IN THE MATTER OF	*	**BEFORE THE MARYLAND**
DAVID A. LEE, M.D.	*	**STATE BOARD OF PHYSICIANS**
Respondent.	*	**Case Number: 2217-0056A**
License No. D71594	*	

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FINAL DECISION AND ORDER

David A. Lee, M.D. is a physician and board-certified dermatologist, who has been licensed by the Maryland State Board of Physicians ("Board") since 2010. On April 17, 2018, Disciplinary Panel A of the Board charged Dr. Lee with unprofessional conduct in the practice of medicine, gross overutilization of health care services, failure to meet appropriate standards for the delivery of quality medical care, and failure to keep adequate medical records, in violation of the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-404(a)(3)(ii), (19), (22), and (40), respectively. The charges followed a Board investigation and review by two peer reviewers of Dr. Lee's care of ten patients, based on a complaint received from Patient 1,[1] a former patient of Dr. Lee. Patient 1 alleged that Dr. Lee had initially recommended and scheduled the performance of Mohs[2] surgery on her, which she described as costly, invasive, time-consuming, and unnecessary. Patient 1 cancelled the scheduled Mohs procedure after obtaining a second opinion from another dermatologist who disagreed with Dr. Lee's recommendation. Patient 1 also alleged that Dr. Lee had altered his notes on her initial pathology report to change his initial recommendation for Mohs surgery to cryosurgery.[3]

Dr. Lee requested and received an evidentiary hearing at the Office of Administrative Hearings on November 15 and 16, 2018. The evidence at the hearing included expert testimony

[1] For purposes of confidentiality, this patient is referred to as Patient 1 throughout this Final Decision and Order.
[2] Mohs surgery involves a microscopically controlled surgical procedure used to treat certain types of cancer.
[3] Cryosurgery involves the application of extreme cold to destroy abnormal or diseased tissue.

from Brett Coldiron, M.D. on behalf of Dr. Lee, and from Jay M. Barnett, M.D. for the State, both of whom are board-certified and specialize in dermatology. In a Proposed Decision issued on January 10, 2019, an Administrative Law Judge ("ALJ") recommended that the charges issued by Panel A be upheld. As a sanction, the ALJ recommended that Dr. Lee be reprimanded and placed on probation for two years, that his practice be subject to supervision, that he successfully complete a course in the appropriate use of Mohs surgery, and that he pay a $20,000 fine.

Dr. Lee filed written exceptions to the ALJ's Proposed Decision, and the State filed a Response to Dr. Lee's exceptions. Both parties appeared before Disciplinary Panel B of the Board for an oral exceptions hearing, on March 27, 2019. After considering the entire record in this case, including the evidentiary record made before the ALJ, and the written exceptions and oral arguments by both parties, Panel B now issues this Final Decision and Order.

FINDINGS OF FACT

Panel B adopts the findings of fact numbered 1-59 proposed by the ALJ.[4] (The ALJ's Proposed Decision of January 10, 2019, is incorporated by reference into this Final Decision and Order and is appended to this Order as Attachment A). The ALJ found that Dr. Lee failed to meet standards of quality care, overutilized Mohs surgeries, and was guilty of unprofessional conduct in the practice of medicine, in violation of §§ 14-404(a)(3)(ii), (19), and (22) of the Health Occupations Article.[5] The ALJ's findings were based on Dr. Lee's recommendations and performance of Mohs surgery on pre-cancerous and pre-invasive skin conditions of five patients in the absence of pathology results supporting the surgeries, and on his performance of Mohs

[4] The ALJ's Findings of Fact incorporated six stipulated facts (Proposed Findings of Fact 1-6) agreed to by the parties.

[5] On page 34 of the Proposed Decision, Panel B modifies the ALJ's references to the "Business Occupations Article" to correctly state "Health Occupations Article" and adopts the Proposed Decision as amended.

surgery on lesions of four patients when the indications for that surgery failed to conform to appropriate use criteria ("AUC")[6] developed by national dermatological organizations. The ALJ also found that Dr. Lee failed to keep adequate medical records with respect to Patient 1, in violation of Health Occ. § 14-404(a)(40). The factual findings were proven by a preponderance of the evidence. The panel also adopts the ALJ's discussion and analysis on pages 13-34 of the Proposed Decision.

CONSIDERATION OF EXCEPTIONS

Dr. Lee does not dispute the ALJ's proposed findings and conclusions that he is guilty of unprofessional conduct in the practice of medicine, that he grossly overutilized health care services, and failed to meet appropriate standards of care. *See* Health Occ. §§ 14-404(a)(3)(ii), (19), and (22). Dr. Lee does take exception to the ALJ's conclusion that he failed to keep adequate medical records regarding Patient 1, in violation of Health Occ. § 14-404(a)(40). The ALJ found that, based on Dr. Lee's medical record keeping system, he improperly altered Patient 1's medical records by applying a new digital stamp on her pathology report that stated "Schedule Cryo"[7] and by removing altogether from Patient 1's medical record his initial treatment recommendation to "Schedule Mohs." Dr. Lee argues that this finding is not warranted by the evidence, that he had no notice that a failure to keep adequate medical records was an area of contention, and that the issue should never have been before the ALJ. The record does not support Dr. Lee's arguments.

