abuse history, including active use of heroin and cocaine;
(e) the Respondent inappropriately prescribed two extended-release opioid medications concurrently, without an appropriate rationale;
(f) the Respondent's progress notes are inadequate in that multiple sections appear to have been copied from previous notes. For example, in many of the record entries, the history of present illness, physical examination and assessment appear to be copied from previous record entries; and
(g) the Respondent failed to document substance abuse in the lifestyle/risk factors section, but an admission note in January 2017 from a hospital documents polysubstance abuse and current illicit drug use.

Patient 7

41. The Respondent began providing medical care to Patient 7, a woman then in her 30s, in December 2014. Patient 7's medical history included chronic low back

pain, depression, anxiety and hypothyroidism. Patient 7 signed a pain management agreement on intake. The Respondent continued to provide medical care to Patient 7 until in or around March 2017. The Respondent initially prescribed MS Contin 30 mg BID and oxycodone 15 mg TID, without verification from her previous provider or pharmacy. In 2015, the Respondent administered trigger point injections and noted that Patient 7 experienced some pain relief.

42. Beginning in 2015, the Respondent discontinued MS Contin and instead substituted Patient 7 on fentanyl patches 50 mcg/hr, while maintaining his prescribing of oxycodone 15 mg TID. The Respondent did not document a clear indication for placing Patient 7 on fentanyl patches other than patient request.

43. The Respondent reduced Patient 7's fentanyl patch prescriptions during 2016 but continued her on her oxycodone regimen and other non-narcotic medications (pregabalin) until 2017. The Respondent also administered lumbar trigger point injections in 2016.

44. During the treatment interval, Patient 7 underwent toxicology screening that was positive for marijuana on at least three occasions (March 30, 2016; November 15, 2016; March 1, 2017), negative for prescribed opioids on two occasions (March 30, 2016; November 15, 2016) and positive for non-prescribed opioids on one occasion (March 1, 2017).

45. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to

Patient 7 for reasons including:

(a) on intake, the Respondent inappropriately placed Patient 7 on a high-dose regimen of opioid medications without verifying her prior opioid usage or ordering toxicology screening;
(b) the Respondent inappropriately placed Patient 7 on a high-dose opioid regimen without documenting or establishing significant physical findings for such prescribing. In 2015, the Respondent noted that Patient 7 experienced some pain relief due to injection therapy but continued Patient 7 on a high-dose opioid medication regimen;
(c) the Respondent inappropriately escalated Patient 7's opioid medication regimen without documented indication;
(d) the Respondent failed to address Patient 7's inconsistent toxicology findings but continued to maintain her on a high-dose opioid medication regimen, without an alteration in treatment;
(e) in April 2015, the Respondent changed Patient 7's MS Contin to fentanyl transdermal patch (50 mcg/hour) every three days, without an appropriate rationale, other than patient request;
(f) the Respondent failed to discuss Patient 7's history of depression with her or collaborate with a mental health professional;
(g) the Respondent's progress notes are inadequate in that in many of the record entries, the history of present illness, physical examination and assessment appear to be copied from previous record entries. In addition, some of the Respondent's record entries also appear to be copied from the records of other patients, because in some sections the BMI and descriptions of complaints do not match Patient 7; and
(h) the Respondent's medication lists for Patient 7 do not clearly indicate the opioid medications he prescribed for her.

Patient 8

46. The Respondent began providing medical care to Patient 8, a woman then in her 50s, in 2013. The Respondent continued providing medical care to Patient 8 until March 2017. Patient 8's medical history included morbid obesity, rheumatoid arthritis, osteoarthritis of the knee, hypertension, seizure disorder, panic disorder and depression.

Patient 8 was also under the care of other specialists including a rheumatologist, orthopedist and neurologist. Patient 8 signed a pain management agreement on intake.

47. During the treatment interval, the Respondent placed Patient 8 on a medication regimen that included diazepam[15] 10 mg BID, MS Contin 30 mg BID, oxycodone 10 mg QID and gabapentin 300 mg TID.

48. Patient 8 underwent toxicology screening and on numerous occasions in 2013, 2015, 2016 and 2017, tested positive for marijuana. The Respondent failed to address or follow up on these findings in his progress notes.

49. On or about February 10, 2017, Patient 8 also tested positive for buprenorphine. The Respondent did not prescribe this medication and failed to address or follow up with the patient and failed to enforce her existing pain management agreement.

50. The Respondent continued to maintain Patient 8 on a medication regimen that included morphine, oxycodone and diazepam, even after Patient 8 violated her pain management agreement on numerous occasions.

51. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or 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 inappropriately prescribed opioids and benzodiazepines in combination;
(b) the Respondent failed to address Patient 8's multiple inconsistent toxicology screening findings or institute management changes based on those findings; and

[15] Diazepam is a benzodiazepine and Schedule IV CDS.

(c) the Respondent's progress notes are inadequate in that many sections in his notes appear to be copied from prior visits. For example, the Respondent's physical examination findings are duplicative of the prior examinations of Patient 8 and the examinations of other patients. In other instances, the history of present illness for Patient 8 is repeated in each monthly visit for a year. The Respondent failed to adequately document how he determined his medical plan for Patient 8.

