IN THE MATTER OF	*	**BEFORE THE**
IQBAL SINGH, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D65494	*	**Case Number: 2220-0247**

* * * * * * * * * * * * *

FINAL DECISION AND ORDER

Iqbal Singh, M.D., was originally licensed by the Maryland State Board of Physicians (the "Board") to practice medicine in Maryland in 2007 and his license is active through September 30, 2023. On June 28, 2021, Board Disciplinary Panel A issued a Cease-and-Desist Order to Dr. Singh, ordering him to immediately stop prescribing controlled dangerous substances (CDS). On June 29, 2021, Panel A charged Dr. Singh with failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in the outpatient surgical facility, office, hospital, or any other location in Maryland (the "standard of care"), in violation of Md. Code Ann. Health Occ. § 14-404(a)(22); and failing to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40).

On January 11 and 12, 2022, pursuant to Health Occ. § 14-405(a), an evidentiary hearing was held at the Office of Administrative Hearings. The State presented testimony from a physician who was admitted as an expert in pain management, and Dr. Singh appeared and testified on his own behalf and was admitted as an expert in neurology and pain management. The Administrative Law Judge ("ALJ") admitted 17 joint exhibits.

On April 8, 2022, the ALJ issued a proposed decision, concluding that Dr. Singh violated the standard of care and failed to keep adequate medical records, *see* Health Occ. § 14-404(a)(22) and (40). The ALJ found that Dr. Singh breached the standard of care and failed to keep adequate medical records because, among other things, (1) his records lacked careful

justification for the high dosage opioids he prescribed; (2) he failed to obtain sufficient outside medical records and supporting information for continued opioid therapy; (3) his records failed to record that he checked the Prescription Drug Monitoring Program (PDMP); (4) he failed to document that he provided patients with sufficient details regarding risk of abuse or misuse of opioids such as a risk-benefit assessment; (5) his records lacked any information about a patient's inconsistent drug screen or how the inconsistent drug screen impacted care and failed to document or discuss inconsistent screens, assessments, or any changes in prescribing behavior that occurred as a result of the inconsistencies; and (6) his records lacked information about whether he discussed alternative therapy.

The ALJ proposed that Dr. Singh be placed on three years of supervised probation and required to complete a twenty-hour course on abiding by appropriate standards of care in medical record keeping and opioid prescribing and proposed that the June 28, 2021 Cease and Desist Order be vacated after the course has been completed.

Neither Dr. Singh nor the State filed exceptions to the ALJ's proposed decision.

FINDINGS OF FACT

Board Disciplinary Panel B ("Panel B") adopts the ALJ's Proposed Findings of Fact (numbered 1-310, ALJ's Proposed Decision at pages 5-55), which are incorporated by reference into this Final Decision and Order as if set forth in full. The Panel further adopts the Discussion section of the ALJ's Proposed Decision. ALJ Proposed Decision at pages 56-83. The ALJ's proposed decision is attached as **Exhibit 1.** The factual findings were proven by the preponderance of evidence.

CONCLUSIONS OF LAW

Based on the undisputed findings of fact, Panel B concludes that Dr. Singh violated the standard of care, in violation of Md. Code Ann. Health Occ. § 14-404(a)(22); and failed to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40).

SANCTION

The ALJ recommended that Dr. Singh be placed on three years of supervised probation and take a course in recordkeeping and opioid prescribing. The ALJ also recommended that the Cease and Desist Order be terminated because the prohibition on prescribing CDS would no longer be necessary after Dr. Singh completed the required instruction and supervision. Panel B adopts the ALJ's recommendations of a three-year probation and completion of a course in recordkeeping by Dr. Singh. Panel B agrees that the Cease and Desist Order may be lifted after the coursework is completed and the supervision is in place. Panel B will modify the ALJ's proposed order to add a reprimand, change the course from opioid prescribing to CDS prescribing, and require supervision until Dr. Singh receives four satisfactory quarterly reports.

ORDER

It is, by an affirmative vote of a majority of a quorum of Disciplinary Panel B, hereby

ORDERED that Iqbal Singh, M.D. is **REPRIMANDED**; and it is further

ORDERED that Iqbal Singh, M.D. is placed on **PROBATION** for a minimum period of **THREE (3) YEARS.**[1] During probation, Dr. Singh shall comply with the following terms and conditions of probation:

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

(1) Within **SIX (6) MONTHS**, Dr. Singh is required to take and successfully complete **TWO COURSES: (1) CDS PRESCRIBING and (2) MEDICAL RECORDKEEPING**. The following terms apply:

(a) It is Dr. Singh's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the courses are begun;

(b) Dr. Singh must provide documentation to the disciplinary panel that Dr. Singh has successfully completed the courses;

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

(d) Dr. Singh is responsible for the cost of the courses;

(2) **SUPERVISION:** Upon completion of the courses, Dr. Singh shall be subject to supervision for CDS prescribing and recordkeeping[2] by a disciplinary panel-approved supervisor who is board-certified in the area of Dr. Singh's practice, as follows:

(a) Dr. Singh shall provide the disciplinary panel with the name, pertinent professional background information of the supervisor whom Dr. Singh is offering for approval, and written notice to the disciplinary panel from the supervisor confirming his or her acceptance of the supervisory role of Dr. Singh, and that there is no personal or professional relationship with the supervisor;

(b) Dr. Singh's proposed supervisor, to the best of Dr. Singh'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;

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

(d) upon completion of the required courses and upon the disciplinary panel's approval of the proposed supervisor, the June 28, 2021 Cease and Desist Order shall be **TERMINATED;**

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

[2] If Dr. Singh is not practicing medicine, the supervision shall begin when Dr. Singh resumes the practice of medicine and the disciplinary panel has approved the proposed supervisor. Dr. Singh shall submit the name of a proposed supervisor within 30 days of resuming the practice of medicine and shall be subject to supervision by a disciplinary panel approved supervisor upon the return to the practice of medicine.

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

(g) Dr. Singh shall grant the supervisor access to patient records selected by the supervisor from a list of all patients, which shall, to the extent practicable, focus on the type of treatment at issue in Dr. Singh's charges;

(h) if the supervisor for any reason ceases to provide supervision, Dr. Singh shall immediately notify the Board and shall not prescribe CDS beyond the 30th day after the supervisor has ceased to provide supervision and until Dr. Singh has submitted the name and professional background of a proposed replacement supervisor to the disciplinary panel;

(i) it shall be Dr. Singh's responsibility to ensure that the supervisor:

(1) reviews the records of **TEN (10) patients** each month, such patient records to be chosen by the supervisor and not Dr. Singh;

(2) meets in-person with Dr. Singh at least **ONCE EACH MONTH** to discuss in-person with Dr. Singh the care Dr. Singh has provided for these specific patients;

(3) be available to Dr. Singh 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 Dr. Singh'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 Dr. Singh may pose a substantial risk to patients;

(j) Dr. Singh shall follow any recommendations of the supervisor;

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

(l) upon receipt of four satisfactory quarterly reports, the supervision provision will be deemed completed;

(3) The disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for Dr. Singh's Controlled Dangerous Substances ("CDS") prescriptions. The administrative subpoenas will request the Respondent's CDS prescriptions from the beginning of each quarter; and it is further

ORDERED that Dr. Singh shall not apply for early termination of probation; and it is further

ORDERED that, after Dr. Singh has complied with all terms and conditions of probation and the minimum period of probation imposed by the Final Decision and Order has passed, Dr. Singh 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. Dr. Singh 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 Dr. Singh has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

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

ORDERED that Dr. Singh is responsible for all costs incurred in fulfilling the terms and conditions of this Final Decision and Order; and it is further

ORDERED that, if Dr. Singh allegedly fails to comply with any term or condition imposed by this Final Decision and Order, Dr. Singh shall be given notice and an opportunity for a hearing. If the disciplinary 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 disciplinary panel determines there is no genuine dispute as to a material fact, Dr. Singh 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 Dr. Singh has failed to comply with any term or condition imposed by this Final Decision and Order, the disciplinary panel may reprimand Dr. Singh, place Dr. Singh on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke Dr. Singh'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 Dr. Singh; and it is further

ORDERED that this Final Decision and Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

08/01/2022
Date

Signature On File

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408, Dr. Singh has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within 30 days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Singh files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Executive Director
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

David S. Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201
David.Finkler@maryland.gov

Exhibit 1

MARYLAND STATE	*	**BEFORE ABENA Y. WILLIAMS,**
BOARD OF PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
IQBAL SINGH, M.D.,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	
LICENSE No.: D65494	*	**OAH No.: MDH-MBP2-71-21-20966**

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
STIPULATIONS OF FACT
PROPOSED FINDINGS OF FACT
DISCUSSION
PROPOSED CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On June 29, 2021, the Maryland State Board of Physicians issued charges (Charges) against Iqbal Singh, M.D. (Respondent) alleging violations of the State law governing the practice of medicine, the Maryland Medical Practice Act (Act). Md. Code Ann., Health Occ. §§ 14-101 through 14-508, and 14-601 through 14-607 (2021).[1] The Respondent is charged with violating two provisions in section 14-404 of the Act. Specifically, the Respondent is charged with the following:

- **Standard of Care**: Failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care

[1] Unless otherwise note, all references to hereinafter to the Health Occupations Article cite the 2021 Replacement Volume of the Maryland Annotated Code.

performed in an outpatient surgical facility, office, hospital, or any other location in Maryland; and

- **Medical Record Keeping**: Failing to keep adequate medical records as determined by appropriate peer review.

Health Occ. § 14-404(a)(22) and (40); Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d).

The disciplinary panel to which the complaint was assigned forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) to issue proposed findings of fact, proposed conclusions of law, and a proposed disposition. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

I held a hearing on January 11 and 12, 2022, from the OAH via Webex, a video conferencing platform. Health Occ. § 14-405(a) (2021); COMAR 10.32.02.04; COMAR 28.02.01.20B(1)(b). Gregory Lockwood, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State). Thomas Whiteford, Esquire, represented the Respondent, who was present.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings before the Board, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2021); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent violate the cited provisions of the Act? If so,
2. What sanctions are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following joint exhibits into evidence on behalf of the State and the Respondent:

Ex. 1 - OCSA referral with attachments
Ex. 2 - Respondent's written response
Ex. 3 - Respondent's interview transcript
Ex. 4 - Prescription Drug Monitoring Program (PDMP) Report, November 7, 2018
Ex. 5 - Medical Records for Patients (AC, BC, SB, CU, CM, PF, JA, KK, SL, TP)
Ex. 5(a)- *Medical Record re: Patient AC*
Ex. 5(a)(i) – Respondent's Summary of Care
Ex. 5(a)(ii) – Certification of Medical Records Form
Ex. 5(a)(iii) – Medical record provided by Respondent, January 17, 2020
Ex. 5(a)(iv) – Additional medical record provided by Respondent, August 11, 2020
Ex. 5(b) – *Medical Record re: Patient BC*
Ex. 5(b)(i) – Respondent's Summary of Care
Ex. 5(b)(ii) – Certification of Medical Records Form
Ex. 5(b)(iii) – Medical record provided by Respondent, January 17, 2020
Ex. 5(b)(iv) – Additional medical record provided by Respondent, August 11, 2020
Ex. 5(c) - *Medical Record re: Patient SB*
Ex. 5(c)(i) – Respondent's Summary of Care
Ex. 5(c)(ii) – Certification of Medical Records Form
Ex. 5(c)(iii) – Medical record provided by Respondent, August 11, 2020
Ex. 5(d) - *Medical Record re: Patient CU*
Ex. 5(d)(i) – Respondent's Summary of Care
Ex. 5(d)(ii) – Certification of Medical Records Form
Ex. 5(d)(iii) – Medical record provided by Respondent, January 17, 2020
Ex. 5(d)(iv) – Additional medical record provided by Respondent, August 10, 2020
Ex. 5(e) - *Medical Record re: Patient CM*
Ex. 5(e)(i) – Respondent's Summary of Care
Ex. 5(e)(ii) – Certification of Medical Records Form
Ex. 5(e)(iii) – Medical record provided by Respondent, January 17, 2020
Ex. 5(e)(iv) – Additional medical record provided by Respondent, August 17, 2020
Ex. 5(f) - *Medical Record re: Patient PF*
Ex. 5(f)(i) – Respondent's Summary of Care
Ex. 5(f)(ii) – Certification of Medical Records Form
Ex. 5(f)(iii) – Medical record provided by Respondent, January 17, 2020
Ex. 5(f)(iv) – Additional medical record provided by Respondent, August 17, 2020

Ex. 5(g) - *Medical Record re: Patient JA*
Ex. 5(g)(i) – Respondent's Summary of Care, August 17, 2020
Ex. 5(g)(ii) – Certification of Medical Records Form
Ex. 5(g)(iii) – Medical record provided by Respondent, June 4, 2020
Ex. 5(g)(iv) – Additional medical record provided by Respondent, October 9, 2020
Ex. 5(h) - *Medical Record re: Patient KK*
Ex. 5(h)(i) – Respondent's Summary of Care
Ex. 5(h)(ii) – Certification of Medical Records Form
Ex. 5(h)(iii) – Medical record provided by Respondent, June 1, 2020
Ex. 5(h)(iv) – Additional medical record provided by Respondent, August 11, 2020
Ex. 5(i) - *Medical Record re: Patient SL*
Ex. 5(i)(i) – Respondent's Summary of Care
Ex. 5(i)(ii) – Certification of Medical Records Form
Ex. 5(i)(iii) – Medical record provided by Respondent, June 3, 2020
Ex. 5(i)(iv) – Additional medical record provided by Respondent, October 9, 2020
Ex. 5(j) - *Medical Record re: Patient TP*
Ex. 5(j)(i) – Respondent's Summary of Care
Ex. 5(j)(ii) – Certification of Medical Records Form
Ex. 5(j)(iii) – Medical record provided by Respondent, June 4, 2020
Ex. 5(j)(iv) – Additional medical record provided by Respondent, July 28, 2020
Ex. 6 - Maryland Board of Physicians (Board) Report of Investigation
Ex. 7 - Initial correspondence letter to Respondent with Information Form and ten (10) Certification of Medical Records Forms
Ex. 8 - Certificate from Diplomate of the American Board of Pain Medicine
Ex. 9 - Peer Review Report of [redacted] M.D.
Ex. 10 - Addendum received from [redacted] M.D.
Ex. 11 - Curriculum Vitae of [redacted] M.D.
Ex. 12 - Peer Review Report of [redacted] M.D.
Ex. 13 - Curriculum Vitae of [redacted] M.D.
Ex. 14 - Email correspondence from Respondent, January 3, 2021 with attachment: CDC Advises Against Misapplication of the Guideline for Prescribing Opioids for Chronic Pain, Media Statement, April 24, 2019
Ex. 15 - Supplemental response received from Respondent
Ex. 16 - Cease and Desist Order
Ex. 17 - Charges Under the Maryland Medical Practice Act

Testimony

The Board presented the testimony of [redacted] M.D., who was admitted as an expert in pain management; standards of care as they relate to the prescribing of pain medication, including controlled dangerous substances; pain management practice; and the standards of adequate medical documentation.

The Respondent testified on his own behalf and was admitted as an expert in neurology and pain management.[2]

PROPOSED FINDINGS OF FACT

I find the following facts by a preponderance of the evidence:

Background

1. At all times relevant to the Charges,[3] the Respondent was licensed to practice medicine in the State of Maryland. The Respondent became licensed to practice medicine in Maryland on January 10, 2007, under license number D65494. The Respondent's license expired on September 30, 2021.

2. While in medical school, the Respondent received some training in pain management.

3. The Respondent became licensed to practice neurological medicine in North Carolina in North Carolina in June 2002 and practiced with a group of solo practitioners in North Carolina until 2007.

4. The Respondent was Board certified in Neurology and Vascular Neurology, both certifications expired on March 1, 2021.

5. After becoming licensed to practice medicine in Maryland on January 10, 2007, the Respondent joined a neurology practice in Columbia, Maryland.

6. On November 30, 2011, the Respondent joined Dr. [redacted] at [redacted] [redacted], a pain management and neurology practice located in Glen Burnie, Maryland. While there, the Respondent received "on-the-job" pain management training.

[2] The State objected to the Respondent being admitted as an expert in pain management.
[3] The Charges are identified below.

7. In addition to the on-the-job training he received from Dr. [redacted], the Respondent took continuing medical education courses (CME) in pain management.

8. On April 12, 2013, the Respondent obtained certification from the American Board of Pain Medicine. The certification expires April 12, 2023.

9. The Respondent ultimately purchased [redacted] on a date uncertain from Dr. [redacted] and at the time of the events giving rise to the Charges, he operated as a sole practitioner in neurology and pain management and had hospital privileges at [redacted] and [redacted].

10. Following a referral from the Maryland Office of Controlled Substances Administration (OCSA) tip line alleging that the Respondent's controlled drug prescribing habits indicated a pattern excessive dosages and dangerous drug combinations for six patients in September of 2019,[4] Board staff commenced an investigation on a date uncertain in September 2019.

11. On July 14, 2020, a Board compliance analyst interviewed the Respondent and subpoenaed the six patient medical records identified in the OCSA referral along with four other patient medical records selected from a PDMP report for patients who were prescribed CDS by the Respondent from approximately January 1, 2019 to January 15, 2020. The Respondent also provided the Board with summaries of care for each patient.