At the evidentiary hearing, it was undisputed that Patient 1's medical history with Dr. Lee included his removal of a skin lesion from her left forehead on June 24, 2016, a biopsy of the

[6] A 2012 Report issued by the American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery created an appropriate use criteria ("AUC") for determining when Mohs surgery is indicated.
[7] "Cryo" is an abbreviation for cryosurgery.

lesion, and a pathology report in her medical record summarizing the results. She attached to her complaint a copy of the "Final Dermatopathology Report" faxed to her by Dr. Lee on July 1, 2016, which stated:

> Traumatized actinic keratosis,[8] transected at the base. Comment: Dermis is not present and as such, an underlying process cannot be excluded on those sections.

That final report bore the digital stamp "Schedule Mohs" as Dr. Lee's treatment recommendation. Patient 1 also attached to her complaint a copy of the same final pathology report sent to her again by Dr. Lee in November, 2016. This time, the report bore the digital stamp "Schedule Cryo." The initial digital stamp "Schedule Mohs" was deleted from the report. In her complaint, the patient listed Dr. Lee's alteration of his notes in her pathology report as one of her main concerns. In his supplemental response to the peer reviews, Dr. Lee acknowledged that "[i]f patients change their decision on how to proceed, [he] typically change[s] the digital stamp to reflect the new treatment, and [he] delete[s] the previous stamp to avoid any confusion." He also acknowledged that he "sometimes changes his recommendation on the digital stamp to a lesser invasive option . . ." From the very beginning of the Board's investigation, therefore, when a copy of Patient 1's complaint was sent to Dr. Lee, he was on notice that this alteration of his prior pathology note in her medical record was a concern.

In fact, Paragraphs 6 through 13 of the charging document, issued on April 17, 2018, set forth explicitly and notified Dr. Lee of Patient 1's allegations regarding the alteration of his prior notes in her medical record. Based on the nature of the patient's complaint, the charges, and Dr. Lee's acknowledgment that he deleted his prior digital stamp in the patient's medical record, he had ample notice before the evidentiary hearing that this alteration of Patient 1's pathology report in her medical record was an area of contention.

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[8] "Actinic keratosis" ("AK") is a scaly growth caused by damage from exposure to ultraviolet light. AK is a precancerous skin lesion.

Dr. Lee also argues that this issue should never have been before the ALJ, because Patient 1 never had the Mohs surgery initially recommended by Dr. Lee. The issue, however, is not whether Patient 1 ever had Mohs surgery performed by Dr. Lee, but whether her medical record accurately reflected Dr. Lee's recommendation that she have that procedure. It did not. It was undisputed that the patient's medical record sent to the Board by Dr. Lee contained only the pathology report with the digital stamp "Schedule Cryo," and did not reflect his initial Mohs recommendation. Had Patient 1 not sought a second opinion, she would have undergone the clinically unnecessary and costly Mohs surgery that Dr. Lee strongly recommended.

Dr. Lee further argues that the written report by the State's expert, Dr. Barnett, indicated that Dr. Lee kept adequate medical records with respect to Patient 1. But during direct examination of Dr. Barnett at the evidentiary hearing, it became apparent that at the time he wrote his peer review report, Dr. Barnett was unaware of the deletion of the initial Mohs recommendation in Patient 1's medical record sent to the Board by Dr. Lee. When that fact was brought to Dr. Barnett's attention, he testified that if the preliminary treatment recommendation was for Mohs, and if that recommendation was not present in the pathology report, it would reflect an inaccurate medical record. Dr. Barnett further testified that to change or remove the original digital stamp without actually showing the original stamp, constituted inadequate keeping of medical records. In his view, Dr. Lee could have drawn a line through the original stamp rather than deleting it. Dr. Coldiron, who testified on Dr. Lee's behalf, stated that an adequate medical record is important to provide continuity of care and documentation of a physician's treatment rationale and thought process. The panel agrees. As a result of Dr. Lee's deletion of the digital stamp with his earlier treatment recommendation to "Schedule Mohs," Patient 1's medical record maintained by Dr. Lee did not accurately represent her medical history

as his patient. Her medical record, therefore, would not provide the necessary information to a subsequent physician to determine Dr. Lee's medical rationale or thought process regarding his two differing treatment recommendations, and was therefore inaccurate and inadequate. Dr. Lee's exceptions pertaining to the charge of failure to keep adequate medical records, Health Occ. § 14-404(a)(40), are denied.

Dr. Lee also excepts to the length of the period of probation and the requirement of a practice supervisor recommended by the ALJ. The panel agrees with Dr. Lee that probation for a lesser period that two years may be sufficient to address the problems with his practice. The panel will impose probation for a minimum of 18 months. The panel will not require supervision of Dr. Lee's practice, but will require that Dr. Lee take an ethics course and be subject to a chart and/or peer review. The panel will not require a course on Mohs surgery.

CONCLUSIONS OF LAW

Based on the findings of fact and discussion of Dr. Lee's exceptions, as set forth above, Disciplinary Panel B concludes that Dr. Lee is guilty of unprofessional conduct in the practice of medicine, grossly overutilized health care services, failed to meet appropriate standards, as determined by appropriate peer review, for the delivery of quality care, and failed to keep adequate medical records, in violation of Md. Code Ann., Health Occ. II § 14-404(a)(3)(ii), (19), (22), and (40), respectively.

ORDER

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

ORDERED that David A. Lee, M.D., License No. D71594, is **REPRIMANDED**; and it is further

ORDERED that Dr. Lee is placed on **PROBATION** for a minimum of **EIGHTEEN (18) MONTHS.**[9] During probation, Dr. Lee shall comply with the following terms and conditions:

(1) Within **SIX (6) MONTHS** from the effective date of this Final Decision and Order, Dr. Lee shall take and successfully complete a panel-approved **ethics course** that addresses the alteration of medical records and overutilization of health care services. The following terms apply:

(a) It is Dr. Lee's responsibility to locate, enroll in, and obtain the disciplinary panel's approval of the course before the course begins;

(b) The disciplinary panel will not accept a course taken over the internet;

(c) Dr. Lee shall provide documentation to the disciplinary panel that he has successfully completed the course;

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

(e) Dr. Lee is responsible for the cost of the course.