Patient 9

52. The Respondent began providing medical care to Patient 9, a woman then in her 60s, in March 2014. Patient 9 had a medical history that included diabetes, hypertension, depression and chronic low back pain, which radiated to both lower extremities. The Respondent had Patient 9 sign a pain management agreement on intake.

53. The Respondent initially placed Patient 9 on MS Contin 60 mg BID and oxycodone 10 mg, along with other non-opioid medications. In or around April 2014, the Respondent discontinued Patient 9's MS Contin and switched her to OxyContin 80 mg BID and oxycodone 10 mg TID. In 2015, the Respondent reduced Patient 9's OxyContin to 60 mg BID and continued her on oxycodone 10 mg TID until her last visit in May 2017.

54. The Respondent did not order baseline toxicology screening or obtain verification of prior opioid usage prior to placing Patient 9 on high-dose opioid therapy. The Respondent did not institute toxicology screening until almost three years after he initiated high-dose opioid prescribing. When the Respondent did initiate such screening, he failed to adequately document an interpretation of the results in his progress notes.

55. When the Respondent switched Patient 9 from MS Contin to OxyContin, he

failed to convert her to an equivalent dosage, resulting in Patient 9 receiving a significantly higher morphine milligram equivalent dosage.

56. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or 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 verify Patient 9's prior opioid usage or corroborate pathological findings on imaging studies prior to placing her on high-dose opioid treatment;
(b) the Respondent prescribed escalating dosages of opioid medications for Patient 9 without establishing appropriate objective findings or a clinical indication to support such prescribing;
(c) the Respondent failed to adequately monitor for abuse and addiction of opioids. The Respondent did not order toxicology screening for several years after initiating opioid therapy;
(d) the Respondent prescribed high-dose opioids for Patient 9 over a three-year period without adequate justification, clear clinical indication or without clear benefit or increased function;
(e) the Respondent failed to prescribe an equivalent dose to Patient 9 when he discontinued her MS Contin and substituted OxyContin. The Respondent significantly increased Patient 9's opioid intake without establishing a need for such prescribing. The Respondent did not correlate his increase in prescribing with a worsening of symptoms or progression of disease;
(f) the Respondent failed to follow up on Patient 9's mental health issues. Although Patient 9 had a history of depression, the Respondent failed to follow-up with a mental health consultation;
(g) the Respondent's progress notes are inadequate in that many sections of his clinic notes appear to duplicate findings noted in prior visits. The Respondent failed for over a three-year period to update the monthly documented physical examination findings, chief complaint, history of illness, and

review of systems, which remained the same for over a three-year period. The Respondent failed to update Patient 9's age in his progress notes during the three years he treated her; and

(h) the Respondent failed to adequately update the medication list and/or medication changes.

Patient 10

57. The Respondent began providing general medical and chronic pain care to Patient 10, a woman then in her 20s, in or around November 2013. Patient 10's medical history included carpal tunnel syndrome, hypertension, asthma and chronic low back pain. On November 18, 2013, the Respondent prescribed non-narcotic medications and tramadol.[16]

58. On December 2, 2013, the Respondent discontinued Patient 10's tramadol and substituted hydrocodone[17] 5 mg TID. On January 28, 2014, the Respondent started Patient 10 on methadone 5 mg once per day without an appropriate indication or confirmatory physical examination findings. In March 2014, the Respondent added tramadol to Patient 10's existing regimen of methadone and hydrocodone. In June 2014, Patient 10 had a positive throat culture, whereupon she was also prescribed cough medicine containing codeine. On February 12, 2015, the Respondent discontinued Patient 10's methadone (which had been increased to BID), reportedly after Patient 10 complained of vomiting, and substituted her on oxycodone 5 mg and tramadol 50 mg TID.

59. The Respondent also intermittently administered trigger point injections

[16] Tramadol is an opioid pain medication and Schedule IV CDS.
[17] Hydrocodone is an opioid pain medication and Schedule II CDS.

and ankle injections for Patient 10 from 2014 to 2016. The Respondent continued to prescribe oxycodone to Patient 10 until her last visit on December 13, 2016. Patient 10 underwent toxicology screening and tested positive for cocaine on July 13, 2016, and in November and December of 2016, tested negative for opioids.

60. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or 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 initially placed Patient 10 on an opioid medication, hydrocodone, without appropriate objective findings;
(b) the Respondent continued Patient 10 on opioid therapy for many months for pain complaints of unknown etiology, even after the Respondent noted that there were no abnormalities according to diagnostic studies (MRI);
(c) the Respondent prescribed opioids for Patient 10 without physical findings that justified prescribing opioids;
(d) the Respondent failed to appropriately address Patient 10's positive toxicology finding in July 2016 for cocaine, after which he continued to prescribe opioid medications without tapering or an alteration in treatment;
(e) the Respondent treated Patient 10 for depression but failed to refer her for a mental health consult and continued to prescribe opioids; and
(f) the Respondent failed to keep adequate medical records. Many sections of the Respondent's progress notes, including the chief complaint, history of present illness, review of systems, and physical examinations appear to be copied from previous entries.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that 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).