12. Between June 1, 2020 and October 9, 2020, the Respondent transmitted the medical records and case summaries of Patients AC, BC, SB, CU, CM, PF, JA, KK, SL, and TP.

13. On November 12, 2020, the Board sent the cases to be peer-reviewed by practitioners who are board certified in pain management.

[4] A woman contacted the tip line and left a voice mail alleging that the Respondent prescribed pain medication to a family member that already overdosed and was ultimately listed as an overdose death on the medical examiner's report included with the OCSA referral. (Exhibit 1, pp. 1-2).

14. On December 22, 2020, the Board received peer review reports from Doctors [redacted] and [redacted] The reviewers opined that in ten out of ten cases, the Respondent failed to deliver appropriate standards of care and failed to maintain adequate medical records.

15. On December 28, 2020, the peer review reports were provided to the Respondent and the Board requested that the Respondent provide a Supplemental Board Response to them.

16. In response to Dr. [redacted]'s concerns regarding the Respondent's CDS prescribing practices, the Board staff asked that he opine regarding the safety of the Respondent continuing to prescribe CDS during the complaint resolution process.

17. On January 4, 2021, Dr. [redacted] submitted an addendum to his report in which he opined there were enough concerns to warrant a temporary suspension of the Respondent's privilege to prescribe CDS.

18. On January 13, 2021, the Board received the Respondent's Supplemental Board Response.

19. Following the referral and investigation, on or about June 28, 2021, the Board issued a Cease and Desist Order to the Respondent ordering him to immediately stop prescribing controlled dangerous substances.

20. On June 29, 2021, the State issued Charges against the Respondent for violations of the Act and specifically failing to meet appropriate standards of care and failing to maintain adequate records.

21. The Respondent has not previously been disciplined by the Board and there are no reported incidents of patients being harmed as a result of his care.

Standard of Care

22. The standard of care or treatment of patients suffering from chronic pain with opioids includes:

    a. The physician taking a history and physical examination at each patient visit which includes reviews of imaging or laboratory results as needed.

    b. If the patient is taking controlled substances, the physician should follow the patient with face-to-face visits every one to three months depending on the risk of abuse or misuse.

    c. During such follow-up visits, the physician should assess patients taking opioids for:

        i. Risk of abuse/misuse (i.e., Current Opioid Misuse Measure (COMM))

        ii. Functional impact of chronic pain (i.e., Pain Disability Index (PDI) and/or impact of opioid on function/quality of life (i.e., pain score))

        iii. Compliance (i.e., Chesapeake Regional Information System for our Patients (CRISP), Urine Drug Screen (UDS), or similar laboratory testing every three to six months depending on risk of abuse/misuse)

        iv. Need to decrease or wean off opioids if possible

        v. Need for alternative therapy (i.e., physical therapy, adjunct medications, etc.)

    d. Patients taking opioids must sign an Opioid agreement.

    e. The physician must have a willingness to discharge patients from the practice for non-compliance.

    f. The physician must provide careful justification for prescribing high doses of opioids.

g. Pain management providers are required to provide careful justification for opioid dosages greater than 150 MME.[5]

h. Inadequate record keeping is a breach of the standard of care.

The Ten Patients at Issue

Patient AC

23. Patient AC was fifty-three years old in 2018. Patient AC's medical history included renal insufficiency, coronary artery disease, hypertension, hyperlipidemia, and thyroid disease.

24. On or around February 27, 2018, the day of the initial visit, the Respondent dictated his consultation notes. He noted AC was previously treated by a provider at [redacted].

25. The Patient signed a pain management agreement.

26. On February 27, 2018, the Respondent dictated that Patient AC has a complex medical history of chronic pain in multiple joints, severe low back pain, fibromyalgia, migraines, neck pain, bilateral hip pain, bilateral knee pain, peripheral neuropathy, common migraines, bipolar disorder I, and anxiety.

27. On the same day, the Respondent noted that while at [redacted], she was prescribed a combination of fentanyl patch, oxycodone, benzodiazepine, and carisoprodol. AC was in the process of having her medications weaned when she transitioned from [redacted] to the Respondent's care and her regimen was over 90 MME.

28. The Respondent dictated his observations of Patient AC's subjective reports, her current medications, surgical history, family history, past medical history, social history, and

[5] Morphine Milligram Equivalents (MME) is a conversion tool that is used to provide a basis for understanding the value of an opioid. Medical societies have decided that all opioids should be converted to morphine equivalents for a clear understanding of how strong or how much medication is being prescribed.

systems including her mental status, cranial nerves, motor skills, reflexes, senses, and gait. Based on his observations, the Respondent dictated that AC had pain issues due to neck pain, low back pain, degenerative disease in the lumbar and cervical spine, fibromyalgia, common migraines, bipolar disorder I, anxiety, and peripheral neuropathy.

29. In his treatment plan the Respondent prescribed the following medications: Zanaflex, 4 mg three times a day for spasms, migraine prevention, and fibromyalgia; he increased Imitrex to 100 mg at onset of migraines; and increased Cymbalta to 90 mg daily for fibromyalgia, migraine prevention, and peripheral neuropathy pain. He also noted that she needed MRIs of both hips, both knees and cervical spine and to "come back in four weeks' time" and in "four weeks' time, we take over her pain management."[6]

30. The Respondent did not give AC opioids at her initial visit.

31. On March 27, 2018, the Respondent added oxycodone 15 mg, four times daily; carisoprodol 350 mg, three times daily; and fentanyl patch 50 mg, up to four every seventy-two hours. The total opioid dose of the oxycodone combined with the fentanyl patch calculates to 210 MME to 330 MME daily.

32. On or around May 22, 2018, the Respondent noted that the MRIs that he ordered for Patient AC were denied by the insurance company. The Respondent then ordered X-rays of the patient's hips, both knees, cervical, and lumbar spine. From April 2018 to September 2019, AC received monthly prescriptions and saw the Respondent monthly.

33. AC was listed on the dispensing report for [redacted]

[6] Jt. Ex. 5(a), pp. IS0169-IS0170.

34. The Respondent gave AC a monthly UDS and her usual pain medications were refilled which included the fentanyl patch, oxycodone, Soma,[7] Lyrica, Cymbalta, and Zanaflex. The fentanyl patch was initially started at 50 mcg every seventy-two hours then increased to 75 mcg.

35. On July 16, 2018, the Respondent reported that AC complained of "more pain" and he increased her fentanyl patch to 75 mcg.[8]

36. On September 13, 2018, the Respondent reported that AC was "doing better" with the increased fentanyl dosage.[9]

37. On October 11, 2018, the Respondent noted that AC reported that she "cannot sleep at night because of pain...migraines are coming back."[10] The Respondent then added doxepin 50 mg, for sleep and migraines.

38. On November 8, 2018, the Respondent noted that AC reported she was sleeping better on doxepin 50 mg, and it helped her migraines.

39. On November 28, 2018, the Respondent noted, "worsening weakness and numbness of the whole left leg...could be a disc herniation of the lower back" and ordered, "get MRIs done, especially the lumbar spine is the most important."[11]

40. The Respondent's notes for Patient AC from November 18, 2018 to October 10, 2019, are virtually identical and no changes were made to her medications during that time.

[7] The brand name for carisoprodol is Soma.
[8] Jt. Ex. 5(a), pp. IS0127-IS128.
[9] Jt. Ex. 5(a), pp. IS0157-IS158.
[10] Jt. Ex. 5(a), pp. IS0155-IS156.
[11] Jt. Ex. 5(a), pp. IS0153-IS154.

41. On October 10, 2019, the Respondent noted that AC reported that her left foot was swelling, however, no further changes were made to her medications at the time until January 2, 2020.

42. On January 2, 2020, the Respondent added Klonopin 2 mg, two times daily to Patient AC's medication regimen, for which no justification was provided in his report.[12]

43. On February 27, 2020, the Respondent noted that he warned AC about taking Xanax when "I am prescribing her Klonopin."[13]

44. On May 5, 2020, the Respondent noted the patient had a prior MRI of the lumbar spine in 2017, which showed degeneration throughout the lumbar spine but that since then she has had no imaging. The Respondent noted that he has not "had much success because it has been denied by insurance company, [redacted]"[14]

45. In his last note dated May 5, 2020, the Respondent noted that when the patient first came to see him, he told her, "He did not usually use fentanyl, it is a very strong narcotic…I only used it because she had been on it before…my go to long-acting narcotic is morphine ER but since she had been on fentanyl, I continued the fentanyl."[15]

46. The patient remained compliant with the Respondent's treatment plan while under his care.

47. The patient's medication regimen included a combination of opioids, benzodiazepines, and Soma, which can be dangerous.

48. The Respondent met the standard of care when he had monthly face-to-face visits with AC and had her sign an opioid agreement.

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[12] In a later note dated May 5, 2020, the Respondent noted that the patient's psychiatrist prescribed her Klonopin 2 mg three times a day for bipolar disorder I. Jt. Ex. 5(a), pp. 102-103.
[13] Jt. Ex. 5(a), pp. IS0107-IS108.
[14] Jt. Ex. 5(a), pp. IS0102-IS103.
[15] Jt. Ex. 5(a), pp. IS0102-IS103.

49. The Respondent breached the standard of care by failing to provide sufficient justification for prescribing high doses of opioids to patient AC, failing to obtain sufficient outside medical records[16] and supporting information for continued opioid therapy, failing to indicate whether he discussed alternative therapies with AC, failing to document AC's PDMP review, and failing to document risk-benefit assessments that were completed with AC.

Patient BC

50. Patient BC was fifty years old in 2018. He is the spouse of patient AC, lived at the same address of AC, and was listed on the dispensing report for [redacted].

51. At the time of his first visit to the Respondent's office, the patient was on 90 MME of opioids including oxycodone 15 mg four times per day and his pain was not controlled.

52. On October 17, 2017, Dr. [redacted] treated BC for radiculopathy of the lumbar region with a lumbar epidural steroid shot. He also noted that BC had primary osteoarthritis of both knees, fibromyalgia, low back pain, low back pain, other chronic pain, and long-term current use of opiate analgesic.

53. On November 30, 2017, Dr. Quainoo dictated the following impressions: L4 and L5 decompressive laminectomies with transpedicular screws L4 to S1; complete chronic ankylosis L5-S1 level stable; mild new L1-2 central canal stenosis stable; small new left paracentral left lateral recess disk protrusion L1-L2. He noted that BC's back was tender to palpation over lumbar sacral region, lumbar tenderness, thoracic tenderness, and cervical tenderness.

[16] Outside medical records are records generated from providers outside of the pain management provider's care.

54. Patient BC initially visited the Respondent on February 27, 2018 and signed a pain management contract. He reported worsening low back pain and sciatica down both legs with numbing of feet, burning of feet, severe bilateral knee pain, minimal neck pain, calves going numb, and migraines three to four times a month for which he took Imitrex 100 mg.

55. Patient BC had a clinical and surgical history of low back pain with bilateral lower extremity radiculopathy, two lumbar spinal fusions, right knee surgery, gallbladder surgery, failed back surgery, and left knee surgery. The Respondent included Dr. [redacted]'s results in the patient's notes.

56. At the time he came to the Respondent for treatment, he was taking the following medications: oxycodone 15 mg, four times daily; Reglan 5 mg, two times daily; Soma 350 mg, three times daily; Imitrex 100 mg, two times daily; dicyclomine 10 mg, three times daily; omeprazole 40 mg, twice daily; and metoclopramide 5 mg, twice daily.

57. In his patient summary notes, the Respondent dictated that Patient BC was not on any long-acting narcotic at the time. During his initial visit, the Respondent noted the following impressions: chronic low back pain, minimal neck pain, bilateral severe knee pain, common migraines.

58. In his case summary notes, the Respondent noted the following treatment plan: Neurontin 600 mg at bedtime for neuropathic pain and migraine prevention; Imitrex 100 mg two times a day for migraines, one at onset the other one hour into the migraine, maximum of 200 mg a day; oxycodone 15 mg, four times daily; Soma 350 mg, three times daily; fentanyl packs 50 mcg, every 72 hours for pain; MRI both knees; and referral to neurosurgery for low back problems.

59. On March 27, 2018, the Respondent stopped prescribing Neurontin because BC "could not tolerate it."[17]

60. On April 24, 2018, the Respondent dictated, "BC comes to see me for low back pain…he wants to increase his fentanyl to 75 mcg, I said fine" and on the same day the Respondent added 75 mcg of fentanyl to BC's medication regimen.[18]

61. On August 16, 2018, the Respondent dictated "the doxepin[19] 50 mg [every four hours] was too strong for him for sleep…he emptied the capsule in half and took 25 mg [every four hours]. The note did not have a discussion of why doxepin was prescribed. He further noted that he "cut down [BC's] doxepin to 25 mg every four hours."[20]

62. On September 13, 2018, the Respondent increased BC's doxepin to 50 mg every four hours. Specifically, he noted "cutting down the dose of doxepin to 25 mg [every four hours] has stopped working…[h]e does not sleep on it…he wants to go back to 50 mg every four hours."[21]

63. On October 11, 2018, the Respondent prescribed Protonix 40 mg daily and noted "I am not sure he is taking the omeprazole" without elaboration.[22]

64. On November 8, 2018, the Respondent prescribed 10 mg of Sonata every four hours for "sleep initiation" and dictated that BC reported "the doxepin helps him maintain sleep but does not help him fall asleep…he lies in bed for two to three hours."[23]

65. On November 28, 2018, the Respondent dictated that BC reported that the Sonata that was added at his last visit made a difference and "he can fall asleep now."[24]

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[17] Jt. Ex. 5(b), pp. IS0294-IS295.
[18] Jt. Ex. 5(b), pp. IS0292-IS293.
[19] On October 11, 2018, the Respondent indicated doxepin was prescribed to BC for "sleep to help with migraines…it is one week now, and it helps to sleep…sleeps five hours on it." Jt. Ex. 5(b), pp. IS0280.
[20] Jt. Ex. 5(b), pp. IS0284-IS0285.
[21] Jt. Ex. 5(b), pp. IS0282-IS0283.
[22] Jt. Ex. 5(b), pp. IS0281.
[23] Jt. Ex., 5(b), pp. IS0278-IS0279.
[24] Jt. Ex. 5(b), pp. IS0276.

66. On January 31, 2019, the Respondent added Zofran ODT 4 mg, twice daily to the Respondent's medication regimen and ordered a venous doppler for the left leg to rule out DVT.[25]

67. On March 28, 2019, the Respondent noted that an MRI showed a "tear of the medial meniscus" and referred BC to "Dr. [redacted] for knee pain and meniscal tears."[26] The Respondent stopped prescribing Sonata, noting that BC could not sleep and added Ambien to BC's medication regimen.

68. On April 25, 2019, the Respondent dictated that BC was not sleeping on Ambien 10 mg every four hours and doxepin 50 mg every four hours. The Respondent noted BC needs a sleep study.

69. On May 23, 2019, the Respondent dictated that a sleep study was completed and did not make additional changes to BC's medication regimen.

70. On July 18, 2019, the Respondent indicated that the sleep study showed moderate sleep apnea. He noted "we are going to order CPAP[27] for him."[28] No changes were made to BC's medication regimen at that time.

71. On September 12, 2019, the Respondent noted that BC was sleeping better on Ambien 10 mg every four hours. The Respondent prescribed Elavil 75 mg every four hours and noted that BC's "headaches are better." He noted "we stopped the doxepin last visit."[29]

72. The Respondent did not make any changes to the patient's medication regimen from September 13, 2019 and through March 26, 2020.

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[25] Deep Vein Thrombosis.
[26] Jt. Ex. 5(b), pp. IS0268.
[27] Continuous Positive Airway Pressure
[28] Jt. Ex. 5(b), pp. IS0260-IS0261.
[29] Jt. Ex. 5(b), pp. IS0256.

73. As of November 19, 2019, the combined calculated daily MME for the patient's monthly opioid prescriptions was 270 MME.

74. On March 26, 2020, the Respondent reduced BC's Elavil from 50 to 37.5 mg every four hours daily for migraines. At this date, the Respondent listed the patient's final medications as: "Ambien 10 mg four times daily for sleep, Imitrex 100 mg at onset of migraine, oxycodone 15 mg four times a day, Soma 350 mg three times a day for low back spasms, fentanyl patch 75 mcg every [every 48 hours], this is the maximum he will get as I have told him, Elavil reduced to 37.5 [four times daily] for migraines, and Zofran ODT 4 mg [twice daily] for nausea and vomiting. The patient comes every month."[30]

75. On May 5, 2020, the Respondent noted that BC's migraines were controlled by amitriptyline 75 mg four times daily but later reduced the dose due to 37.5 mg four times daily due to dry mouth. The Respondent did not list this medication in any previous treatment note.

76. The patient was compliant with treatment.

77. The patient's medication regimen included a combination of opioids, benzodiazepines, and Soma, which can be dangerous.

78. The Respondent met the standard of care when he had monthly faceto-face visits with BC and had her sign an opioid agreement.

79. The Respondent breached the standard of care by failing to provide sufficient justification for prescribing high doses of opioids to patient BC, failing to obtain sufficient outside medical records and supporting information for continued opioid therapy, failing to indicate whether he discussed alternative therapies with BC, failing to document BC's PDMP review, and failing to document risk-benefit assessments that were completed with BC.

[30] Jt. Ex. 5(b), pp. IS0239-IS0240.