(2) Within **EIGHTEEN (18) MONTHS** from the effective date of this Final Decision and Order, Dr. Lee is subject to a chart and/or peer review conducted by the disciplinary panel or its agents as follows:

(a) Dr. Lee shall cooperate with the peer review process;

(b) The disciplinary panel in its discretion may change the focus of the peer review if Dr. Lee changes the nature of his practice;

(c) If the disciplinary panel, upon consideration of the peer review and Dr. Lee's response, if any, determines that Dr. Lee is meeting the standard of quality care in his practice, the disciplinary panel shall consider the peer review condition of this Order met;

(d) If the disciplinary panel, upon consideration of the peer review and Dr. Lee's response, if any, has a reasonable basis to believe that Dr. Lee is not meeting the standard of quality care in his practice or cannot safely and competently practice, the disciplinary panel may charge Dr. Lee with a violation under the Medical Practice Act.

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

(3) Within **EIGHTEEN (18) MONTHS** from the effective date of this Final Decision and Order, Dr. Lee shall pay a civil fine in the amount of **TWENTY THOUSAND DOLLARS ($20,000).** The payment or payments shall be made by money order or bank certified check(s) made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate Dr. Lee's license if Dr. Lee fails to timely pay the fine to the Board; and it is further

ORDERED that a violation of probation is a violation of this Final Decision and Order; and it is further

ORDERED that after a minimum of eighteen months, if Dr. Lee has complied with all terms and conditions of probation, Dr. Lee may submit a written petition for the termination of probation. After consideration of the petition, the probation may be terminated through an order of a disciplinary panel. Dr. Lee may be required to appear before a disciplinary panel to discuss his petition to terminate the probation. A disciplinary panel may grant the petition to terminate the probation through an order of the disciplinary panel, if Dr. Lee has complied with all of the probationary conditions, and there are no pending complaints related to the charges; and it is further

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

and conditions, or suspend or revoke Dr. Lee'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 upon Dr. Lee; and it is further

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

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

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

07/15/2019
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. Lee has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (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. Lee 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:

Noreen Rubin
Assistant Attorney General
Maryland Department of Health
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Attachment A

MARYLAND BOARD OF	*	BEFORE TRACEY JOHNS DELP,
PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
DAVID A. LEE, M.D.,	*	OF ADMINISTRATIVE HEARINGS
RESPONDENT	*	OAH No.: MDH-MBP2-71-18-24597
LICENSE No.: D71594	*	

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PROPOSED DECISION

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

STATEMENT OF THE CASE

On April 17, 2018, a disciplinary panel of the Maryland Board of Physicians (Board) issued charges against the Respondent alleging violations of the State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 through 14-508, and 14-601 through 14-607 (2014 & Supp. 2018). Specifically, the Respondent is charged with violating sections:

- 14-404(a)(3)(ii) (unprofessional conduct in the practice of medicine),
- 14-404(a)(19) (grossly overutilizes health care services),
- 14-404(a)(22) (failure to meet standards of care), and
- 14-404(a)(40) (failure to keep adequate medical records).[1]

[1] On November 15, 2018, the Administrative Prosecutor withdrew the allegation that failure to document lesion size before a biopsy constituted a violation of section 14-404(a)(40).

Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d). The disciplinary panel 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) for issuance of 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 November 15 and 16, 2018, at the OAH in Hunt Valley, Maryland. Health Occ. § 14-405(a) (Supp. 2018); COMAR 10.32.02.04. Robert C. Maynard, Esquire, and Armstrong, Donohue, Ceppos, Vaughan and Rhoades, Chartered, represented the Respondent, who was present. Victoria H. Pepper, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State).

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board of Physicians, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2018); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

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

SUMMARY OF THE EVIDENCE

Exhibits

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

State Ex. A – Diagram of skin including basal and squamous cells

Three-Ring Binder containing State Exhibits One through Thirty-three.
State Ex. 1 – February 6, 2017 Complaint (received by the Board on March 7, 2017)
State Ex. 2 – April 3, 2017 Respondent's response to the complaint

State Ex. 3 – Patient One[2] - medical record and certification
State Ex. 4 – Patient One - billing record
State Ex. 5 – (Blank)
State Ex. 6 – Patient One's records from [redacted]
State Ex. 7 – Board subpoena for patient records
State Ex. 8 – Patient Two[3] - medical record excerpt[4] and certification
a. Service date 11/3/16: Bates DL0117 – DL0130
b. Service date 10/15/14: Bates DL0245 – DL0256
c. Service date 8/20/14: Bates DL0304 – DL0306
State Ex. 9 – Patient Two - billing record
State Ex. 10 – Patient Two Respondent's summary of care
State Ex. 11 – Patient Three[5] - medical record excerpt and certification
a. Service date 11/3/16: Bates DL0373 – DL0382
b. Service date 10/20/16: Bates DL0383 – DL0393
c. Service date 4/21/16: Bates DL0437 – DL0451
State Ex. 12 – Patient Three - billing record
State Ex. 13 – Patient Three Respondent's summary of care
State Ex. 14 – Patient Five[6] - medical record excerpt and certification
a. Service date 11/3/16: Bates DL0771 – DL0794
State Ex. 15 – Patient Five - billing record
State Ex. 16 – Patient Five Respondent's summary of care
State Ex. 17 – Patient Six[7] - medical record except and certification
a. Service date 4/22/16: Bates DL0935 – DL0947
b. Service date 2/2/16: Bates DL0949 – DL0957
c. Service date 11/10/15: Bates DL0977 – DL0985
d. Service date 10/28/15: Bates DL1006 – DL1010
State Ex. 18 – Patient Six - billing record
State Ex. 19 – Patient Six Respondent's summary of care
State Ex. 20 – Patient Eight[8] - medical record except and certification
a. Service date 11/18/16: Bates DL1382 – DL1405
b. Service date 12/15/15: Bates DL1578 – DL1595
c. Service date 11/20/15: Bates DL1612 – DL1629
d. Service date 3/13/15: Bates DL1706 – DL1725
e. Service date 3/14/14: Bates DL1872 – DL1891
State Ex. 21 – Patient Eight - billing record
State Ex. 22 – Patient Eight Respondent's summary of care