ORDER

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

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

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **TWO (2) YEARS**.[18] During probation, the Respondent shall comply with the following terms and conditions of probation:

1. Within **SIX (6) MONTHS,** the Respondent is required to take and successfully complete two (2) courses. The first course will address the appropriate prescribing of CDS and the second course will address appropriate record keeping. The following terms apply:

    (a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the courses are started;

    (b) the disciplinary panel will not accept courses taken over the internet;

    (c) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

    (d) the courses may not be used to fulfill the continuing medical education credits required for license renewal;

    (e) the Respondent is responsible for the cost of the courses;

2. For the full duration of probation, the Respondent is prohibited from certifying a patient for the medical use of cannabis;

3. During the **first year** of probation:

    (a) the Respondent is prohibited from prescribing and dispensing all opioids, benzodiazepines, and stimulants;

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

(b) in emergency cases, the Respondent may issue no more than one prescription for a CDS listed above for each patient per year, 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 under the authority of this paragraph;

(c) the Respondent is prohibited from delegating to a Physician Assistant the prescribing or dispensing of the categories of CDS limited by this Order;

4. During the **second year** of probation:

(a) after the Respondent has successfully completed the panel-approved courses in appropriate CDS prescribing and medical record keeping and the panel has approved a supervisor, the Respondent may resume prescribing and dispensing of opioids, benzodiazepines, and stimulants;

(b) the Respondent's prescriptions for any opioid, benzodiazepine, or stimulant may not exceed 50 MME;

(b) the Respondent shall be subject to supervision by a disciplinary panel-approved supervisor who is board-certified in pain medicine as follows:

(i) prior to the end of the first year of probation, the Respondent shall provide the disciplinary panel with the name, pertinent professional background information of the supervisor whom the Respondent is offering for approval, and written notice to the disciplinary panel from the supervisor confirming his or her acceptance of the supervisory role of the Respondent and that there is no personal or professional relationship with the supervisor;

(ii) the Respondent's proposed supervisor, to the best of the Respondent's knowledge, should not be an individual who is currently under investigation, and has not been disciplined by the Board within the past five years;

(iii) if the Respondent fails to provide a proposed supervisor's name, the Respondent may not resume prescribing or dispensing of CDS until a supervisor is approved by the disciplinary panel;

(iv) the disciplinary panel, in its discretion, may accept the proposed supervisor or request that the Respondent submit a name and professional background, and written notice of confirmation from a different supervisor;

(v) the supervision begins after the disciplinary panel approves the proposed supervisor;

(vi) the disciplinary panel will provide the supervisor with a copy of this Consent Order and any other documents the disciplinary panel deems relevant;

(vii) the Respondent shall grant the supervisor access to patient records selected by the supervisor, which shall, to the extent practicable, focus on the type of treatment at issue in the Respondent's charges;

(viii) if the supervisor for any reason ceases to provide supervision, the Respondent shall immediately notify the Board and shall not practice medicine beyond the 30th day after the supervisor has ceased to provide supervision and until the Respondent has submitted the name and professional background, and written notice of confirmation, from a proposed replacement supervisor to the disciplinary panel;

(ix) it shall be the Respondent's responsibility to ensure that the supervisor:

(1) reviews the records of 10 patients each month, such patient records to be chosen by the supervisor and not the Respondent;

(2) meets in-person with the Respondent at least once each month and discuss in-person with the Respondent the care the Respondent has provided for these specific patients;

(3) be available to the Respondent for consultations on any patient;

(4) maintains the confidentiality of all medical records and patient information;

(5) provides the Board with quarterly reports which detail the quality of the Respondent's practice, any deficiencies, concerns, or needed improvements, as well as any measures that have been taken to improve patient care; and

(6) immediately reports to the Board any indication that the Respondent may pose a substantial risk to patients.

(x) if the disciplinary panel, upon consideration of the supervisory reports and the Respondent's response, if any, has a reasonable basis to believe that the Respondent is not meeting the standard of quality care or is failing to keep adequate medical records in his or her practice, the disciplinary panel may find a violation of probation after a hearing.

5. 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; 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 to the Board 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 the Respondent has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

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

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If the Panel determines 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 the Panel determines 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 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 with appropriate terms and conditions, 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 Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; 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. 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 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).

09/03/2019
Date

Signature on File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

CONSENT

I, Ebenezer K. Quainoo, 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

8/27/19
Date

Ebenezer K. Quainoo, M.D.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 27 day of August 2019, before me, a Notary Public of the foregoing State and City/County, personally appeared Ebenezer K. Quainoo, 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.

RAFAEL PUENTES CERVANTES
NOTARY PUBLIC
BALTIMORE COUNTY
MARYLAND
My Commission Expires 03-05-2023

Notary Public

My Commission expires: 03/05/23