Patient SB

80. Patient SB was forty-four years old in 2018.

81. SB was previously treated for pain management by [redacted] in Owings Mills, Maryland which had been shut down. She had a history of lumbar schwannoma[31] removed from her lumbar spine in 2014, chronic low back pain radiating down the backs of her legs, bilateral sciatica, bilateral leg weakness, severe bilateral knee pain, and used a cane.

82. While active, [redacted] prescribed methadone 10 mg twice daily and oxycodone 20 mg four times daily for pain.

83. On April 10, 2018, SB visited the Respondent's office for the first time. The Respondent dictated his notes on the same day, "I told her that I cannot give her any more methadone and I do not prescribe 20 mg oxycodone tablets."[32]

84. SB was accepted into the Respondent's practice, signed a pain management contract on April 10, 2018, and received monthly prescriptions from the Respondent from April 2018 to August 2019.

85. SB prescribed the following medications at the patient's initial visit: morphine ER 30 mg, three times a day; oxycodone 15 mg, five times a day; Topamax 100 mg, every four hours; Flexeril 10 mg, three times a day; ClearLax power 34 grams, twice daily for the constipation caused by morphine; and ordered that the patient follow up with "orthopedic spine."[33]

[31] A schwannoma is a tumor on the back of the lumbar spine. Jt. Ex. 5(c), pp. IS0414.
[32] *Id.*
[33] Jt. Ex. 5(c), p. IS0413.

86. On May 8, 2018, the Respondent dictated, "the morphine 30 mg three times a day worked for the first two weeks and then stopped working…she has a lot of pain at night."[34] The Respondent increased SB's morphine ER from 30 mg to 60 mg, three times a day.

87. On June 5, 2018, the Respondent dictated that SB reported that the morphine 60 mg three times a day made her sick and she cut it down to 30 mg, three times daily.

88. The Respondent dictated that he would stop prescribing morphine, and prescribed fentanyl patch 50 mcg every 72 hours, in addition to the already prescribed oxycodone 15 mg, five times a day; Topamax 100 mg, four times daily; and Flexeril 10 mg, three times daily.

89. On July 3, 2018, the Respondent dictated that SB reported that the fentanyl patch gave her diarrhea, and it did not help her pain. The Respondent noted that SB wanted to go back to morphine. On the same day the Respondent restarted SB on morphine ER 30 mg in the morning, 30 mg in the afternoon, and 60 mg at night because, "pain is worse at night."[35]

90. The Respondent stopped the fentanyl patch that was prescribed at the earlier visit on June 5, 2018.

91. On July 31, 2018, the Respondent dictated that the morphine ER 30 mg twice daily during the day was "not holding her and she wants to increase the dose."[36] He noted that the 60 mg at night, helps her. She also reported that she stopped taking Topamax because she was losing weight. The Respondent noted that SB was taking Excedrin for headaches.

92. On July 31, 2018, the Respondent introduced morphine again into SB's medication regimen and increased the dosage from 30 mg to 60 mg, three times a day. He also added doxepin 25 mg four times daily for sleep and headaches.

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[34] Jt. Ex. 5(c), p. IS0412.
[35] Jt. Ex. 5(c), pp. IS0409.
[36] Jt. Ex. 5(c), pp. IS0406-IS0407.

93. On August 28, 2018, the Respondent dictated that doxepin 25 mg every four hours is helping SB sleep. The Respondent did not make any changes to the patient's medication regimen.

94. On September 25, 2018, the Respondent dictated that the doxepin 25 mg helped SB sleep six hours per night. The Respondent reported that SB remained on Morphine ER 60 mg, three times daily; oxycodone 15 mg, five times a day; and Flexeril 10 mg, three times a day, taken occasionally. He further noted, SB complained of increasing hip pain and low back pain because of cold weather.

95. On September 25, 2018, the Respondent noted SB's treatment plan as follows[37]:

a. Morphine ER 60 mg three times a day
b. Oxycodone 15 mg five times a day
c. Continue omeprazole
d. Relafen[38] 500 mg twice daily
e. Compazine 10 mg twice daily for nausea, vomiting
f. Doxepin 25 mg every four hours for sleep and headaches

96. On October 23, 2018, the Respondent noted that he added Relafin 500 mg, twice daily, at her last visit. The Respondent added Augmentin 875 mg, twice daily for ten days for tooth abscess, stopped Compazine, and added Phenergan[39] 25 mg, twice daily to SB's medication regimen.

97. On November 20, 2018, the Respondent dictated that doxepin 25 mg four times daily helps her sleep four to five hours at night and that SB was still getting migraines three times per week. As of that date, the patient's medication regimen included the following medications: Augmentin 875mg, twice daily; morphine ER 60 mg, three times a day;

[37] *Id.* at p. IS0403.
[38] In a later note dated May 5, 2020, the Respondent noted this medication is an anti-inflammatory. Jt. Ex. 5(c), pp. IS0358-IS0359.
[39] In a later note dated March 12, 2019, the Respondent dictated that Phenergan was prescribed for nausea. Jt. Ex. 5(c), pp. IS0390-IS0391.

oxycodone 15 mg, five times a day; Relafen 500 mg, twice daily; Phenergan 25 mg, twice daily; and doxepin 50 mg, every four hours for sleep and headaches.

98. On December 18, 2018, the Respondent removed Augmentin 875 mg from SB's medication regimen. No explanation or justification was provided in the note.

99. On January 15, 2019, the Respondent dictated that SB had "an infection in her left nostril which appears to be somewhat of a skin infection."[40] The Respondent made one change to the patient's medication regimen, adding doxycycline 100 mg twice daily for fourteen days for a skin infection.

100. On February 12, 2019, the Respondent dictated that SB reported increasing pain in the evening and "she wants a repeat MRI of the lumbar spine."[41] The Respondent ordered an MRI lumbar spine without contrast repeat at [redacted] and increased the Relafen dosage from 500 mg twice daily to 750 mg twice daily.

101. On March 12, 2019, SB complained of increasing pain in the evening and the Respondent dictated, "she wants to try oxymorphone ER[42]...she stopped doxepin because she gained weight...she wants to go back to Topamax."[43] The Respondent stopped prescribing morphine ER 60 mg, three times a day and added oxymorphone ER, 40 mg every twelve hours. The Respondent added Topamax 50 mg, every four hours for seven days and then increased the dosage to 100 mg, every four hours.

102. On April 9, 2019, the Respondent noted that SB reported the oxymorphone ER 40 mg every twelve hours, did not work for her. He dictated, "she is going back for

[40] Jt. Ex. 5(c), pp. IS0394-IS0395.
[41] Jt. Ex. 5(c), pp. IS0392-IS0393.
[42] Extended Release or long-acting medication.
[43] Jt. Ex. 5(c), p. IS0390.

morphine ER 60 mg three times a day…she is on oxycodone 15mg five times a day."[44] On that day, the Respondent listed SB's medication regimen as follows: morphine ER 60 mg, three times a day; oxycodone 15mg, five times a day; Phenergan 25 mg, twice daily; Topamax 5 mg every four hours;[45] doxepin 50 mg every four hours; and Relafen 750 mg, twice daily.

103. On May 7, 2019, the Respondent referred SB to podiatry for right toe pain and to "Dr. [redacted] for low back pain." The Respondent increased the dosage of Topamax from 5 mg to 100 mg every four hours.[46]

104. On June 4, 2019, the Respondent dictated that an MRI of the lumbar spine was completed. The Respondent did not make any additional changes to SB's medication regimen on this day. SB's medication remained the same from this date to August 27, 2019.

105. On July 2, 2019, the Respondent dictated that the MRI lumbar spine showed, "L4-L5 canal 9 mm and facet arthropathy L5-S1…no change from prior MRI…seeing podiatry for broken toenail."[47]

106. On September 24, 2019, the Respondent dictated SB's report of "worsening back spasms, severe low back pain, worsening in the evening" and added Zanaflex 4mg three times daily.[48]

107. On November 19, 2019, SB reported to the Respondent that, "she was involved in a car accident in which her car was totally totaled…now in physical therapy."[49]

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[44] Jt. Ex. 5(c), p. IS0389.
[45] No explanation for the reduction of the Topamax from 100mg to 5mg was provided by the Respondent.
[46] Jt. Ex. 5(c), p. IS0387.
[47] Jt. Ex. 5(c), pp. IS0381-IS0382.
[48] In a later case summary note, on October 22, 2019, the Respondent noted, "back spasm responded to Zanaflex 4 mg three times a day." Jt. Ex. 5(c), p. IS0373.
[49] Jt. Ex. 5(c), pp. IS0371-IS0372.

108. As of November 2019, the patient's medication regimen was the equivalent of 232 MME daily.

109. On December 17, 2019, the Respondent noted that SB came to him complaining of burning feet and noted she was already on Cymbalta, gabapentin, and doxepin. The Respondent also noted that SB could not tolerate Lyrica explaining that it was probably peripheral neuropathy. The Respondent prescribed a medication regimen including morphine ER 60mg, three times daily; Zanaflex 4 mg, three times daily; oxycodone 15 mg, five times a day; Flexeril 10 mg, three times daily; Phenergan 25 mg, twice daily; Topamax 100 mg, every four hours; doxepin 50 mg, every four hours discontinued by patient; and Relafen 750 mg, twice daily.

110. The Respondent did not make any additional changes to SB's medication regimen from December 18, 2019 to April 7, 2020.

111. On May 5, 2020, in his final case summary note, the Respondent dictated, "it is not surprising that the morphine ER had to be increased to 60 mg three times a day because morphine ER is a weaker narcotic than methadone 10mg twice a day."[50] He also noted "the methadone 10mg twice a day is a very strong and potent narcotic, and the morphine ER comparatively is a weak narcotic." He also added that, "the patient has been on this regimen together with the Neurontin 800 mg three times a day."[51]

112. The Respondent dictated that SB has had consistent toxicology results throughout his treatment.

113. The Respondent met the standard of care when he had monthly face-to-face visits with SB and had her sign an opioid agreement.

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[50] Jt. Ex. 5(c), pp. IS0358-IS0359.
[51] *Id.*

114. The Respondent breached the standard of care by failing to provide sufficient justification for prescribing high doses of opioids to patient SB, failing to obtain sufficient outside medical records and supporting information for continued opioid therapy, failing to indicate whether he discussed alternative therapies with SB, failing to document SB's PDMP review, and failing to document risk-benefit assessments that were completed with SB.

Patient CU

115. CU was thirty-two years old in 2018. He had a history of a T12-L2 spinal cord injury from a motor vehicle accident in 2011. He was surgically stabilized, however he remained paralyzed from T12-L2,[52] suffered from chronic central neuropathic pain in the same region of the spine, a burning sensation from his waist, through his torso, knees, and side of the thighs, and he required a wheelchair for mobility.

116. CU initially visited the Respondent's office on September 5, 2018. At the time, he was still a patient at a pain management practice in Frederick, Maryland.

117. The Respondent dictated that CU reported he has weakness in his legs, cannot walk and bear weight, and is in a wheelchair today.

118. The Respondent dictated that he told the patient he could not treat his pain because he was already seeing a pain management doctor in Frederick, and he would need to discharge himself from the pain practice to receive the Respondent's services.

119. At his initial visit, CU was taking gabapentin 400 mg, six times a day; baclofen 10 mg as needed; Elavil 50 mg every four hours; oxycodone 15 mg, five times a day; Opana ER 30 mg, every twelve hours; Lexapro 20 mg daily; Soma 350 mg, twice daily;

[52] During testimony, the Respondent referred to T11 to L2. He explained this region refers to thoracic 11 to lumbar 2.

Ambien ER 12 mg every four hours. This medication regimen calculated to over 90 MME.

120. The Respondent noted the following impressions: spinal cord injury, central neuropathic pain due to spinal cord injury, low back pain, mid back pain, and right knee pain.

121. The Respondent prescribed a treatment plan by requesting six months' worth of records from CU, added Lyrica[53] 100 mg twice daily for the first week and then an increase to 150 mg twice daily, cut back gabapentin to 400 mg four times a day, increased Elavil to 75 mg every four hours, and to return in one month, "so I can take over his pain management."[54]

122. The Respondent did not give CU any narcotics at the first visit because he was already being treated by a pain management doctor. The Respondent dictated the patient did a pre-toxicology screen that came back showing oxycodone alone. The patient discharged himself from his prior pain management specialist on October 1, 2018.

123. On October 3, 2018, the Respondent took CU as a patient and dictated that CU, "is currently on Lyrica 150 mg twice daily, Neurontin 400 mg three times daily, amitriptyline 75 mg every four hours, oxymorphone ER 30 mg every twelve hours and oxycodone 15 mg five times daily."[55] The Respondent increased the dosage of Soma to 350 mg, three times daily.

124. The Respondent prescribed the following medication regimen: Lyrica 150mg, twice daily; gabapentin 400 mg, four times a day; Elavil 75 mg every four hours;

[53] Neuropathic pain agent.
[54] Jt. Ex. 5(d), p. IS0543.
[55] *Id.*

oxymorphone ER 30 mg every twelve hours; oxycodone 15 mg, five times daily; and Soma 350 mg, three times daily.

125. On October 31, 2018, CU signed a pain management contract with the Respondent's practice.

126. On January 23, 2019, The Respondent dictated, "CU comes to see me today…he wants to do medical marijuana [and] has a certificate."[56] In his case summary note for the same date, the Respondent noted that he told CU, "If he wants to stay in my practice, he should not do medical marijuana…either he takes the narcotics or medical marijuana [and] has to make a choice."[57] No changes were made to the patient's medication regimen between October 3, 2018 to May 4, 2020.

127. On April 17, 2019, the Respondent drafted a letter indicating that CU, "has failed fentanyl patches and morphine extended release in the past, [he] has been stable on oxymorphone ER 40 mg every twelve hours for a long time for his paraplegic spinal cord injury in the thoracic spine at T11 through L2 which left him paraplegic with spinal cord pain and pain in his legs and lower back and midback…the patient cannot try Embeda because of morphine allergy. He has had a bad reaction [to] hydrocodone in the past and OxyContin has not worked well for him in the past and hence Xtampza ER would not be a good choice."[58] The Respondent further noted, "the only long acting that has worked well for him in the past is oxymorphone ER…kindly approve oxymorphone ER 40 mg every twelve hours for him."[59]

128. Between oxymorphone ER and oxycodone, the patient was taking 353 MME.

129. The patient was compliant with the Respondent's medication regimen.

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[56] Jt. Ex. 5(d), p. IS0508.
[57] Jt. Ex. 5(d), p. IS0508.
[58] Jt. Ex. 5(d), p. IS0501.
[59] Jt. Ex. 5(d), p. IS0501.

130. CU passed away on a date uncertain in 2019. At the time of his death, he was taking oxycodone prescribed by the Respondent. Two other opioids were found during his autopsy. There is no indication that the patient's cause of death was related to the Respondent's prescribing practices.

131. The Respondent met the standard of care when he had monthly face-to-face visits with CU and had her sign an opioid agreement.

132. The Respondent breached the standard of care by failing to provide sufficient justification for prescribing high doses of opioids to patient CU, failing to obtain sufficient outside medical records and supporting information for continued opioid therapy, failing to indicate whether he discussed alternative therapies with CU, failing to document CU's PDMP review, failing to document risk-benefit assessments that were completed with CU, and failing to prescribe the lowest available dosage of medication.

Patient CM

133. CM was thirty-one years old in 2018. He initially visited the Respondent's practice on October 22, 2018 and signed a pain management contract. At the time of his initial visit, CM was taking Percocet 325 mg three times daily from his prior pain provider.

134. The patient had a history of three lumbar surgeries[60] with fusion from L4-S1, severe chronic low back pain, degenerative changes in the cervical, thoracic-lumbar spine, burning sensation in limbs, nerve damage, and postsurgical changes in the lumbar spine. At some point in 2018, the patient suffered a fall at home and developed bilateral weakness and low back pain.

[60] Low back surgeries. Jt. Ex. 5(e), p. IS0602.

135. The Respondent diagnosed the patient with chronic neck pain, chronic low back pain, cervical and lumbar radiculopathy, peripheral neuropathy, and burning in the arms and legs.

136. The Respondent prescribed the following treatment plan: hold off pain medications due to a lack of records, continue gabapentin 900 mg three times daily, doxepin 50 mg every four hours for burning pain and sleep, "the patient only sleeps three to four hours at night...once we get pain records of six months' duration from Virginia, we will start pain medications long-acting and short-acting,"[61] ordered blood work for rheumatological causes and neuropathy workup, and noted he was awaiting MRI records of his cervical and lumbar spine from [redacted]

137. In an addendum to the case summary dated October 22, 2018, the Respondent dictated that CM returned with his medical records, he prescribed CM pain medication, and had CM sign a pain management contract. The Respondent prescribed the following amended treatment plan: Percocet 10/325 mg four times daily, 120 prescribed, morphine ER 30 mg every twelve hours, 60 prescribed.

138. On November 19, 2018, the Respondent prescribed a treatment plan that consisted of oxycodone 15 mg four times daily, oxymorphone ER 20 mg every twelve hours, and doxepin 50 mg at night for burning pain and sleep.

139. On December 17, 2018, the Respondent dictated that CM reported burning in both arms and legs, "probably due to radiculopathy" and "the burning starts from his groin down and all the way down to his feet and starts from his neck down all the way to his hands."[62]

[61] Jt. Ex. 5(e), p. IS0606.
[62] Jt. Ex. 5(e), p. IS0601.