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[2] Patient One is used instead of the individual's proper name for privacy reasons.
[3] Patient Two is used instead of the individual's proper name for privacy reasons.
[4] The parties agreed to submit complete patient records via computer disc, and utilize a paper extract of relevant pages during the hearing. The computer disc is located within the three-ring binder containing State exhibits 1-33 and was made part of the record.
[5] Patient Three is used instead of the individual's proper name for privacy reasons.
[6] Patient Five is used instead of the individual's proper name for privacy reasons.
[7] Patient Six is used instead of the individual's proper name for privacy reasons.
[8] Patient Eight is used instead of the individual's proper name for privacy reasons.

State Ex. 23 – Patient Nine[9] - medical record except and certification
a. Service date 6/8/17: Bates DL1933 – DL1946
b. Service date 12/8/16: Bates DL1986 – DL2004
State Ex. 24 – Patient Nine - billing record
State Ex. 25 – Patient Nine Respondent's summary of care
State Ex. 26 – Dr. Barnett's curriculum vitae
State Ex. 27 – Dr. Barnett's peer review report - Health Occ. §§ 14-404(a)(22) and (40)
State Ex. 28 – Dr. Barnett's peer review report - Health Occ. §§ 14-404(a)(3)(ii) and (19)
State Ex. 29 – Connolly SM, Baker DR, Coldiron BM *et al.*, AAD/ACMS/ASDSA/ASMS 2012, Appropriate use criteria for Mohs surgery
State Ex. 30 – Speiser, J. *et al.*, Actinic Keratosis, Transected: What Lies Beneath? American Journal of Dermatopathology, Vol. 37, 10 (Oct. 2015)
State Ex. 31 – Rogers, H. and Coldiron, B. A relative value unit-based cost comparison of treatment modalities for nonmelanoma skin cancer
State Ex. 32 – Respondent's supplemental response to peer review reports
State Ex. 33 – April 17, 2018 charging document

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

Resp. Ex. 1 – Dr. Lee's curriculum vitae
Resp. Ex. 2 – Two photographs, Patient Three: Bates DL0364
Resp. Ex. 3 – Dr. Coldiron's curriculum vitae

I admitted the following as a joint exhibit on behalf of the State and the Respondent.

Jt. Ex. 1 – Dr. Coldiron's report[10]

Testimony

The following witnesses testified on behalf of the State: Patient One and Jay M. Barnett, M.D., F.A.A.D.,[11] F.A.C.P.,[12] whom I accepted as an expert in the following areas:

- Diagnosis and treatment of non-malignant and malignant forms of skin cancer;
- Application of the appropriate use criteria for Mohs micrographic surgery;
- The overall general medical specialty of dermatology;
- Generally accepted treatment for skin cancer;
- Biopsy techniques;
- The interpretation of biopsy reports;
- Appropriate medical documentation;
- Billing codes used in the field; and
- Use of electronic medical records.

[9] Patient Nine is used instead of the individual's proper name for privacy reasons.
[10] A highlighter pen was used on this document prior to its admission into evidence.
[11] Fellow of the American Academy of Dermatology
[12] Fellow of the American College of Physicians

The Respondent testified in his own behalf, and presented the following witness: Brett Coldiron, M.D., F.A.C.P., whom I accepted as an expert in the following areas:

- Diagnosis and treatment of non-malignant and malignant forms of skin cancer;
- Application of the appropriate use criteria for Mohs micrographic surgery;
- The overall general medical specialty of dermatology;
- Generally accepted treatment for skin cancer;
- Appropriate medical documentation; and
- Billing codes used in the field.

PROPOSED FINDINGS OF FACT

The Parties stipulated to the following facts:

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on November 16, 2010. His license is scheduled to expire on September 30, 2018. The Respondent holds an active license in the District of Columbia.

2. The Respondent is Board-certified in dermatology.

3. The Respondent maintains an office for the private practice of dermatology in Damascus, Maryland.

4. The Board initiated an investigation of the Respondent after receiving a complaint dated March 7, 2017, from a former patient (identified as Patient One) of the Respondent.

5. In furtherance of the investigation, the Board obtained patient records from the Respondent for review. The Board referred the patient charts and related materials to a peer review entity for review.

6. The medical records, transmitted to the Board by the Respondent in response to the Board's subpoena, are authentic.

Having considered all of the evidence presented, I find the following facts by a preponderance of the evidence:

7. Actinic keratosis (AK) is a precancerous growth. (State Ex. 30, p. 759; Test. Dr. Barnett.)

8. The standard of care for the treatment of AK is cryodestruction, curettage and destruction, application of chemical agents such as 5-fluorouracil or Imiquimod, and photodynamic therapy. (State Ex. 27; Test. Dr. Barnett.)