140. The Respondent also noted that CM did not do the blood work that he ordered.

141. The Respondent added Neurontin 900 mg, three times daily and Soma 350 mg, three times daily to CM's medication regimen without explanation or justification.

142. No changes were made to CM's medication regimen between December 17, 2018 and May 6, 2019.

143. On April 4, 2019, the Respondent ordered an MRI of the lumbar spine, noting that CM complained of worsening low back pain and left leg sciatica.

144. On May 6, 2019, the Respondent dictated that CM failed to obtain an MRI and that he ordered it at CM's last visit. The Respondent added Zanaflex 8 mg every four hours for back spasms. No changes were made to CM's medication regimen between May 7, 2019 and July 1, 2019.

145. On July 23, 2019, the Respondent dictated that CM went to the emergency room on Sunday and a spinal X-ray showed, "some loosening of the spacer at L5-S1…he is experiencing extreme low back pain [and] wants something extra for his pain."[63] The Respondent also noted "they turned down his MRI of the lumbar spine."[64] The Respondent added Dilaudid 4 mg three times daily "for seven days for extra pain."[65]

146. On July 29, 2019, the Respondent continued Dilaudid for an additional fourteen days, noting that the patient "wants some more Dilaudid."[66]

147. On August 22, 2019, the Respondent dictated that the patient had "problems with hardware in his lower back [and] they are going to remove it [on] September 16, 2019."[67]

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[63] Jt. Ex. 5(e), p. IS0590.
[64] Jt. Ex. 5(e), pp. IS0590-IS0591.
[65] *Id.*
[66] Jt. Ex. 5(e), pp. IS0582-IS0583.
[67] Jt. Ex. 5(e), pp. IS0580-IS0581.

Noting the CM "wants two more weeks of Dilaudid", the Respondent extended the prescription for an additional fourteen more days.[68]

148. On September 23, 2019, the Respondent dictated again that CM had problems with the hardware in his lower back. He noted CM wanted to get back surgery at the [redacted] and to see Dr. [redacted]. The Respondent continued CM's Dilaudid prescription for another fourteen days and referred him to [redacted] to see Dr. [redacted].

149. On October 8, 2019, CM underwent an MRI of his lumbar spine without contrast. Dr. [redacted] noted the following impressions, "degenerative findings with foraminal stenosis...most prominent at L5-S1...findings suggesting right subarticular vertebral disk osteophyte at L5-S1 with disk and facet contacting the descending right S1 nerve root and resulting in right lateral recess stenosis."[69]

150. On October 21, 2019, the Respondent dictated CM would "be put on probation [because his] urine toxicology came back positive for cocaine."[70] The Respondent discontinued Dilaudid, placed CM on a cocaine probation program and prescribed a two-week supply of oxycodone and oxymorphone ER.

151. On November 4, 2019, CM signed a probation contract for suboxone and marijuana.[71] The treatment plan prescribed by the Respondent included oxycodone 15 mg four times daily, two weeks supply; oxymorphone ER 30 mg every twelve hours, four weeks supply; doxepin 50 mg every four hours; Zanaflex 8 mg at night; Neurontin 900 mg three times daily; and Soma 350 mg three times daily.

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[68] *Id.*
[69] Jt. Ex. 5(e), p. IS0577.
[70] Jt. Ex. 5(e), pp. IS0574-IS0575.
[71] The Respondent noted that CM signed one for cocaine at the last visit. Jt. Ex. 5(e), p. IS0572.

152. On November 11, 2019, the Respondent dictated that CM was on probation for suboxone, marijuana, and cocaine. The Respondent noted that Dr. [redacted], CM's primary care physician, contacted him and reported that CM was complaining of pain and asking for pain medication and asked if she could add on anything to CM's pain medication. He noted that CM was "CRISP'd and the PDMP be checked every visit."[72]

153. On the same day, November 11, 2019, the Respondent dictated that CM came to his office stating he has excruciating pain because of neurogenic bladder, urinary retention. The Respondent noted, "we will send him to the [redacted] [emergency] room with a note stating he has neurogenic bladder with urinary retention and requires immediate attention, perhaps admission."[73]

154. CM's monthly medication regimen was the equivalent of 270 MME.

155. On November 19, 2019, CM underwent a mouth swab toxicology test, revealing cocaine positivity. No changes were made to CM's medication regimen at that time.

156. On December 2, 2019, the Respondent dictated that CM's toxicology mouth swab taken on November 19, 2019, revealed cocaine positivity. The Respondent noted that CM was discharged from the practice as a result. The Respondent also noted that CM was due for low back surgery by Dr. [redacted] on December 13, 2019.

157. The Respondent met the standard of care when he had monthly face-to-face visits with CM and had her sign an opioid agreement.

158. The Respondent breached the standard of care by failing to provide careful justification for prescribing high doses of opioids to patient CM, failing to obtain

[72] Jt. Ex. 5(e), p. IS0571.
[73] Jt. Ex. 5(e), p. IS0570.

sufficient outside medical records and supporting information for continued opioid therapy, failing to indicate whether he discussed alternative therapies with CM, failing to document CM's PDMP review, failing to document risk-benefit assessments that were completed with CM, and failing to document and address aberrant urine drug screen results.

Patient PF

159. PF was sixty-four years old in 2018 and began treatment with the Respondent on September 5, 2018, at which time she signed a pain management contract.

160. [redacted] was PF's prior pain management provider. She had a history of one low back surgery in 2001, chronic severe low back pain, disc bulging at multiple levels in the lumbar spine with severe facet joint disease, burning sensation in feet, right shoulder pain, neck pain, and pain radiating down the legs, and lumbar radiculopathy due to facet joint disease.

161. At the time of her initial visit, PF was taking oxycodone 5 mg every eight hours; Soma 350 mg, three times a day; and baclofen 10 mg (a muscle relaxant) every twelve hours. She reported that her previous pain management provider attempted to obtain approval for transforaminal epidural steroidal injection, but it was rejected by the insurance company.

162. The Respondent dictated that PF reported that she had right shoulder pain and was advised by her orthopedist to receive physical therapy. She also reported that she has had burning feet for two years, has severe low back pain radiating down the back of both legs, and right shoulder pain.

163. The Respondent made the following diagnoses: low back pain, lumbar radiculopathy, peripheral neuropathy, right shoulder pain. The Respondent prescribed

morphine ER 15 mg to be taken at bedtime and oxycodone 10 mg four times daily with the aim to increase the dosage over time. This calculates to 113 MME. The Respondent ordered the results from MRIs of PF's lumbar spine and right shoulder, peripheral neuropathy blood workup, and EMG/NCV[74] of the lower extremities.

164. On October 10, 2018, based on the EMG/NCV report, the Respondent made the following diagnosis: bilateral axonal peripheral neuropathy. PF's neuropathy bloodwork revealed insignificant results. The Respondent dictated that PF reported daily migraines in addition to right shoulder pain, neck pain, low back pain, burning feet, severe low back pain, had rotator cuff tear on the right side and underwent physical therapy. The Respondent prescribed morphine ER 15 mg at bedtime; Topamax 15 mg[75] every four hours at bedtime for migraine prevention; Soma 350 mg three times daily; and oxycodone 10 mg, four times daily.

165. On October 10, 2018, the Respondent ordered a cervical MRI.

166. On November 7, 2018, the Respondent dictated that PF reported she did not take the morphine ER at night nor the Topamax that he prescribed. He noted that she takes the oxycodone 10 mg four times daily and Soma 350 mg three times daily. The Respondent noted that a cervical MRI showed degenerative joint disease (DJD) and no cervical stenosis. No changes were made to the Respondent's medication regimen at that visit nor at PF's subsequent visit on November 21, 2018.

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[74] Electromyography or study of electrical activity in the muscles (EMG). NCV stands for nerve conduction study. EMG/NCV Study, Comprehensive Neurosciences, https://www.csneuro.com/emg-ncv-study/#:~:text=WHAT%20DOES%20EMG%2FNCV%20STAND,of%20your%20nerves%20is%20measured, March 15, 2022.

[75] All subsequent case summary notes for PF list the Topamax dosage at 50 mg.

167. On January 2, 2019, the Respondent dictated that the insurance company would not approve his prescription for Soma and noted he would try methocarbamol 750 mg, three times daily. He also notes, "she wants to increase the dose of oxycodone [from 10 mg] to 15 mg [four times daily], I said OKAY."[76] The Respondent prescribed morphine ER 15 mg at bedtime, methocarbamol 750 mg, three times daily; and oxycodone 15 mg, four times daily.

168. No changes were made to PF's medication regimen between January 2, 2019 and July 17, 2019.

169. On August 14, 2019, the Respondent dictated that patient PF reported that she was taking oxycodone 15 mg as needed. He also noted she is on Zanaflex 2 mg three times daily and "methocarbamol was not approved by insurance company."[77,78] The treatment plan prescribed by the Respondent included Zanaflex 2 mg three times daily and oxycodone 15 mg four times daily.

170. On October 9, 2019, the Respondent prescribed Ambien 5 mg every four hours in addition to the Zanaflex 2 mg, three times daily; and oxycodone 15 mg, five times daily or as needed.

171. On January 29, 2020, the Respondent noted that PF stopped taking the Ambien that he prescribed on October 9, 2019, noting that she reported that it caused her anxiety to worsen.

172. On March 25, 2020, the Respondent dictated that the patient, "is still complaining of neck pain, low back pain, radicular pain in the neck and lower back, burning feet,

[76] Jt. Ex. 5(f), pp. IS0712-IS0713.
[77] Jt. Ex. 5(f), p. IS0698.
[78] The Respondent noted PF was taking Topamax 50 mg every four hours and Morphine ER 15 mg at bedtime. Jt. Ex. 5(f), p. IS0698.

severe low back pain, right shoulder, and right rotator cuff pain."[79] He further noted that the oxycodone 15 mg five times a day is controlling her pain reasonably well.

173. The Respondent did not make changes to PF's medication regimen between October 9, 2019 and March 25, 2020.

174. PF was compliant with the Respondent's treatment plan while under his care.

175. The Respondent met the standard of care when he had monthly face-to-face visits with PF and had her sign an opioid agreement.

176. The Respondent breached the standard of care by failing to provide sufficient justification for prescribing high doses of opioids to patient PF, failing to obtain sufficient outside medical records and supporting information for continued opioid therapy, failing to indicate whether he discussed alternative therapies with PF, failing to document PF's PDMP review, failing to document risk-benefit assessments that were completed with PF, and acquiescing to patient requests for increased dosages without justification.

Patient JA

177. The Respondent began treating JA on August 6, 2015, after a hospital consultation in July 2015, when she was sixty-three years old.[80] The Respondent saw JA again in his office on August 6, 2015, accepted her into his practice, and scheduled bimonthly follow-up appointments.[81] The Respondent dictated that JA reported a history of failed gabapentin, Topomax, Depakote, tricyclic antidepressants, Effexor, calcium channel blockers, and beta-blockers, chronic headaches, nausea, vomiting, chest pain, and left leg sciatica.

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[79] Jt. Ex. 5(f), p. IS0681.

[80] The earliest case summary note dictated by the Respondent in the State's exhibits is dated January 8, 2019. Jt. Ex. 5(g), p. IS0806.

[81] Final case summary note addressed to the Christine Farrelly, Executive Director of the MSBP. Jt. Ex. 5(g), pp. IS0785-IS0787.

178. The Respondent dictated that JA began complaining of left leg sciatica and increasing neck pain sometime in late 2018 and "we did an MRI of the cervical spine and the lumbar spine…it showed moderate stenosis at C5-C6 and C6-C7 in the cervical spine causing left S1 radiculopathy causing sciatica down the left leg, causing sciatica down the left leg."[82]

179. The Respondent dictated that as of May 6, 2020, "the patient is still experiencing daily excruciating headaches…no prophylactic has worked."[83]

180. On January 8, 2019, the Respondent prescribed the following treatment plan to address JA's conditions: start Emgality, 240 mg first month subcutaneous, then 120 mg thereafter; Dilaudid 4 mg daily; oxycontin 20 mg every twelve hours; Nortriptyline 50 mg every four hours; Namenda XR 21mg daily; Zanaflex 8 mg, three times daily; Zofran 4 mg, three times daily; Lyrica 100 mg, twice daily; valium 2 mg every four hours; Ambien ER 12.5 mg every four hours; B12 1000 mcg monthly; 28-gauge needle for B12; and 1 cc syringe for B12.

181. On March 5, 2019, the Respondent added Aimovig 17 mg subcutaneous to be taken monthly to JA's medication regimen.

182. On May 9, 2019, the Respondent noted, "they will not approve Aimovig for her but approved Emgality or Ajovy."[84]

183. The Respondent then removed Aimovig from JA's medication regimen and returned her to Emgality 240 mg for the first month, then 120mg subcutaneous thereafter every month.

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[82] Jt. Ex. 5(g), p. IS0786.
[83] Jt. Ex. 5(g), p. IS0786.
[84] Jt. Ex. 5(g), p. IS0802.

184. On July 9, 2019, the Respondent noted the patient took the first 240 mg dose of Emgality and was going to take the second dose. The Respondent dictated the Emgality, "did not make any difference, but I told her she needs to try it for six months."[85] He also indicated that the patient's neurosurgeon did not recommend surgery. The Respondent added Valium 2 mg to JA's medication regimen.

185. In the third month of using Emgality, on September 11, 2019, JA reported no difference in her migraines.

186. On November 6, 2019, the Respondent dictated that Emgality is not working for her migraines and "we will switch her to Aimovig [which has the] advantage of being able to titrate from 70 mg to 140 mg if the lower dose does not work."[86] No additional changes were made to JA's medication regimen.

187. On November 6, 2019, Diazepam, although prescribed, was not detected in the patient's UDS results.

188. On January 6, 2020, the Respondent dictated that JA failed Emgality and her insurance company did not approve Aimovig. He noted "OxyContin not approved anymore by the insurance company…they want her to switch to Xtampza."[87] The Respondent altered the patient's treatment plan in the following manner: Periactin 4mg at night for migraine prevention; Dilaudid[88] 4mg, four times daily; Xtampza[89] ER 27mg every twelve hours; Nortriptyline 75 mg every four hours; Namenda XR 21 mg daily; Zanaflex 8 mg, three times daily; Zofran 4 mg every three days; Lyrica 100 mg, twice

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[85] Jt. Ex. 5(g)
[86] Jt. Ex. 5(g), p. IS0796.
[87] Jt. Ex. 5(c), pp. IS0793-IS0794.
[88] In his last note to the MSBP, the Respondent dictated that JA developed renal insufficiency, so the morphine ER was stopped.
[89] In the Respondent's final case summary note, he explained that Xtampza ER is the brand name for OxyContin. Jt. Ex. 5(g); p. IS0786.

daily; Valium 2 mg every four hours; Ambien ER 12.5 mg every four hours; B12 1000 mcg quarter monthly; and 1 cc syringe for B12.

189. On March 2, 2020, the Respondent dictated that JA asked for more Dilaudid and he noted that he did not prescribe more. While noting that she was on Xtampza ER 27mg every twelve hours, he stated that she continued to have migraines. The Respondent increased the Periactin dosage from 4 mg to 8 mg at night for migraine prevention and sleep. No additional changes were made to her medication regimen.

190. The patient's medication regimen equated to 154 MME per day.

191. On March 2, 2020, Hydrocodone, although not prescribed, was detected in the patient's UDS results.

192. In his final case summary note dated May 6, 2020, the Respondent reported that during the course of his treatment of JA, he continued her on morphine and increased the dosage from 15 mg three times daily to morphine ER 30 mg every twelve hours. The Respondent also prescribed nortriptyline and continued Namenda XR for migraine control. He noted the patient's migraines were extremely difficult to control and she has had them for many years.

193. On May 6, 2020, the Respondent noted the patient is still experiencing excruciating headaches, low back and neck pain, and sciatica and no prophylactic had worked. The Respondent reported he told JA, "She has got to live with it...I am not increasing her pain medication anymore."[90]

194. The Respondent met the standard of care when he had monthly face-to-face visits with JA and had her sign an opioid agreement.

[90] Jt. Ex. 5(c), pp. IS0785-IS0787.

195. The Respondent breached the standard of care by failing to provide careful justification for prescribing high doses of opioids to patient JA, failing to obtain sufficient outside medical records and supporting information for continued opioid therapy, failing to indicate whether he discussed alternative therapies or dangerous risk factors with JA, failing to document JA's PDMP review, failing to document risk-benefit assessments that were completed with JA, and failing to document inconsistent UDS results, corresponding assessments, or changes in prescribing behavior that were a direct result of the inconsistencies.

Patient KK

196. KK was twenty-nine years old in 2018 and began treatment with the Respondent on June 4, 2018, at which time she signed a pain management contract, and a urine toxicology was conducted.

197. The Respondent reported that he conducted a PDMP search that revealed the patient was prescribed hydrocodone, tramadol, and oxycodone in the past for pain issues.

198. The Patient's prior pain management physician is not listed in the Respondent's notes. She had a history of severe low back pain, burning feet, sciatica down both legs, neck pain, bipolar disorder, infertility, pelvic inflammatory disease, and depression.

199. At the time of her initial visit, KK was taking Norco, tramadol, oxycodone from multiple providers and Percocet.

200. The Respondent diagnosed KK with low back pain, peripheral neuropathy, lumbar radiculopathy bilateral, and bilateral knee pain.

201. At the initial visit, the Respondent ordered an MRI of the lumbar spine, cervical, and both knees. He prescribed Neurontin 400mg three times daily for neuropathic pain

but noted, "no pain management today because we do not have prior records...once testing has been done, we may consider enrolling in pain management."[91]

202. The same day the Respondent prescribed 600 mg of Gabapentin, three times daily, and oxycodone 10 mg, four times daily.

203. On June 18, 2018, the Respondent dictated that the patient's neck pain, low back pain, burning feet, pain in both knees was progressing. He noted that KK signed a pain management contract. Based on MRIs of the knees and lumbar spine, the Respondent diagnosed the patient with impingement syndrome in both knees, degenerative joint disease of the lumbar spine, low back pain, peripheral neuropathy, lumbar radiculopathy bilateral, bilateral knee pain, suprapatellar fat impingement in both knees.

204. On July 16, 2018, the Respondent dictated that he referred KK to orthopedics for knee pain.

205. On August 13, 2018, the Respondent noted that the patient reported her pain improved with Neurontin[92] 600 mg three times daily. The Respondent noted, she is "still having a lot of pain in the knees, cervical spine, and lumbar spine. Having headaches every day."[93]

206. On August 13, 2018, alcohol was present in the patient's urine drug screen. The inconsistency was not discussed in the Respondent's medical note.

207. The Respondent continued the Gabapentin 600 mg three times daily, increased the dosage of oxycodone from 10 mg to 15 mg four times daily, and added Topamax 50 mg every four hours for seven nights and 100 mg every four hours for headaches.

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[91] Jt. Ex. 5(h), pp. IS0937.
[92] Neurontin is the brand name for gabapentin.
[93] Jt. Ex. 5(h), pp. IS0937.

208. On September 10, 2018, the Respondent noted that the patient reported she could not sleep at night, Topamax worsened her headaches, and the burning feet sensation improved with Neurontin three times daily.

209. On September 10, 2018, the Respondent dictated that he discontinued the patient's Topamax and added Zanaflex 8 mg every four hours "for sleep following headaches."[94] The patient's gabapentin and oxycodone prescriptions were continued with the same frequency and dosage.

210. On October 8, 2018, the Respondent dictated, "she is sleeping well on the Zanaflex 8 mg every four hours…headaches are better. Burning feet better on Neurontin…but still not controlled."[95]

211. On October 8, 2018, the Respondent discontinued the patient's prescription for gabapentin and added Lyrica 100 mg twice daily. No explanation was provided in the note.

212. On November 5, 2018, the Respondent dictated the patient was on Lyrica 100 mg twice daily for burning feet and the Neurontin 600 mg three times daily worked better. The Respondent noted, "we will increase the dose of Lyrica to 150 mg twice daily."[96]

213. On November 5, 2018, the Respondent prescribed the following treatment plan: Zanaflex 8 mg every four hours for sleep and headaches; Gabapentin 150 mg, twice daily; oxycodone 15 mg, four times daily, and vitamin D 50,000 every Sunday.

214. On November 5, 2018, urine drug screen results revealed the presence of fentanyl and alcohol, which were not prescribed by the Respondent.

[94] Jt. Ex. 5(h), pp. IS0935-IS0936
[95] Jt. Ex. 5(h), pp. IS0933-IS0934.
[96] Jt. Ex. 5(h), pp. IS0931-IS0932.

215. On November 27, 2018, the Respondent dictated Lyrica 150 mg twice daily did not help the patient's burning feet. He also noted her, "cervical spine is better." The Respondent continued the patient's prescription of Gabapentin at a dosage of 600 mg three times daily.

216. On January 2, 2019, the Respondent dictated the patient was returned to gabapentin 600 mg three times daily because the Lyrica 150 mg twice daily did not help her burning feet. The Respondent noted that the patient complained about fidgeting, a lack of focus, ADD,[97] and an inability to concentrate.

217. On January 2, 2019, the Respondent diagnosed the patient with ADD and added Adderall XR 10 mg in the morning, 10 mg in the afternoon. The Respondent also increased the dosage of gabapentin 600 mg to 1200 mg three times daily. No specific explanation was provided for the increase in dosage.

218. On January 30, 2019, the Respondent dictated that the patient requested "more oxycodone, I said no."[98] The Respondent reduced the dosage of the patient's gabapentin from 1200 mg to 400 mg three times daily and did not provide any explanation for the reduction.

219. On February 27, 2019, the Respondent dictated the patient was on gabapentin 1200 mg three times daily and later in the same note, prescribed gabapentin with a dosage of 400 mg three times daily.

220. On March 27, 2019, the Respondent prescribed Gabapentin 1200 mg three times daily. No explanation was provided in the Respondent's note.

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[97] Attention Deficit Disorder.
[98] Jt. Ex. 5(h), p. IS0925.

221. On April 24, 2019, the Respondent dictated the patient continued reporting ADD symptoms, noting that she cannot concentrate and stated that the patient's headaches improved. In the same note, the Respondent added Morphine ER 30 mg every twelve hours to the patient's medication regimen. The Respondent did not include an explanation for the addition of Morphine ER to the patient's medication regimen.

222. On May 22, 2019, the Respondent added Medrol XR 10 mg in the morning and 10 mg in the afternoon to the patient's medication regimen. The Respondent did not provide any explanation for the additional prescription.

223. On June 19, 2019, the Respondent removed Medrol XR 10 mg in the morning, 10 mg in the afternoon from the patient's medication regimen and replaced it with Adderall XR 10 mg in the morning and 10 mg in the afternoon without explanation.

224. On September 11, 2019, the patient requested, and the Respondent ordered, an orthopedic referral for knee pain to Dr. [redacted]. The patient complained of nausea which the Respondent listed as a diagnosis. The Respondent increased the dosage of Adderall XR from 10 mg in the morning and afternoon to 30 mg in the morning and afternoon.

225. On October 9, 2019, the Respondent adjusted the patient's Adderall XR dosage from 30 mg in the morning and afternoon to 30 mg in the morning and 10 mg in the afternoon. The Respondent did not include an explanation for the adjusted dosage in the dictated note.

226. On November 6, 2019, the Respondent adjusted the patient's Adderall XR dosage from 30 mg in the morning and 10 mg in the afternoon to 10 mg in the morning and 10 mg in the afternoon. The Respondent did not include an explanation for the adjusted dosage in the dictated note.

227. On December 4, 2019, the Respondent adjusted the patient's Adderall XR from 10 mg in the morning and afternoon to 30 mg in the morning and 10 mg in the afternoon.

228. The Respondent did not make any further adjustments to the patient's medication regimen between December 5, 2019 and May 20, 2020.

229. On January 2, 2020 and January 29, 2020, Morphine ER was prescribed but not detected in the patient's urine drug screens. The inconsistencies were not discussed in the patient's note.

230. On May 6, 2020, the Respondent noted the patient was stable on her pain regimen and noted, "we will not increase dose further."[99] The Respondent also indicated that the patient was in need of a psychiatrist, he assisted her with locating one, and noted it was difficult due to her lack of insurance.

231. The Respondent met the standard of care when he had monthly face-to-face visits with KK and had her sign an opioid agreement.

232. The Respondent breached the standard of care by failing to provide careful justification for prescribing high doses of opioids to patient KK, failing to obtain sufficient outside medical records and supporting information for continued opioid therapy, failing to indicate whether he discussed alternative therapies or dangerous risk factors with KK, failing to document KK's PDMP review, failing to document risk-benefit assessments that were completed with KK, and failing to document inconsistent UDS results, corresponding assessments, or changes in prescribing behavior that were a direct result of the inconsistencies.

[99] Jt. Ex. 5(h), pp. IS0887-IS0889.

Patient SL

233. Patient SL was twenty-four years old when she visited the Respondent's medical office on December 4, 2012. She was referred by Dr. [redacted] for chronic pelvic pain management. The patient has a medical history of endometriosis, migraine headaches, lower pelvic pain, low back pain, and rare nausea.

234. Prior to being treated by the Respondent, SL was a patient of Dr. [redacted] who prescribed Topamax,[100] Fioricet,[101] Percocet 5/325 mg every six hours, and Depo-Provera every three months.

235. The Respondent diagnosed the patient with chronic pelvic pain, endometriosis, weekly migraines, and low back pain.

236. The patient signed a pain management agreement.

237. The Respondent prescribed the following treatment plan: Tramadol 50 mg every six hours; increase Percocet to 10/325 mg five times a day 150 mg tablets, no refill; and samples of Maxalt-MLT six sachets for abortive therapy of weekly migraines. The patient's medication regimen equated to 173 MME.

238. On January 30, 2013, the Respondent dictated that the patient reported the patient, "aches all over"[102] and noted she was prescribed Cymbalta, however her insurance would not cover it.

239. On January 30, 2013, the Respondent added Neurontin 300 mg, three times daily.

240. On February 27, 2013, the Respondent reported the patient's migraines "are better now on Neurontin 300 mg three times daily" and she complained of "some arm and leg swelling for which venous ultrasound was negative…complaining of insomnia."[103]

[100] Frequency not noted in record. Jt. Ex 5(i), p. IS1145.
[101] Frequency not noted in record. Jt. Ex 5(i), p. IS1145.
[102] Jt. Ex. 5(i), p. IS1142.
[103] Jt. Ex. 5(i), p. 1141.

241. The Respondent prescribed the following treatment plan: continue Cymbalta 30 mg daily for fibromyalgia, continue Neurontin 300 mg three times daily for migraine prophylaxis and fibromyalgia, continue Percocet 10/325 mg five times a day for pain, and "come back in four weeks' time at which time we will increase the Cymbalta to 60 mg daily."[104]

242. On April 16, 2013, the Respondent dictated the patient, "is on Cymbalta 60 mg daily."[105]

243. On the same day, the Respondent reported that the patient was taken off Percocet, placed on oxycodone 5 mg four times a day, and her migraines were well controlled.

244. On April 16, 2013, made the following changes to the patient's treatment plan: increase the patient's oxycodone from 5 mg to 15 mg five times a day as needed, continue Neurontin 200 mg three times daily, add Ambien 5 mg every four hours, and increased the dosage of Cymbalta 30 mg daily for fibromyalgia to 60 mg.

245. On June 11, 2013, the Respondent prescribed Relpax samples for abortive therapy for migraines.

246. On July 9, 2013, the Respondent increased the dosage of Neurontin from 200 mg to 600 mg three times daily to treat the patient's migraines and increased the dosage of Ambien from 5 mg to 10 mg every four hours for sleep.

247. On September 3, 2013, the Respondent added Imitrex 100 mg for abortive therapy of migraines to the patient's medication regimen.

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[104] *Id.*

[105] Jt. Ex. 5(i), p. IS1139.

248. On December 19, 2013, the Respondent dictated that Neurontin, despite being prescribed, did not show up in her urine toxicology and noted "probably wants higher, now we will not increase the dose of pain medications anymore."[106]

249. On January 20, 2014, the Respondent noted that the patient's migraines stopped and that she was no longer taking Neurontin. No additional changes were made the patient's medication regimen.

250. On March 17, 2014, the Respondent added Neurontin 600 mg back to the patient's medication regimen.

251. On June 10, 2014, the Respondent dictated the patient stopped taking Neurontin and Ambien because they were too expensive. The Respondent amended the patient's treatment plan as follows: Oxycodone 15 mg, five times per day; and Nortriptyline[107] 50 mg every four hours for migraine prevention and sleep.

252. On July 8, 2014, the Respondent noted that Nortriptyline controlled the patient's migraines but caused dry mouth. He noted Neurontin and Ambien were stopped because they were too expensive. The Respondent continued oxycodone 15 mg, five times a day; and nortriptyline 50 mg every four hours for migraine prevention and sleep.

253. The Respondent did not make any changes to the patient's medication regimen between September 30, 2014 and February 14, 2017.[108]

254. On March 13, 2017, the Respondent added Imitrex 100 mg at onset of migraine to the patient's medication regimen and increased the dosage of nortriptyline from 50 mg to 75 mg every four hours for migraine prevention and sleep.

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[106] Jt. Ex. 5(i), p. IS1130.

[107] In a subsequent note dated July 8, 2014, the Respondent noted Nortriptyline is cheap at $10.00 and is controlling her migraines.

[108] On July 5, 2016, the Respondent noted the patient was considering having a hysterectomy procedure for uterine pain. On February 14, 2017, the Respondent noted the patient was having lower left quadrant pain.

255. On March 13, 2017, the Respondent noted the patient's headaches started to return and she had three headaches in the past week that were full blown migraines.

256. On April 11, 2017, the Respondent reported he prescribed Sumatriptan 100 mg for abortive therapy for migraines and noted, "it really helped her."[109]

257. On June 5, 2017, the Respondent reported the patient miscarried. The Respondent did not make any changes to the patient's medication regimen.

258. On September 25, 2017, the Respondent dictated the patient was rushed to the hospital due to vaginal bleeding and had an emergency operation as a result. No changes were noted in her medication regimen.

259. On January 16, 2018, the Respondent dictated the patient complained of low back pain, headaches, and migraines. The Respondent noted, "now complaining of right sided neck pain, right-sided low back pain"[110] and ordered MRI of the patient's cervical and lumbar areas for right-sided back pain and right-sided low back pain.

260. On February 12, 2018, the Respondent dictated the patient reported increasing pain during the day and night and difficulty sleeping. The Respondent reported that the patient had not had an MRI of the lumbar spine. The Respondent amended the patient's treatment plan to include oxycodone 15 mg five times daily for abdominal pain; nortriptyline 75 mg every four hours for migraine prevention and sleep; morphine ER 15 mg every twelve hours; Senokot S two tabs at night for constipation, Imitrex 100 mg for abortive therapy of migraines.

261. On March 12, 2018, the Respondent dictated the patient's "pain is still 6/10."[111] No additional alterations were made to the patient's medication regimen on this day.

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[109] The Sumatriptan prescription was not included in the treatment plan section of the Respondent's prescribed treatment plan. Sumatriptan was not mentioned in the previous note dated March 13, 2017.
[110] Jt. Ex. 5(i), pp. IS1059-IS1060.
[111] This was the first time the Respondent quantified the patient's pain level in a dictated note.

262. On April 9, 2018, the Respondent added Valium 5 mg before MRI to the patient's medication regimen.

263. On May 7, 2018, the Respondent diagnosed the patient with worsening low back pain with straight raising test positive in the right leg, power weaker in the right leg, low back pain straight leg raise test positive in right leg, migraines, chronic pelvic pain due to endometriosis post-surgery, and neck pain. No changes were made to the Respondent's medication regimen.

264. On June 4, 2018, the Respondent dictated the patient was unable to do the MRI of the cervical spine with a dosage of 5 mg of Valium. The Respondent increased the dosage to 10 mg before MRI. The Respondent dictated the patient complained of increasing low back pain, neck pain, "legs giving out."[112]

265. On July 30, 2018, the Respondent dictated a cervical MRI dated July 8, 2018, showed "cervical spondylosis with multilevel spondylosis and neck spasm."[113] The Respondent also dictated the patient reported chronic pelvic pain, severe low back pain radiating down the right leg and noted her "pain is about 8/10."[114]

266. On December 17, 2018, the Respondent dictated that the patient was having headaches for the last three days and "Imitrex [100 mg] taken rarely."[115] The Respondent amended the patient's medication regimen as follows: Medrol dosepak for migraines; oxycodone 15 mg, five times daily; nortriptyline 75 mg every four hours; Senokot-S two tablets nightly; Imitrex 100 mg for abortive therapy; and valium 10 mg before MRI.

267. On January 14, 2019, the Respondent dictated the patient still had headaches on nortriptyline, complained of mouth dryness, and reported the Medrol dosepak helped

[112] Jt. Ex. 5(i), pp. IS1049-IS1050.
[113] Jt. Ex. 5(i), pp. IS1044-IS1045.
[114] Jt. Ex. 5(i), pp. IS1044-IS1045.
[115] Jt. Ex. 5(i), pp. IS1034-IS1035.

with her last bout of migraines and "pain is 8/10."[116] The Respondent also prescribed Ambien 5 mg every four hours for sleep and "encouraged [the patient] to get Biotene mouthwash for mouth dryness."[117]

268. On February 11, 2019, the Respondent dictated that the patient reported she was sleeping better on Ambien 5 mg every four hours and taking Biotene mouthwash.

269. On March 11, 2019, the Respondent dictated the patient's insurance approved a CT scan of the lumbar spine.

270. On March 14, 2019, the patient had a CT scan of her lumbar spine.

271. On April 8, 2019, the Respondent dictated that the CT "showed a disc bulge to the left at L4-L5." [118]

272. The Respondent did not make any additional changes to the patient's medication regimen.

273. On May 6, 2019, the Respondent prescribed Morphine ER 30 mg every twelve hours.

274. On March 9, 2020, prescribed oxycodone was detected in the patient's urine but below the prescribed amount. This inconsistency was not discussed in the Respondent's patient note.

275. The Respondent did not make any additional changes to the patient's medication regimen between May 6, 2019 and May 4, 2020.