9. The major types of skin cancer are basal cell carcinoma (BCC) which is the most common of skin cancers, then squamous cell carcinoma (SCC), which is slightly less common, and then melanoma which is much less common than the other two and is the most serious. (Test. Dr. Barnett.)

10. Melanomas have a very high potential to metastasize and result in death. (Test. Dr. Barnett.)

11. There is no movement among the different types of skin cancer – so if one has an AK and it becomes a SCC, not treating it will not result in development of a melanoma. (Test. Dr. Barnett.)

12. Mohs surgery "is a technique for the removal of complex or ill-defined skin cancer with histologic examination of 100 [percent] of the surgical margins." (State Ex. 29, p. 536.)

13. A 2012 Report of the American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery created an appropriate use criteria[13] (AUC) for Mohs surgery.[14] (Test. Drs. Barnett and Coldiron; State Ex. 29.)

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[13] AUC score 1-3: Inappropriate for Mohs surgery; AUC score 4-6: Uncertain for Mohs surgery; AUC score 7-9: Appropriate for Mohs surgery.

[14] Dr. Coldiron co-authored this report.

14. The standard of care for skin cancers which score 1 – 3 on the AUC is excision or destruction, or chemical treatment – not Mohs surgery. (State Ex. 29; Test. Dr. Barnett.)

15. The Respondent is a Fellow of the American College of Mohs Surgery, American Academy of Dermatology, and the American Society for Dermatologic Surgery. (Resp. Ex. 1.)

16. The Respondent treated Patient One as a new patient in his Damascus office in August 2013, and saw her for office visits on February 28, 2014 and June 24, 2016. (State Ex. 3.)

17. During the June 24, 2016 office visit, the Respondent performed a biopsy on an area of Patient One's left forehead. The resulting dermatopathology report revealed a final diagnosis of traumatized AK transected at the base.[15] The Respondent recommended Mohs surgery which he would perform, and sent Patient One a copy of the dermatopathology report stamped "Schedule Mohs" as the Respondent's treatment recommendation.

18. Transected AKs are not covered in the AUC. (Test. Dr. Coldiron.)

19. Patient One scheduled the Mohs surgery for August 9, 2016, and then cancelled the surgery after obtaining a second opinion. Thereafter, the Respondent mailed a letter via United State Postal Service Certified Mail® to Patient One on November 20, 2016, changing his treatment recommendation from Mohs surgery to cryosurgery[16] and explaining that if left untreated, the lesion could evolve into a fatal cancer.

20. The November 20, 2016 mailing to Patient One enclosed Patient One's dermatopathology report wherein the "Schedule Mohs" digital stamp no longer appeared and a new digital stamp of "Schedule Cryo" was in its place. (State Ex. 1, 3.)

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[15] "If the base of the lesion cannot be visualized and a concern for a more invasive component exists, the dermatopathologist will often designate the specimen an 'actinic keratosis, transected at the base . . .' to convey their concern to the clinician." (State Ex. 30, p. 759.)

[16] Cryosurgery is performed with an instrument that freezes and destroys abnormal tissue. (Test. Dr. Barnett.)

21. The Respondent's record system wherein application of the "Schedule Cryo" digital stamp removed the original "Schedule Mohs" digital stamp on Patient One's dermatopathology report is a system which improperly altered medical records.

22. On July 14, 2016, Patient One received a second opinion from [redacted] regarding her left forehead area. [redacted] staff recommended Patient One monitor the area rather than take any immediate action. As of the hearing date, Patient One remained in the care of [redacted] for follow-up appointments. The left forehead area has been observed, and no action has been determined necessary. (State Ex. 6; Test. Patient One.)

23. The Respondent performed twelve Mohs surgeries on Patient Two. (State Ex. 10.)

24. As the result of an August 20, 2014 biopsy, the Respondent performed Mohs surgery to Patient Two's mid frontal scalp on September 23, 2014. The preliminary dermatopathology report revealed hypertrophic AK, at least, transected at the base. (State Ex. 9, 10.)

25. Hypertrophic AK is a thicker precancerous growth. (Test. Dr. Barnett.)

26. As the result of an October 15, 2014 biopsy, the Respondent performed Mohs surgery to Patient Two's left wrist on November 4, 2014. The preliminary dermatopathology report revealed SCC deep margin involved. (State Ex. 9, 10.)

27. Squamous cells have a slightly higher risk of metastasizing, especially in certain areas of the body, thus SCCs are more serious than basal cells. (Test. Dr. Barnett.)

28. As the result of a November 3, 2016 biopsy, the Respondent performed Mohs surgery to Patient Two's right forehead on December 6, 2016. The preliminary dermatopathology report revealed inflamed and traumatized AK, transected at base. (State Ex. 9, 10.)

29. Also as the result of a November 3, 2016 biopsy, the Respondent performed Mohs surgery to Patient Two's mid-frontal scalp on December 13, 2016. The preliminary dermatopathology report revealed atypical squamous proliferation extending to biopsy base; re-excision was recommended by the dermatopathologist. (State Ex. 9, 10.)

30. The Respondent performed nine Mohs surgeries on Patient Three. (State Ex. 13.)

31. As the result of an April 21, 2016 biopsy, the Respondent performed Mohs surgery to Patient Three's left inferior scapula on May 17, 2016. The preliminary dermatopathology report revealed BCC superficial type, margins involved. (State Ex. 11, 13.)