276. On May 4, 2020, the Respondent dictated the patient "failed NSAIDs."[119]

277. The Respondent breached the standard of care by failing to provide careful justification for prescribing high doses of opioids to patient SL in each progress note,

[116] Jt. Ex. 5(i), pp. IS1032-IS1033.
[117] Jt. Ex. 5(i), p. IS1032-IS1033.
[118] Jt. Ex. 5(i), pp. IS1024-IS1025.
[119] *Id.*

failing to obtain sufficient outside medical records and supporting information for continued opioid therapy, failing to consistently indicate whether he discussed alternative therapies or dangerous risk factors with SL, failing to document SL's PDMP review, failing to consistently document risk-benefit assessments that were completed with SL, and failing to document one inconsistent UDS result and corresponding assessments.

Patient TP

278. Patient TP has been a patient at the Respondent's practice since March 17, 2014, when he was forty-nine years old. He was incarcerated the same year and returned to the Respondent's practice in December 2017.

279. TP had a history of bilateral carpal tunnel, hand numbness, severe hand pain, chronic low back pain, right leg sciatica due to L5-S1 distribution.

280. On March 17, 2014, the Respondent diagnosed the patient with left lumbar radiculopathy L5-S1, bilateral CTS,[120] query right cubital tunnel, and right knee pain due to right ACL[121] problems. The patient signed a pain management agreement.

281. The Respondent ordered a nerve conduction study for both hands and prescribed oxycodone 5 mg three times daily 90 tablets as needed for pain.

282. On April 14, 2014, the Respondent increased the dosage of oxycodone from 5 mg to 15 mg, four times a day and noted the patient was going to see orthopedics and neurosurgery for knee and low back pain.

283. At a date uncertain in April 2014, the patient was involved in a motor vehicle accident.

[120] Carpel Tunnel Syndrome.
[121] Anterior Cruciate Ligament.

284. On May 12, 2014, the Respondent conducted a nerve conduction study of the upper and lower extremities due to the patient's reports of arm and leg pain. The Respondent diagnosed the patient with bilateral severe CTS, worse on right, bilateral cubital tunnel, left L5/S1 RAD[122] and referred the patient to hand surgery, ortho, and neurosurgery follow-up.

285. In addition to oxycodone, the Respondent prescribed Valium 5 mg twice daily or as needed for spasms. In the same note, the Respondent noted urine toxicology showed a high amount of tramadol and the patient was not discharged because, "I gave him a pass because he may have told me…otherwise urine toxicology is consistent…he is having a lot of hand pain and joint pains."[123]

286. On July 8, 2014, the patient did not show up for his hand surgery appointment because his truck stopped working. The Respondent noted the patient's prescriptions for oxycodone 15 mg, four times daily for pain and Flexeril 10 mg every four hours were renewed.

287. On December 28, 2017, the Respondent dictated the patient was incarcerated and came to him complaining of increasing numbness of the hands and feet, neck and low back pain, pain in all his joints.

288. In addition to bilateral severe CTS and cubital tunnel, the Respondent diagnosed the patient with right ACL problems, diffuse joint aches and pains, neck and low back pain, and onset headaches.

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[122] Radiculopathy.
[123] Jt. Ex. 5(j), p. IS1385.

289. The Respondent prescribed the following treatment plan: Topamax 75 mg every four hours for headaches and oxycodone 15 mg four times daily. He ordered a cervical and lumbar MRI, CT head, nerve conduction studies of the upper and lower extremities, and another rheumatological and neuropathy blood workup once the nerve conduction studies were complete.

290. On January 10, 2018, the patient underwent a cervical and lumbar MRI, CT head, and nerve conduction study of the upper and lower extremities.

291. The Respondent noted the patient had bilateral CTS, severe on the right, moderate on the left, no cubital tunnel, sensory neuropathy in hands, motor, and sensory neuropathy in right leg. The Respondent recommended hand surgery and a neuropathy workup.

292. On January 25, 2018, the Respondent increased the patient's Topamax dosage from 75 mg to 150 mg every four hours and oxycodone 15 mg every four hours daily. The Respondent also ordered an MRI of the patient's lumbar spine, rheumatological and peripheral neuropathy blood workup, and peripheral neuropathy in the hands and legs.

293. On February 28, 2018, the Respondent dictated the patient's lumbar MRI shows some degenerative changes and MRI of the knee showed medial meniscal tear in the right knee. The Respondent referred the patient to hand surgery, prescribed Topamax 150 mg every four hours, refer for right knee, oxycodone 15 mg every four hours daily, start vitamin D 50,000 once a week.

294. On October 23, 2018, the Respondent dictated the patient was complaining of new onset sciatica in the right leg, increasing low back pain, spasms in the lower back, severe, bilateral carpal tunnel, and severe pain in the hands. No changes were made to the patient's medication regimen.

295. On November 20, 2018, the Respondent made the following additional impressions: disc herniation at L3-L4 6 mm causing right leg sciatica, bilateral severe CTS, and right hand and moderate left hand.

296. On November 20, 2018, the Respondent prescribed Topamax 150 mg every four hours; oxycodone 15 mg, fives times per day; oxymorphone ER 20 mg every twelve hours; and vitamin D 50,000 once per week.[124]

297. On July 2, 2019, the Respondent added Voltaren gel 5 mg to be rubbed on the hands twice daily.

298. On July 30, 2019, the Respondent added Flexeril 10 mg three times daily and stopped prescribing Voltaren gel as it was turned down by the insurance company.

299. On August 27, 2019, the Respondent noted that the patient reported sensory neuropathy in the hands and legs and prescribed steroids for right Bell's palsy in addition to Topamax 150 mg every four hours; Flexeril 10 mg, three times daily; oxycodone 15 mg, five times daily; oxymorphone ER 20 mg every twelve hours; and vitamin D 50,000 weekly.

300. On August 27, 2019, morphine, though not prescribed, was detected in the patient's urine. The inconsistency was not discussed in the Respondent's note.

301. On September 24, 2019, the Respondent noted the patient's right Bell's palsy was "getting better" and removed the steroids for right Bell's palsy.

302. On September 24, 2019, oxymorphone and oxycodone, though prescribed, were not detected in the patient's urine. This inconsistency was not discussed in the Respondent's note.

[124] In a final case summary note May 6, 2020, the Respondent noted he prescribed oxymorphone ER 20 mg every twelve hours to his regimen because he has excruciating pain.

303. On November 19, 2019, the Respondent added prednisone 60 mg in the morning for ten days to the patient's medication regimen. The Respondent did not include an explanation for the addition in the case summary note.

304. On December 17, 2019, morphine, though not prescribed was detected in the patient's urine. The inconsistency was not discussed in the Respondent's note.

305. On January 15, 2020, codeine, though not prescribed, was detected in the patient's urine. The inconsistency was not discussed in the Respondent's note.

306. On February 11, 2020, the Respondent prescribed Neurontin 400 mg three times daily for radicular pain of sciatica.

307. On March 10, 2020, oxycodone and oxymorphone, though prescribed, were not detected in the patient's urine drug screen. This inconsistency was not discussed in the Respondent's note.

308. On May 5, 2020, the Respondent added gabapentin 400 mg three times daily to the patient's medication regimen.

309. The Respondent met the standard of care when he had monthly face-to-face visits and had TP sign an opioid agreement.

310. The Respondent breached the standard of care by failing to provide careful justification for prescribing high doses of opioids to patient TP, failing to obtain sufficient outside medical records and supporting information for continued opioid therapy, failing to indicate whether he discussed alternative therapies or dangerous risk factors with TP, failing to document TP's PDMP review, failing to document risk, benefit and compliance assessments, failing to document inconsistent weaning or tapering of medication, UDS inconsistencies or changes in prescribing behavior that were a direct result of inconsistencies.

DISCUSSION

Burden of Proof and Legal Framework

When not otherwise provided by statute or regulation, the standard of proof in a contested case hearing before the OAH is a preponderance of the evidence, and the burden of proof rests on the party making an assertion or a claim. Md. Code Ann., State Gov't § 10-217 (2021); COMAR 28.02.01.21K. To prove an assertion or a claim by a preponderance of the evidence means to show that it is "more likely so than not so" when all the evidence is considered. *Coleman v. Anne Arundel Cty. Police Dep't*, 369 Md. 108, 125 n.16 (2002). In this case, the State bears the burden to show the Respondent violated the standard of care or failed to keep adequate medical records by a preponderance of the evidence. COMAR 28.02.01.21K(1)-(2)(a).

The grounds for reprimand or probation of a licensee, or suspension or revocation of a license under the Act include the following:

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

Health Occ. § 14-404(a) (2021).

The Charges

The Board charged the Respondent with failing to meet the standard of care, in violation of Health Occupations Article section 14-404(a)(22) and failed to keep adequate medical records, in violation of Health Occupations Article section 14-404(a)(40) by:

a) Failing to document justification for high-dose opioid therapy (Patients: all);
b) Failing to record any review of Prescription Drug Monitoring Program (PDMP) information (Patients: all);
c) Failing to keep adequate progress notes (Patients: all);
d) Failing to address aberrant toxicology results (Patients: BC, CM, JA, KK, SL, TP);
e) Failing to utilize or record recommendation of a multi-modal approach to pain relief (Patients: CU, JA, KK, SL);
f) Failing to document any attempts to reduce opioid dosages (Patients: AC, TP);
g) Failing to address dangerous risk factors such as prescribing combination high-dose opioid therapy to individuals sharing the same residence (Patients: AC, BC);
h) Increasing patient's dosages without documented justification (Patients: CU, CM, PF);
i) Prescribing a dangerous combination of opioid, benzodiazepine, and Soma that has a high risk of abuse and overdose (Patient: AC);
j) Increasing a patient's opioids without documented justification beyond the patient's request (Patient: PF).

(Jt. Ex. 17, p. 5).

Arguments of the Parties

The State argued, at all times relevant to the proceeding, that the Respondent breached the standard of care by failing to provide justification for prescribing high doses of opioids to patients in his pain management practice. In 2016 the CDC published a guideline (Guideline) for physicians who prescribe opioids due to the concerning numbers of deaths and addiction related to prescription opioids. The Guideline, among other things, advises physicians to provide careful justification when prescribing high doses of opioids over 90 MME to non-cancer patients. In its discussion regarding the Respondent's lack of justification for high dose medication regimens, the State highlighted a lack of outside records to substantiate patient claims and the Respondent's prescribing practices. The State also argued the Respondent's medical notes are

insufficient because they failed to indicate whether the Respondent assessed his high dose patients for risk of abuse or misuse and the impact of their chronic pain on their daily functioning. The State contended the Respondent's medical notes failed to discuss aberrant urine drug test results, explaining the importance of weaning or tapering to patients, or prescribing or suggesting alternative therapies. The State maintained the Respondent retained patients who had positive urine drug screens for drugs that either were not prescribed or negative screens for drugs that were prescribed and failed to change his prescribing practices as a result. The State also maintained many of the Respondent's patients were being weaned by other physicians and those attempts were ignored and reversed when they transferred to his practice. The State sought the imposition of disciplinary sanctions against the Respondent's license including three years of supervised probation, a lifetime-ban from prescribing opioids and/or alternatively a sixteen- to twenty-hour course on prescribing opioids safely.

The Respondent argued the Guideline's guidance only applies to primary care physicians. The Respondent claimed that pain management physicians often prescribe high dosages for chronic pain patients who often seek treatment because alternative therapies have failed. He explained that most of his patients are chronic pain patients who have gone to other pain practices and have failed lower doses.

The Respondent averred careful justification is only required in those instances where patients are prescribed opioids at dosages of greater than 150 MME. The Respondent also averred the State's peer reviewer does not know his patients like he does, and he is better equipped to make determinations on what is best for his patients. The Respondent acknowledged that he failed to track and note PDMP in his patient's records. He claimed, however, he never takes on a new patient without obtaining medical records and all new patients are tested to ensure they have a clean urine toxicology evaluation. He argued when patients are

unable to obtain medical records from prior providers, he orders MRIs of the brain, cervical, lumbar spine, and if needed, EMGs. He also contended he has patients undergo monthly urine drug screening and if their tests are inconsistent, they undergo random pill counts or if he deems it appropriate, they are discharged. The Respondent argued that his notes were sufficient because he employed the SOAP[125] method. The Respondent maintained that although he did not always make a note of it, he assessed patients for the risk of opioid abuse or misuse, the functional impact of their chronic pain on the patient, and discussed aberrant urine drug screen results, and alternative treatments or therapies.

He further maintained that a failure to record these assessments and discussions is not an indication they did not occur. Regarding inconsistent urine drug screens, the Respondent argued the decision to discharge is ultimately left to the prescribing doctor and depending on what his patients reported, he gave them a second chance. The Respondent maintained there are some instances where discharge is inappropriate after an inconsistent drug screen due to the likelihood of withdrawal. The Respondent contended that at an uncertain time he had to change the toxicology laboratory that he contracted to conduct urine drug tests because patients were receiving false positives for fentanyl. He asserted it took six months to discover the inconsistency.

The Respondent also contended his patients have a right to change doctors if they disagree with their provider's treatment plan. He noted that often patients come to him on opioid regimens well over 90 MME and he increases or keeps the patient at the same dosage to allow the patient to be able to function in their activities of daily living. He also noted abruptly stopping or tapering a patient's medication can be dangerous.

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[125] Subjection, Objective, Assessment, Plan.

The Respondent argued the determination of whether a provider's notes breach the standard of care is a subjective assessment. He averred the standard of care depends on the complexity of the case, how well the provider knows the patient, and how useful the note is to the specific provider. He contended the standard of care put forward by the State is not common practice. The Respondent requested a dismissal of the Cease and Desist Order and all charges or, alternatively, that he be ordered to take medical courses.

For the following reasons, I propose that the charges filed by the State be upheld in part and propose the Respondent be sanctioned with three years of supervised probation and shall take a course on the standard of care for medical record keeping and prescribing opioids.

Expert Witnesses

On the issue of expert testimony, the Court of Appeals has held: "The premises of fact must disclose that the expert is sufficiently familiar with the subject matter under investigation to elevate his opinion above the realm of conjecture and speculation, for no matter how highly qualified the expert may be in his field, his opinion has no probative force unless a sufficient factual basis to support a rational conclusion is shown." *Bohnert v. State*, 312 Md. 266, 274 (1988) (social worker's expert testimony that child under the age of fourteen was a victim of sexual abuse was inadequately supported and was inadmissible in prosecution for second-degree sexual offense) (citing *State, Use of Stickley v. Critzer*, 230 Md. 286, 290 (1962)). The Maryland Rules provide: "Expert testimony may be admitted . . . if the court determines that the testimony will assist the trier of fact to . . . determine a fact in issue. In making that determination, the court shall determine . . . whether a sufficient factual basis exists to support the expert testimony." Md. Rule 5-702.

Dr. [redacted] was accepted as an expert in the field of pain management without objection. He has decades of experience, has published articles in the same field, and teaches students at [redacted]

[redacted] Dr. [redacted] provided valuable information and insight. The State objected to the Respondent being admitted as an expert, namely citing that he could not provide an expert opinion on his own conduct.[126]

The Respondent testified that he has practiced in the pain management field for over ten years. He explained that medical school, fellowships, and residencies included courses in pain management. He received on the job training at his current clinic before purchasing it, and has, prior to the Board's investigation, treated over five hundred patients. I determined in accordance with Maryland Rule 5-702 the Respondent is qualified as an expert based on his knowledge, experience, training, and education. Further, the implicit bias that the State argues is in existence is a factor that will influence the weight accorded to the Respondent's testimony.

An expert opinion may be tested for bias. As noted by the Court of Appeals of Maryland in *Wrobleski v. de Lara*, 353 Md. 509 (1999):

> The professional expert witness advocating the position of one side or the other has become a fact of life in the litigation process. Practicing lawyers can quickly and easily locate an expert witness to advocate nearly anything they desire. In each part of the country, if you need an expert medical witness to state that plaintiff suffered a whiplash injury, call expert X; if you need a medical expert to dispute that fact, call expert Y. The use of the expert witness has become so prevalent that certain expert witnesses now derive a significant portion of their total income from litigated matters.

Id. at 515-516 (internal citations omitted). Although Dr. [redacted] has testified for the State previously, he has no personal connection with the Respondent, and no apparent interest in the outcome of the hearing. He was compensated by the State for the time he took to review the Respondent's records and had no role in determining whether the Respondent will be sanctioned. Additionally, Dr. [redacted] testified he does not derive a significant amount of his income from testifying as an expert in matters such as the instant case.

[126] The State argued the Respondent is not recognized as a board-certified pain management specialist. I do not find this argument changes my determination of whether the Respondent should be qualified as an expert.

The Respondent has a clear bias, as he most certainly has an interest in the outcome of the hearing and wants to be able to continue practicing. This bias, however, goes to the weight of the Respondent's expert testimony and I have weighed his testimony accordingly.

I note that Dr. [redacted] and the Respondent are more familiar than I am with the technical, scientific, and medical terms used. I deferred to both experts on some of the issues before me and evaluated their opinions as to whether the Respondent failed to meet the standard of care for quality medical care or failed to keep adequate medical records and gave those opinions the weight that I determined they deserved.

In analyzing the evidence, I have assessed the Respondent's credibility. His responses largely were supported by the evidence of record. He testified consistently and acknowledged some of the areas in which he failed to keep adequate medical records such as PDMP tracking and recording discussions regarding patient risk. For these reasons I found his testimony to be credible.

Medical Record Keeping and Breach of the Standard of Care

Dr. [redacted] opined regarding the requirement for physicians to create and maintain adequate records. He opined that inadequate record keeping in and of itself, is a breach of the standard of care. He explained, a well understood tenet in medical practice is that if something is not written down, it did not occur. He testified that adequate medical progress notes require the use of the SOAP method. The physician includes subjective reports of the patient along with a review of the patient's medical notes, the physician's objective observations and findings, the physician's impression of the patient's condition or clinical diagnoses based on subjective and objective observations, and a treatment plan. While Dr. [redacted] acknowledged the Respondent employed this method, he opined the Respondent failed to include significant details, making it difficult to

determine whether he complied with the standard of care. Specifically, Dr. [redacted] opined the Respondent failed to include the following categories of details in his progress notes: (1) Justification of high doses of opioids or increases in patient's dosages, (2) PDMP review, (3) addressing aberrant or inconsistent urine drug screen results, (3) recommendations for alternative therapies, (4) attempts to taper or reduce opioid dosages, and (5) discussion of dangerous risk factors. Each category is discussed below.

1. Justification of high doses of opioids or increases in patient's dosages (All)

Dr. [redacted] opined that the Guideline applied to all physicians, including pain management specialists. Although the State and Dr. [redacted] referred to the Guideline, it was never offered into evidence. The Respondent, referred to a CDC media statement (Statement) published on April 24, 2019, that advised against misapplication of the Guideline due to potential risks to patient health and safety. The Statement, which was offered and admitted into evidence states the following:

> CDC is raising awareness about the following issues that could put patients at risk:
>
> - **Misapplication of recommendations to populations outside of the Guideline's scope.** *The guideline is intended for primary care clinicians treating chronic pain for patients 18 and older.* Examples of misapplication include applying the Guideline to patients in active cancer treatment, patients experiencing acute sickle cell crises, or patients *experiencing post-surgical pain.*
>
> - **Misapplication of the guidelines dosage recommendation that results in hard limits or cutting off opioids.** The Guideline states, "When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should...*avoid increasing dosage to greater than 90 MME per day or carefully justify a decision to titrate dosage to greater than 90 MME per day.*"
>
> - **The guideline does not support abrupt tapering or sudden discontinuation of opioids.** These practices can result in severe opioid withdrawal symptoms including pain and psychological distress, and some patients might seek other sources of opioids. In addition, policies that mandate hard limits conflict with the guidelines emphasis on individualized assessment of

the benefits and risks of opioids given the specific circumstances and unique needs of each patient.

. . . .

The Guideline was developed to ensure that primary care clinicians work with their patients to consider all safe and effective treatment options for pain management. CDC encourages clinicians to continue to use their clinical judgment, base treatment on what they know about their patients, maximize use of safe and effective non opioid treatments, and consider the use of opioids only if their benefits are likely to outweigh their risks.

The Guideline includes guidance on management of opioids in patients already receiving them long term at high dosages, including advice to providers to:

- Maximize nonopioid treatment
- Emphatically review risks associated with continuing high dose opioids
- Collaborate with patients who agree to taper their dose
- If tapering, taper slowly enough to minimize withdrawal symptoms
- Individualize the pace of tapering
- Closely monitor and mitigate overdose risk for patients who continue to take high dose opioids

. . . .

Some Policies, Practices Attributed to the Guideline are Inconsistent with its Recommendations, CDC Media Statement, April 24, 2019 (Emphasis added).[127]

The Respondent opined that careful justification of high dosage prescriptions is only required when patients are being treated with a dosage of over 150 MME. He also testified the requirement for careful justification at dosages over 90 MME is limited to primary care physicians not pain management specialists. The Respondent testified that it is a common practice for pain management specialists to prescribe high doses of opioids. The Respondent further argued the Guideline is not a black and white rule and as the treating physician, he is in a unique position of knowing his patients personally over many years and understanding their pain issues to make individualized treatment plans.[128]

[127] Jt. Ex. 14., p. 1.
[128] *Id.*

When interpreting a statute, the analysis typically begins by first looking to the normal, plain meaning of the language of the statute.[129] While it is clear the Statement is not a statute, the same principles of interpretation apply. If the Statement's language is unambiguous and consistent with its purpose, my review ceases and I will apply the normal and plain meaning of the Statement.[130] If a statute is unambiguous, the words clearly disclose the legislative intention. The Statement's plain language establishes that the purpose of the Statement is to advise against the misapplications of the Guideline that can risk patient health and safety. In an effort to improve opioid prescribing and reduce opioid misuse and overdose, the Statement warns against hard limits or "cutting off" of opioids, outlines examples of misapplication of the Guideline, encourages individualized treatment plans and close monitoring of patients on high dosages of opioids, and highlights advice from the Guideline that is critical for safe and effective implementation of the Guideline.[131]

In its discussion of the misapplication of the Guideline recommendations to populations outside of the Guideline's scope, the plain language of the Statement demonstrates that the Guideline is intended for primary care clinicians treating chronic pain for patients eighteen and older and provides examples of misapplication of the Guideline particularly to patients in active cancer treatment or patients experiencing post-surgical pain. The Statement does not specifically refer to pain management specialists.

The Statement specifically refers to patients who are started on opioids, the need to prescribe the lowest effective dosage, the need for clinicians to avoid increasing dosages to greater than 90 MME or to carefully justify a decision to titrate dosage to greater than 90 MME.

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[129] *Spaw, LLC v. City of Annapolis*, 452 Md. 314 (2017); *Twigg v. State*, 447 Md. 1 (2016); *Preston v. State*, 444 Md. 67 (2015); *Walker v. State*, 432 Md. 587, 295 (2013); *In re Sean M.*, 430 Md. 695 (2013); 20A M.L.E. Statutes § 68 (2022).
[130] *Id.*
[131] Jt. Ex. 14, p. 1.

The Statement also notes that the CDC does not recommend or suggest discontinuing opioids already prescribed at higher doses.

A separate section of the Statement includes guidance on management of opioids in patients already receiving them at long-term high dosages and includes advice for "providers" such as emphatically reviewing risks associated with continuing high does opioids, collaborating with patients who agree to taper their doses, slow tapering to minimize withdrawal symptoms, and closely monitoring patients to mitigate overdose risks for patients who continue to take high doses.

Both Dr. [redacted] and the Respondent acknowledged that pain management providers utilize many of the tools suggested in the article for long-term high dose patients. The Statement specifically notes that the Guideline does not apply to patients who have post-surgical pain and differentiates between patients starting an opioid regimen from patients who are already on high dosage pain medications. It also differentiates patients receiving high dosage opioids on a long-term basis from patients who are initiating an opioid regimen.

Based on the Statement's plain language, I find the Guideline's advisement regarding careful justification for the prescribing of opioids over 90 MME does not apply to the ten patients identified by the state. All ten patients were already on high dosages when they began treatment with the Respondent and are long-term high dosage patients. Additionally, while I find that patients BC, SB, CU, CM and PF were post-surgical, the Respondent did not indicate in his notes whether the pain that they were experiencing was post-surgical pain. This makes it difficult to determine whether his patients are even contemplated by the Guideline, as noted by the Statement.

Notwithstanding, the Respondent opined that careful justification is required for opioid doses of greater than 150 MME. All but one (PF) of the ten patients selected for review were

receiving dosages well beyond 150 MME.[132] By the Respondent's own admission, the standard of care required him to provide careful justification for at least nine out of the ten patients.

While I do not find the Guideline specifically applies to pain management providers, the Statement, nevertheless, identifies overarching canons for prescribing high dosage opioids that were acknowledged by the Respondent and Dr. [redacted] For example, the Statement requires providers to "closely monitor and mitigate overdose risk for patients who continue to take high dose opioids" and to "maximize non-opioid treatment", i.e., close monitoring requires documentation and discussions regarding alternative therapies should be noted.[133] Dr. [redacted] opined, and I find, documentation of careful justification is necessary due to the risk of death and potential for misuse and the need for continuity of care, so that subsequent providers know the rationale behind the Respondent's care or treatment. A lack of careful justification or documentation is inadequate record keeping and a breach of the standard of care.

2. Careful Justification

Dr. [redacted] asserted he expects a pain management provider who prescribes high doses to lay out the patient's problems or issues in their notes, include what the patient is suffering from, provide medical evidence of imaging studies and consultations from outside providers or orthopedic surgeons, clearly outlining their issues, and then propose a therapy. Dr. [redacted] opined that he expects the provider to then justify the risk by clearly documenting how the provider is monitoring that therapy through the benefits the patient is experiencing as evidenced by notes regarding increased activity, improved pain scores, improved survey scores on functional capacity reports. Dr. [redacted] explained, "That is the type of thinking process and documentation that

[132] Jt. Ex. 5.
[133] Dr. [redacted] and Respondent, Testimony.

I expect for a patient that is taking a very dangerous combination of medications. Not just a simple laundry list of issues and medications that they are taking."[134]

The Respondent testified that he included the justification for high dose prescriptions in his SOAP note. He explained that simply listing the pain diagnoses such as neck pain, low back pain, degenerative disease in the lumbar, etc., is sufficient to justify the use of high dose medications. He opined the standard of care does not require him to use a specific rating system or pain scale and that instead, he asks his patients questions to determine the functional impact of their chronic pain on their activities of daily living. He explained, "Examples of questions that I would ask my patients to determine the functional impact of their chronic pain while sitting, standing, or driving include, are you having any problems with showering, dressing, sitting, standing, working, groceries?"[135] He noted that he asks if their pain is getting better or worse and how they are sleeping. The Respondent explained that these inquiries are important, "[B]ecause it means that the regimen needs to be adjusted or it means the patient needs other modalities like physical therapy or epidural steroidal injections or maybe a referral to a neurosurgeon or repeat MRI or something."[136]

The Respondent opined that a failure to include patient responses is not indicative of a failure to abide by the standard of care. The Respondent testified that he documents patient responses when a patient answers his questions in the affirmative.

The Respondent argued that his SOAP notes in all ten cases provided sufficient justification for the high dosage medication regimens he prescribed. The Respondent also noted that he generally followed the same pattern of "justification" in all ten patient records, thus in analyzing this particular issue, I will highlight a few of those patients below.

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[134] Dr. [redacted] Testimony.
[135] Respondent, Testimony.
[136] Respondent, Testimony.

Patient AC

Dr. [redacted] opined that AC was maintained on high doses of narcotics at 290 MME and the Respondent failed to document justification for the use of such high doses. He noted that her prior pain provider mentioned an MRI report that showed mild disc disease with minimal impairment to her nerves that was not included in the Respondent's notes. Dr. [redacted] opined the patient did not have any surgical consultation from spinal or orthopedic surgeons for the purpose of evaluating the pathology in her lumbar, spine, hips, and knees where her primary areas of pain are located. He averred without a clear understanding of the pathology, the high dose opioid regimen is difficult to justify.[137]

The Respondent testified when the patient came to his practice, she was already on a medication regiment with doses over 90 MME, as she was taking oxycodone, 15 mg three times a day and a fentanyl patch, 15 mcg. The Respondent explained he increased the patient's medication because she was not getting, "the response at the 15 mcg every forty-eight hours with the fentanyl patch. She was still in pain and could not do activities of daily living and she could not sleep." He stated that he documented the problems including neck pain, hip pain, and knee pain as justification for the high dosages he prescribed.

Patient BC

Dr. [redacted] opined that BC was maintained on high doses of narcotics at 290 MME and the Respondent failed to document justification for the use of such high doses. In his report Dr. [redacted] noted, "The patient has had a history of lumbar fusion and laminectomy but there is very little detail regarding the history of the pathology. For example, did his pain develop after surgery due to complications or is this the same pain before his surgery? Is his new pain related to another pathology above the fusion? Is there a nerve conduction study that correlates the patient's pain

[137] Jt. Ex. 9, p. 3

symptoms? Is there potential hardware malfunction or need for further surgery that patients want to avoid?" Dr. [redacted] also opined there is a paucity of records and inadequate monitoring of the patient's prescriptions.

The Respondent explained that when the patient presented at his practice, he was already on 90 MME (oxycodone 15 mg). The Respondent testified that he obtained BC's records from his primary care physician along with MRI reports from [redacted] which showed extensive hardware in his lower back from the prior surgeries that were conducted. The Respondent noted that he conducted a toxicology screen before accepting him as a patient. "And once everything came back, I determined that I could see the patient. I added on a fentanyl patch with a strength of 15 micrograms. And I was able to stabilize his pain."

Patient SB

Dr. [redacted] opined that SB was maintained on high doses of narcotics at 293 MME per day and the Respondent failed to document justification for the use of such high doses. In his report, Dr. [redacted] noted, "The patient has had a history of lumber schwannoma resection but there is very little detail regarding the history of the pathology. For example, did her pain develop after surgery due to complications or is this the same pain before the surgery? Is this new pain related to stenosis found on her MRI in 2019? Is there a nerve conduction study that correlates the patient's pain symptoms? Like the prior cases not enough information is offered regarding the patient's pain pathology and multiple opinions from different specialists in support of her treatment, this high dose opioid regimen is difficult to justify."[138]

The Respondent testified that he was seeing SB for two years and when she arrived at his office the patient was already on a medication regimen in excess of 90 MME. The Respondent noted that he took the additional step of having his own MRI done in 2019. He explained, "[A]

[138] Dr. [redacted] Testimony.

doctor is permitted to believe or accept the history that is provided to them by the patient." He contended, "With regard to the increase in medication in the main body of the history and physical, I [prescribed] morphine extended release three times a day which worked for the first three weeks and then it stopped working. With regard to justification, I write the diagnosis in my impression which is severe chronic low back pain with bilateral weakness, sciatica down both legs, a history of lumbar surgery with removal of lumbar synovial in 2014 and bilateral severe knee pain."[139]

In his medical notes for patients AC, BC, and SB, the Respondent appears to rely heavily on the subjective reports of the patient. Based on his testimony, and in accordance with the standard of care outlined by Dr. [redacted] he asks the patient questions regarding the impact of their pain on their functional capacity and activities of daily living, he reviews and orders medical records, and physically examines his patients to devise a treatment plan. The Respondent did not consistently indicate in his SOAP note that he asked the patients these questions, although he did at times document that a patient was not able to engage in some of their daily activities. While Dr. [redacted] acknowledged it is not a breach of the standard of care to rely on a patient's subjective observations, he also opined the standard of care is to look to a variety of sources to evaluate the pathology of the patient's pain and take appropriate notes to justify a treatment plan. In accordance with the standard of care, I find a simple listing of diagnoses to be insufficient medical record keeping. While I find, based on the Respondent's testimony, the Respondent abided by some portions of the standard of care in practice, his notes were not in full compliance.

Where the Respondent provided some explanation for an increase in dosage, Dr. [redacted] opined that he disagreed with the Respondent's reasoning for the high dosage of opioids he prescribed for SB. Dr. [redacted] explained that he disagreed with the Respondent's claim in his letter

[139] Jt. Ex. 5(c), p. IS0415.

that, "[I]t is not surprising that the morphine ER had to be increased to 60 milligrams three times a day because morphine ER is a weaker narcotic then methadone 10 milligrams twice a day. The methadone 10 milligram twice a day is a very strong and potent narcotic, and the morphine ER comparatively is a weak narcotic."[140] Dr. [redacted] opined that the Respondent justified using the high dosage of morphine ER because it is weaker narcotic than methadone, however it is ideal and more effective to use a lower dose of narcotic. He noted, on the other hand, if you take a weaker medication and prescribe very high doses of it, the potency does not matter because the amount that you are using overwhelms the low potency of the medication.[141]

In SB's case, where the Respondent provided some justification for an increase in dosage, the justification was not in line with the standard of care to use the lowest effective dose as outlined by Dr. [redacted]

Patient CU

Dr. [redacted] opined that CU was maintained on high doses of narcotics at 353 MME per day and the Respondent failed to document justification for the use of such high doses. Dr. [redacted] noted, "Given the extent of the patient's trauma and surgery, there is little question regarding the patient's pain pathology [which] gives merit for using opioids to help control the patient's suffering. However, prescribing such an extraordinary level of opioids requires an extraordinary explanation of the risks and benefits. For example, it is unclear why the patient's oxymorphone ER 30 mg was increased to 40 mg."[142] He then referred to a medical note dated October 31, 2018 that stated, "[H]e is on oxymorphone ER 30 mg and oxycodone 15 mg five times a day. Pain is much better controlled." Despite this note, the Respondent increased the

[140] Jt. Ex. 9, p. 7.
[141] Dr. [redacted] Testimony.
[142] Jt. Ex. 9, p. 10; Ex. 5(d), p. IS0514.

dosage of oxymorphone to 40 mg, without explanation. Dr. [redacted] opined, if the pain is better controlled at 30 mg, there would be no need to increase the patient's pain medication and noted there is a disconnect between the Respondent's history and physical impression note and his treatment plan.