32. A BCC is an epidermal neoplasm, meaning it occurs essentially in the epidermis, the top layers of skin, and occurs from a cell in the basal layer. The basal layer is the interface between the epidermis and the dermis. (Test. Dr. Barnett.)

33. Some basal cells grow more rapidly, but typically basal cells are a slow growing neoplasm. (Test. Dr. Barnett.)

34. Also as the result of an April 21, 2016 biopsy, the Respondent performed Mohs surgery to Patient Three's right scapula on May 10, 2016. The preliminary dermatopathology report revealed BCC superficial type, margins free. (State Ex. 11, 13.)

35. As the result of an October 20, 2016 biopsy, the Respondent performed Mohs surgery to Patient Three's right forearm on November 15, 2016. The preliminary dermatopathology report revealed inflamed atypical squamous proliferation extending to biopsy base; re-excision was recommended by the dermatopathologist. (State Ex. 11, 13.)

36. As the result of a November 3, 2016 biopsy, the Respondent performed Mohs surgery to Patient Three's left earlobe on November 29, 2016. The preliminary dermatopathology

report revealed hypertrophic AK involving appendageal structures, transected at the base. (State Ex. 11, 13.)

37. The Respondent performed six Mohs surgeries on Patient Five. (State Ex. 16.)

38. As the result of a November 3, 2016 biopsy, the Respondent performed Mohs surgery to Patient Five's right medial eyebrow on November 29, 2016. The preliminary dermatopathology report revealed atypical squamous proliferation extending to the biopsy base; re-excision was recommended by the dermatopathologist. (State Ex. 14, 16.)

39. The Respondent performed twenty Mohs surgeries on Patient Six. (State Ex. 19.)

40. As the result of an October 28, 2015 biopsy, the Respondent performed Mohs surgery to Patient Six's right mid back on December 8, 2015. The preliminary dermatopathology report revealed BCC, superficial type, margins free. (State Ex. 17, 19.)

41. Also as the result of an October 28, 2015 biopsy, the Respondent performed Mohs surgery to Patient Six's left dorsal hand on February 2, 2016. The preliminary dermatopathology report revealed atypical squamous proliferation extending to biopsy base; re-excision was recommended by the dermatopathologist. (State Ex. 17, 19.)

42. As the result of a November 10, 2015 biopsy, the Respondent performed Mohs surgery to Patient Six's left anterior thigh on January 26, 2016. The preliminary dermatopathology report revealed SSC, deep margin involved. (State Ex. 17, 19.)

43. As the result of a February 2, 2016 biopsy, the Respondent performed Mohs surgery to Patient Six's right dorsal hand on June 21, 2016. The preliminary dermatopathology report revealed hypertrophic AK, transected at the base. (State Ex. 17, 19.)

44. As the result of an April 22, 2016 biopsy, the Respondent performed Mohs surgery to Patient Six's left anterior ankle on October 18, 2016. The preliminary dermatopathology report revealed hypertrophic AK, transected at the base. (State Ex. 17, 19.)

45. The Respondent performed nineteen Mohs surgeries on Patient Eight. (State Ex. 22.)

46. As the result of a March 14, 2014 biopsy, the Respondent performed Mohs surgery to Patient Eight's right mid upper forehead on April 8, 2014. The preliminary dermatopathology report revealed atypical squamous proliferation extending to biopsy base; re-excision was recommended by the dermatopathologist. (State Ex. 20, 22.)

47. As the result of a March 13, 2015 biopsy, the Respondent performed Mohs surgery to Patient Eight's right sideburn on March 31, 2015. The preliminary dermatopathology report revealed seborrheic keratosis (SK) and atypical squamous proliferation extending to biopsy base; re-excision was recommended by the dermatopathologist. (State Ex. 20, 22.)

48. As the result of a November 20, 2015 biopsy, the Respondent performed Mohs surgery to Patient Eight's left tricep on December 15, 2015. The preliminary dermatopathology report revealed BCC, superficial type, lateral margin involved. (State Ex. 20, 22.)

49. As the result of a December 15, 2015 biopsy, the Respondent performed Mohs surgery to Patient Eight's right abdomen on January 19, 2016. The preliminary dermatopathology report revealed traumatized BCC, superficial type, lateral margin involved. (State Ex. 20, 22.)

50. As the result of a November 18, 2016 biopsy, the Respondent performed Mohs surgery to Patient Eight's left elbow on December 13, 2016. The preliminary dermatopathology report revealed BCC, micronodular type with neuroendocrine features, deep margin involved. (State Ex. 20, 22.)

51. Also as the result of a November 18, 2016 biopsy, the Respondent performed Mohs surgery to Patient Eight's right chin on December 27, 2016. The preliminary dermatopathology report revealed sebaceous adenoma with a positive Muir-Torre immunohistochemical screening test, margins involved.[17] (State Ex. 20, 22.)

52. Sebaceous adenomas are benign growths. (Test. Drs. Barnett and Coldiron.)

53. The standard of care for sebaceous adenoma is excision or no treatment, not Mohs surgery. (State Ex. 27; Test. Dr. Barnett.)

54. The Respondent performed six Mohs surgeries on Patient Nine. (State Ex. 25.)

55. As the result of a December 8, 2016 biopsy, the Respondent performed Mohs surgery to Patient Nine's left tricep on January 17, 2017. The preliminary dermatopathology report revealed BCC, superficial type, lateral margins involved. (State Ex. 23, 25.)

56. Also as the result of a December 8, 2016 biopsy, the Respondent performed Mohs surgery to Patient Nine's right mid back on January 31, 2017. The preliminary dermatopathology report revealed BCC, superficial type, lateral margins involved. (State Ex. 23, 25.)