According to Dr. [redacted] without explanation, the long acting oxymorphone ER went from 61% of the patient's daily medication load to 268%." He further opined, "For a functional patient who is not in palliative care for terminal illness, I typically prescribe a ratio between 30 to 40% extended release or long-acting medication and 60 to 70% immediate release. The higher extended-release ratios will allow the patient to be more comfortable for a longer period but at the cost of higher risk of extended periods of respiratory depression and sedation leading to complications [and] the exception to the rule is patients who have a terminal illness, who are bedridden, and have no capacity left. It is generally safer to prescribe a higher dose of immediate release opioids depending on the patient's abuse potential profile."[143]

The Respondent argued the patient came to his practice with an MME over 90 and had been to multiple providers. The Respondent explained the patient sought care outside of his last provider, [redacted] n Frederick, because his medication was being cut in half.[144]

The Respondent averred and Dr. [redacted] agreed that abruptly cutting the patient's medication is inconsistent with CDC guidelines and a violation of the standard of care. The Respondent noted the patient was fully compliant with his treatment plan, had consistent UDS drug samples, and never had a "bad test."[145]

It is concerning that after a positive report from patient CU, the Respondent's note indicates that he increased CU's dosage without explanation. While the Respondent's reasoning

[143] Dr. [redacted] Testimony.
[144] Jt. Ex. 5(d), p. IS0538.
[145] Dr. [redacted] Testimony; Respondent, Testimony.

for increasing the patient's medication dosage may have been justified, the Respondent failed to indicate his reasoning in the medical note, rendering it inadequate and a breach of the standard of care.

Patient CM

Dr. [redacted] opined that CM was maintained on high doses of narcotics at 270 MME per day and the Respondent failed to document justification for the use of such high doses. CM had three lumbar surgeries, the last being a lumbar fusion in January 2018. Dr. [redacted] noted there were no other outside records made available by the Respondent to justify the use of such high doses. He testified the Respondent's note should include supporting information and documentation of the patient's need for continued use of opioids and compliance with an opioid monitoring program. Dr. [redacted] asserted the Respondent could have described how the patient benefits from opioids using pain scores and functional capacity levels and documented whether the patient was experiencing side effects such as respiratory depression or constipation.

Dr. [redacted] also testified the Respondent increased and changed the patient's medication without documentation. He cited a medication note dated November 19, 2018, where the Respondent replaced Morphine ER 30 mg with Oxymorphone 20 mg without including an explanation for the change.[146]

The Respondent argued the patient came to his practice with an MME over 90. He testified the patient's prior provider was in Virginia and he relocated to Maryland. He testified the patient provided him with an MRI at his second visit and came back with additional records which the Respondent reported he reviewed and then prescribed a medication regimen accordingly.[147] He noted the patient was not functional on short acting narcotic, Percocet, so he

[146] Jt. Ex. 5(e), p. 13.
[147] Jt. Ex. 5(e) pp. IS0607-609, 611-612, 615-618, 619-25, 641

added morphine, a long-acting narcotic, for better pain control. He stated he later replaced the morphine he prescribed with oxymorphone because the patient developed a morphine allergy.[148]

While I find the Respondent's testimony to be consistent with the record, I agree with Dr. [redacted] that he should have included the reason for the change in medication. Just as he gave careful justification during his testimony, the Respondent could have included a note indicating that he changed the patient's medication from morphine to oxymorphone because the patient developed a morphine allergy.

Patient PF

Dr. [redacted] opined PF was maintained on high doses of narcotics at 113 MME per day and the Respondent failed to document justification for the use of such high doses. Dr. [redacted] noted a deep concern over the Respondent's willingness to appease a patient's request for more opioids rather than discuss medical justification for it when he states, "She wants to increase the dose of oxycodone to 15 mg…I said OKAY."[149] Dr. [redacted] acknowledged the Respondent may have had a more in-depth discussion and a thorough rationale for the increased dosage, however, it was not documented. He explained, even though the Respondent may have had good intentions, he cannot read the Respondent's mind and he was left without documentation of a clear justification of why the Respondent agreed to prescribe the increased dosage.

The Respondent again pointed to the patient's list of diagnoses as sufficient justification. He explained his plan was to slowly increase oxycodone, that he wanted to add on a long-acting medication, however it was not approved by the patient's insurance. He noted he increased the dosage of the oxycodone because of the patient's persistent pain.[150]

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[148] Respondent, Testimony.
[149] Jt. Ex. 5(f), p. IS0712.
[150] Respondent, Testimony.

The Respondent argued in practice he met the standard of care and was not required to document everything Dr. [redacted] suggested. He argued the Guideline, was just that, a guideline, not a mandate. While acknowledging that there was room for improvement, he maintained that his medical records were adequate. He characterized the difference between Dr. [redacted] s testimony and his testimony as best practice versus standard of care. I disagree. Given the risk of harm to patients on high doses of opioids, I find the State has met its burden to show that it is more likely than not that the Respondent was required to provide careful justification in his medical notes.

Additionally, it is highly concerning that the Respondent would indicate in his note that he increased the patient's dosage amount after she asked without providing any additional explanation.

3. PDMP Review, Risk Benefit Assessment, Discussion of Risk Factors

Dr. [redacted] opined a SOAP note should include how the patient is being followed by the provider, for example with pill counts, urine drug testing, or PDMP data to show that the benefits of the high dose therapy are worth the risks and close monitoring to minimize those risks.

The State alleged and the Respondent acknowledged he failed to record his review of patient PDMP data. Based on the Respondent's own admission, I find he breached the standard of care for recording PDMP reviews in his medical notes.[151]

According to Dr. [redacted] the risk calculation should be presented very clearly in the impression and plan. The Respondent testified that he asked patients three questions to determine their risk of abuse or misuse: "Have you taken medication from a relative, which is a

[151] If a prescriber decides to prescribe or continue to prescribe an opioid or a benzodiazepine after requesting prescription monitoring data from the Program and assessing the prescription monitoring data, the prescriber shall document in the patient's medical record that the prescription monitoring data was requested and assessed. Md. Code Ann., Health-Gen. § 21-2A-04.2(a)(2).

sign of abuse. Have you gone to the emergency room? This is a sign of abuse and shows the patient is finishing medications faster and they need more. Are you finishing your medication faster than the month is out? This can mean the medication is not working or they are taking extra to get high." The Respondent explained he does not ask his patients the above questions every visit but does so every sixty days. The Respondent noted he included positive answers in his notes and opined the standard of care does not require him to document answers that are in the negative.

The Respondent asserted he complies with the standard of care for assessing the risk of abuse or misuse by having his patients take a urine drug test at every visit to get an understanding of what the patient is doing. The Respondent explained the practice has a bathroom and the laboratory can check to confirm whether the samples are from an animal or human.

Dr. [redacted] opined that the standard of care requires the Respondent to state what he is thinking, note the benefits and risks of the prescribed therapy, monitor the responses to that therapy, use CRISP, have patients engage in self-assessments with questionnaires, and urine screenings every three to six months. While acknowledging that monthly screenings are not a breach of the standard of care, Dr. [redacted] explained random screenings are ideal because patients can prepare for tests when they are monthly.

Dr. [redacted] averred that each patient's circumstance provides a variety of ways to look at the standard of care. He explained even when the basic requirements were met, the Respondent still needed to assess whether the patient's risk should continue and provide a basis. He noted the Respondent's notes had a paucity of information to even get to this stage and given that the Respondent did not record it, he could not determine whether those assessments were done.

Dr. [redacted] also noted the Respondent failed to note that patient AC and BC were married and living in the same household. He explained two patients living together can increase the risk of abuse or misuse because they have access to the other's medication. The Respondent made no effort to document this risk, nor did he include any discussion regarding whether he discussed it with his patients or altered his monitoring to account for their living circumstance.

I agree with Dr. [redacted]'s assessment, by failing to provide enough details regarding risk of abuse or misuse, the Respondent breached the standard of care as to all ten patients.

4. Addressing Aberrant or Inconsistent Urine Drug Screen Results

On multiple occasions the Respondent failed to document the inconsistent drug screen results of CM, JA, KK, SL and TP and continued prescribing to patients as if nothing occurred. Patient CM tested positive for cocaine three times (August 23, 2019, September 23, 2019, and November 19, 2020) before he was discharged.[152] Other tests were positive for suboxone (December 2, 2019), fentanyl (July 23, 2019), and hydrocodone and tramadol (May 6, 2019).[153] Despite what appears to be an abuse of medications, the Respondent continued to prescribe and made no note of a discussion with the patient or acknowledgement of the issue.

The Respondent testified he was not sure if the positive tests were accurate because the laboratory that his clinic used was getting false positives for fentanyl and suboxone and that he had the patient sign a probation contract for illicit substances. The Respondent testified he could not remember when the false positives occurred but remembered it was sometime in 2019 and the problem may have lasted for about three to six months. The Respondent also asserted the

[152] Jt. Ex. 5(e), pp. IS0662, IS0660, IS0651.
[153] Jt. Ex. 5(e), pp. IS0657, IS0664, IS0667.

cocaine that was revealed on the patient's urine test results showed up in minute amounts. The Respondent testified that he discharged the patient after "three strikes" of testing positive for cocaine.

While some of CM's inconsistent results could have resulted from false positives in 2019, it does not negate the fact that the Respondent made no note of the inconsistencies in his progress notes until May 2020, in his last note and around the time that he would have received the news that he was being investigated by the Board.

Dr. [redacted] opined that discharging CM after three tests demonstrated an unwillingness to discharge and is a breach of the standard of conduct. Dr. [redacted] opined that CM should have been discharged after the first positive cocaine test because it is an illicit substance. Dr. [redacted] acknowledged; however, it should be left up to the provider to determine what warrants immediate discharge. Each patient signs an opioid agreement agreeing to not, among other things, take illicit substances or other drugs. The Respondent opined that he is in a better position to determine whether discharge is appropriate.

The Respondent did not breach the standard of care because he discharged CM after three positive cocaine tests or gave his patients second and third chances. He breached the standard of care because he did not record any information regarding the patient's inconsistent urine drug screens, how that impacted the patient's treatment, what patients said regarding the inconsistencies, or his concerns regarding misuse or abuse. Similarly, he failed to take note or discuss the inconsistent screens of JA, KK, SL, and TP.[154] Due to the lack of detail in his notes, it is difficult to discern whether the Respondent addressed the inconsistencies in any way or why it did not change his prescribing behavior. This inadequate record keeping was a breach of the standard of care as to patients CM, JA, KK, SL, and TP.

[154] Jt. Ex. 9, pp. 17, 19, 21, 23.

5. Recommendations for Alternative Therapies

Dr. [redacted] opined the Respondent failed to discuss the need for patients CU, KK, JA, and SL to try alternative therapies.[155] He noted if a patient has tried alternative therapies, it should be documented and reported. The Respondent testified that he did not record discussions regarding therapy because he would not document the fact that a patient is not doing something. He explained typically his patients have failed other modalities, so by the time they come to him, they have gone through a lot and are on chronic opioid therapy.

While I find the Respondent's explanation to be reasonable, the standard of care acknowledged by both the Respondent and Dr. [redacted] requires providers to discuss alternative therapy during follow-up visits. The Respondent should have documented if he engaged in this type of discussion with the above-named patients because I am unable to determine whether he did so because it is not in his progress notes. The Respondent failed to maintain adequate medical records for patients CU, JA, KK, SL, thereby breaching the standard of care.

6. Attempts to Taper or Reduce Opioid Dosages

Dr. [redacted] testified patient AC was in the process of having her medications tapered down at Smart Pain Management. He explained that when the Respondent took over her care, rather than continuing to wean the patient, the Respondent increased her dosage to 270 MME without justification. He opined patients AC and TP were taking a dangerous combination of opioid, benzodiazepine, and Soma, which is highly abused. He explained the euphoric effects of the Soma and opioid combination can mask the depressive effect of the benzodiazepine and patients are unable to self-monitor their breathing and easily overdose. He opined the risks outweigh the benefits. Dr. [redacted] also acknowledged, however, the prescribing of the combination of

[155] Jt. Ex. 16.

medication, is not in itself a breach of the standard of care but that the Respondent needed to eventually wean the patient and document his careful monitoring.

The Respondent testified that patient AC had chronic pain and when she came to his practice, she was already taking over 150 MME. He noted despite this, the patient could not complete her activities of daily living and could not sleep. He further noted she was not getting any relief. He explained he did not believe it was appropriate for her to be weaned at the time due to her high pain index that was uncontrolled by her current medication regimen. He asserted weaning would have worsened her condition and she would have suffered from withdrawal. He noted that CDC guidelines state that weaning abruptly is harmful to the patient and as a result, he decided not to wean her. He reported that he ordered tests to determine the pathology of her pain but was unable to obtain her records because insurance turned it down.

Regarding the medication combination, the Respondent noted he continued prescribing the same combination because the patient was already stable, was tolerant of the medication, and had failed other muscle relaxants.

Similarly, with TP, the Respondent reported that he was already on a medication regimen of over 90 MME. The Respondent explained he increased the patient's medication to address his severe carpal tunnel, pinched nerve in his lower back and resultant sciatica. He testified he saw him three times before he went to jail. He reported there was a lack of records for TP because he was incarcerated for two years before returning to his practice.

While I do not find the Respondent's plan to treat patients AC and TP with the combination of opioid, benzodiazepine, and Soma to be a breach of the standard of care, I find the lack of documentation to be a breach of the standard of care. Dr. [redacted] testified that all patients can obtain a copy of their own medical records. It is not reasonable that after insurance denied the Respondent's request for AC's medical records, that the inquiry stopped there.

Furthermore, the patient's subjective reports are not enough justification for the medication that was prescribed. The Respondent needed to include supporting information and documentation including outside medical records, notes on whether the patient was experiencing side effects including respiratory depression, and risk assessments. This inadequate record keeping constitutes a breach of the standard of care.

Based on the above findings, I conclude the State has shown by a preponderance of evidence that the Respondent breached the standard of care due to inadequate medical record keeping.

I placed a considerable amount of weight on the testimony provided by both the Respondent and Dr. [redacted] however in weighing the testimony in accordance with the apparent bias, I accorded more weight to Dr. [redacted] s expert testimony.

Sanctions

The State seeks to impose the disciplinary sanctions of three years of supervised probation, a lifetime-ban from prescribing opioids and/or alternatively a sixteen- to twenty-hour course on prescribing opioids safely.[156]

COMAR sets out sanctioning guidelines.[157] Under the applicable law, I may propose a sanction not less severe than the minimum listed in the sanctioning guidelines nor more severe than the maximum listed in the sanctioning guidelines for each offense.[158] Depending on the facts and circumstances of each case, and to the extent that the facts and circumstances apply, I may consider the aggravating and mitigating factors.[159]

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[156] Md. Code Ann., Health Occ. § 14-404(a) (2021); COMAR 10.32.02.09B(5) (a-c, g), (6)(c); COMAR 10.32.02.10.
[157] COMAR 10.32.02.10; COMAR 10.32.02.10.
[158] COMAR 10.32.02.09A(2).
[159] COMAR 10.32.02.09B(5) (a, c, g), 6(c).

In the instant case, the mitigating factors include: the absence of a prior disciplinary record; the Respondent voluntarily admitted to the misconduct, the Respondent made full disclosure to the disciplinary panel and was cooperative during the disciplinary panel proceedings, and the misconduct was not premeditated.[160] The aggravating factor to consider is that the offense had the potential for causing patient harm.[161]

Based on the above five mitigating factors and one aggravating factor, I find the State's request for a lifetime-ban from prescribing opioids to be unreasonable. The Respondent vocalized a willingness to improve in the areas identified by the Board and there is no record of any prior disciplinary action. He has complied with the State's investigation and based on his and Dr. [redacted]'s testimony, his misconduct was not done on purpose. I agree with the State that the Respondent needs to be supervised in his practice to ensure that he abides by the applicable standards of care and needs instructional guidance to provide a refresher on standards of care in opioid prescribing and medical record keeping. As such, I propose the following sanctions: three years of supervised probation and a twenty-hour course on abiding by appropriate standards of care in medical record keeping and opioid prescribing.[162]

Cease and Desist Order

For the same reasons highlighted above for sanctions, the Cease and Desist Order shall be dismissed once the patient has taken the above proposed twenty-hour course on abiding by appropriate standards of care in medical record keeping and opioid prescribing. With instruction and supervision, I do not find the Respondent continues to pose a serious risk to the health, safety, and welfare of patients.[163]

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[160] COMAR 10.32.02.09B(2).
[161] *Id.*
[162] COMAR 10.32.02.09B(2); COMAR 10.32.02.10(B) (22, 40).
[163] Health Occ. § 14-206(e)(3).

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent violated the alleged provisions of the law. Md. Code Ann., Health Occ. § 14-404(a) (22, 40). As a result, I conclude that the Respondent is subject to disciplinary sanctions of three years of supervised probation and a twenty-hour course on abiding by appropriate standards of care in medical record keeping and opioid prescribing for the cited violations. *Id.*; COMAR 10.32.02.09A-B(5)(a), (c), (g), (6)(c).

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on June 29, 2021 be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned by three years of supervised probation and a twenty-hour course on abiding by appropriate standards of care in medical record keeping and opioid prescribing; and

I **PROPOSE** that the Cease and Desist Order entered on June 29, 2021 be **VACATED** upon the Respondent's completion of a twenty-hour course on abiding by appropriate standards of care in medical record keeping and opioid prescribing.

April 8, 2022
Date Decision Mailed

Abena Y. Williams
Administrative Law Judge

AYW/at
#197512

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of the Maryland State Board of Physicians that delegated the captioned case to the Office of Administrative Hearings (OAH) and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2021); COMAR 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the Disciplinary Panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the other party will have fifteen (15) days from the filing of exceptions to file a written response addressed as above: *Id.* The disciplinary panel will issue a final order following the exceptions hearing or other formal panel proceedings. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2021); COMAR 10.32.02.05C. The OAH is not a party to any review process.

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