57. Also as the result of a December 8, 2016 biopsy, the Respondent performed Mohs surgery to Patient Nine's right mid abdomen on February 7, 2017. The preliminary dermatopathology report revealed BCC, superficial type, deep margin focally involved. (State Ex. 23, 25.)

58. Also as the result of a December 8, 2016 biopsy, the Respondent performed Mohs surgery to Patient Nine's left mid back on February 14, 2017. The preliminary dermatopathology report revealed BCC, superficial type, lateral margin involved. (State Ex. 23, 25.)

59. As the result of a June 8, 2017 biopsy, the Respondent performed Mohs surgery to Patient Nine's left clavicle. The preliminary dermatopathology report revealed BCC, superficial type, lateral margin involved. (State Ex. 23, 25.)

[17] The report indicated further work-up is indicated to exclude or confirm Muir-Torre Syndrome.

DISCUSSION

Summary of the Complaint that triggered the Charges

On or about March 7, 2017, the Board received a complaint from Patient One. Patient One wrote that as a result of a biopsy of her left forehead, the Respondent recommended Mohs surgery. Patient One stated that the Respondent was insistent on scheduling the Mohs surgery as soon as possible. Although she scheduled the procedure, Patient One also obtained a second opinion. Thereafter, Patient One cancelled the scheduled Mohs surgery because the second dermatology office did not agree with the Respondent's course of treatment. The second opinion was to observe the area and, if treatment was necessary, then cryosurgery would be the recommended course of action. Several months later, Patient One received a letter from the Respondent changing his recommended course of treatment to cryosurgery. (State Ex. 1.)

As a result of this complaint, the Board initiated an investigation which included a peer review of patient records. Thereafter, a disciplinary panel of the Board issued the charges against the Respondent.[18]

Patient One testified at the hearing to her interactions with the Respondent, the Respondent's office staff, and her second dermatologic care provider.

Legal Context

Section 14-404 of the Health Occupations Article provides as follows:

> (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:
>
> . . .
>
> (3) Is guilty of:
>
> . . .
>
> (ii) Unprofessional conduct in the practice of medicine;
>
> . . .

[18] The Board identified its case number as 2217-0056A.

(19) Grossly overutilizes health care services;

. . .

(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;

. . .

(40) Fails to keep adequate medical records as determined by appropriate peer review;

. . .

Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2018).

The Board's enforcement powers include a broad range of sanctions upon finding a violation of section 14-404. In addition to those set forth above in section 14-404(a), the Board may impose a financial penalty against an offending physician. Section 14-405.1 provides:

(a) *Imposition of penalty.* — If after a hearing under § 14-405 of this subtitle a disciplinary panel finds that there are grounds under § 14-404 of this subtitle to suspend or revoke a license to practice medicine of osteopathy, or to reprimand a licensed physician or osteopath, the disciplinary panel may impose a fine subject to the Board's regulations:

(1) Instead of suspending the license; or

(2) In addition to suspending or revoking the license or reprimanding the licensee.

(b) *Disposition of funds.* — The Board shall pay any fines collected under this section into the General Fund.

See also COMAR 10.32.02.09 (addressing disciplinary sanctions and the imposition of fines); and COMAR 10.32.02.10 (providing a chart that lists maximum and minimum sanctions and fines for specific violations).

Burden of Proof

The State (which is prosecuting the charges for the Board), as the moving party, has the burden of proof, by a preponderance of the evidence. Md. Code Ann., State Gov't § 10-217 (2014); Md. Code Ann., Health-Occ. § 14-405 (Supp. 2018); *Comm'r of Labor & Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34 (1996) (citing *Bernstein v. Real Estate Comm'n*, 221 Md.

221, 231 (1959)). For the reasons set forth below, I conclude that the State has met that burden on all of the Board's charges.

Peer Review

The State presented the testimony of Dr. Barnett, whom I accepted as an expert witness. Dr. Barnett is Board-certified in dermatology with current recertification, as well as Board-certified in internal medicine without recertification. He is a Fellow of the American Academy of Dermatology and the American College of Physicians. (State Ex. 26.) In addition to maintaining a private practice of dermatology in Maryland, he holds academic appointments with The George Washington University. (State Ex. 26.)

Dr. Barnett discussed his peer review of the Respondent's patient records. He testified that while he also considered the Respondent's responses and Dr. Coldiron's expert report, neither altered his opinions in any way. Dr. Barnett identified the issue in this case as being whether the Respondent used Mohs surgery appropriately. His opinions in this regard are based on his twenty-five years of dermatology experience, including what is and what is not a malignant lesion.

Dr. Barnett stated that non-malignant lesions are never treated with Mohs surgery, and many – but not all – malignant lesions are treated with Mohs surgery. He explained that AK is a precancerous growth; it is not cancer, and so the treatment of AK can fall into several appropriate categories. Only a small fraction of AK if given enough time will turn into a skin cancer, and if they do, they become SCC. He advised that because it takes considerable time for AK to turn into a cancer, if a patient has a very thin-looking AK, a dermatologist might chose to observe it because the AK may go away on its own without any treatment at all. Another course of action Dr. Barnett explained would be to freeze the AK with liquid nitrogen, which is a few second

spray of liquid nitrogen or application of the liquid nitrogen with a Q-tip® to freeze the lesion, causing some superficial frostbite and damage. The lesion then peels off after several days, and in most cases the AK is gone. Other appropriate courses of action include the application of 5-fluorouracil or Imiquimod, both of which treat the AK chemically. Dr. Barnett opined repeatedly that a dermatologist should not use Mohs surgery on an AK under any circumstances.

With regard to cancer, Dr. Barnett explained that the major types are BCC which is the most common of skin cancers, then SCC which is slightly less common, and then melanoma which is much less common than the other two and is the most serious. Melanomas have a very high potential to metastasize and result in death. Dr. Barnett explained that there is no movement among the different types of skin cancer – so if one has an AK and it becomes a SCC, not treating it will not result in development of a melanoma.

The standard treatments for BCC and SCC identified by Dr. Barnett are: (1) destructive methods to include freezing, burning, or application of 5-fluorouracil; and (2) excisional techniques such as an elliptical excision or Mohs surgery. He stated that a 2012 Report of the American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery created an appropriate use criteria (AUC) for Mohs surgery. (State Ex. 29.) Dr. Barnett testified that he applied this AUC algorithm where appropriate during his peer review. And while the report disclaims that it should not be interpreted as setting a standard of care, Dr. Barnett said the report and its guidelines are highly valued in the profession.

Having considered his peer review, the Respondent's responses, and Dr. Coldiron's report, Dr. Barnett opined within a reasonable degree of medical probability that the Respondent did not meet the standard of quality of care with regard to his recommendations for Mohs surgeries for

the lesions discussed in his peer review. Further, Dr. Barnett opined within a reasonable degree of medical probability that, as a result, the Respondent grossly overutilized health care services. Dr. Barnett opined that a medical retention system whereby a changed treatment recommendation removes the previously recommended treatment stamp from the record is a system which fails to maintain adequate medical records, because medical records should never be altered. He testified the appropriate record retention system would notate a changed treatment recommendation without removing the original recommendation. Finally, Dr. Barnett opined within a reasonable degree of medical probability that the Respondent engaged in unprofessional conduct because the Respondent treated patients for conditions they did not have.

Patient One Summary

Regarding Patient One's records, based on his training and experience, Dr. Barnett opined within a reasonable degree of medical probability that the Respondent's recommendation of Mohs surgery for Patient One's left forehead AK is a grossly inappropriate treatment recommendation because the lesion is not skin cancer. Furthermore, Dr. Barnett opined that, although a true statement, the Respondent's November 20, 2016 letter to Patient One, wherein the Respondent stated that AK can evolve into SCC which if untreated may be fatal, was overly dramatic considering the banality of the pathology report. In addition, Dr. Barnett testified to his concern that the Respondent would change his treatment recommendation from Mohs surgery to cryosurgery simply because Patient One had not been in contact with his office. Had the original treatment recommendation been an appropriate course of action, there was no basis to change it.

Patient Two Summary

On September 23, 2014, the Respondent performed Mohs surgery on Patient Two's mid frontal scalp. The preliminary dermatopathology report revealed hypertrophic AK, at least,

transected at the base. Dr. Barnett opined the Mohs surgery was inappropriate. He explained that hypertrophic means it is thicker under the microscope, but regardless, AK is not cancer. Again, Dr. Barnett stated that transected at the base means it is unknown what lies beneath the biopsy sample. He added unequivocally what is unknown is just that – being unknown does not make something cancerous. Had the Respondent wanted a definitive answer, he could have performed another biopsy.

Regarding the Respondent's November 4, 2014 Mohs surgery on Patient Two's left wrist, the preliminary dermatopathology report revealed SCC, deep margin involved. Dr. Barnett applied the AUC and determined a score of three, indicating that the Mohs surgery was inappropriate. Dr. Barnett said there is plenty of tissue in the wrist. He explained Mohs is a tissue-sparing technique, and because there is extra tissue in the wrist area, it is not difficult to close the wounds. Additionally, Dr. Barnett said the wounds in this area heal very well and they do not, even if the scar is a little longer than it could have been with Mohs, require costlier Mohs surgery.

Pertaining to the Respondent's December 13, 2016 Mohs surgery to Patient Two's mid-frontal scalp, the preliminary dermatopathology report revealed atypical squamous proliferation extending to biopsy base; re-excision was recommended. Dr. Barnett explained that an atypical squamous proliferation means that the squamous cells in the biopsy specimen are abnormal, but specifically not malignant, and it extends to the base. He believes the pathologist recommended re-excision of this lesion because atypical squamous proliferations are somewhere between an AK and SCC, so to be safe, removal is generally recommended to give the pathologist a larger sample in order to determine whether or not the lesion was malignant. Dr. Barnett opined that Mohs surgery was not necessary: first, because there was no prima facie evidence of skin

cancer, and second, because there are other "less significant" procedures available. (Test. Dr. Barnett, Transcript Vol. 89.)

Finally, on December 6, 2016 the Respondent performed Mohs surgery to Patient Two's right forehead. The preliminary dermatopathology report revealed inflamed and traumatized AK, transected at base. Dr. Barnett opined that Mohs surgery was inappropriate because the lesion was not a skin cancer.

Patient Three Summary

On November 15, 2016, the Respondent performed Mohs surgery to Patient Three's right forearm. The preliminary dermatopathology report revealed inflamed atypical squamous proliferation extending to biopsy base; re-excision was recommended. Dr. Barnett opined that while there was no evidence of SCC, he suspected strongly that there is SCC and would have recommended removal. However, Dr. Barnett applied AUC and opined that Mohs surgery would not be appropriate; an excision would be the appropriate technique in this case.

Pertaining to the Respondent's November 29, 2016 Mohs surgery to Patient Three's left earlobe, the preliminary dermatopathology report revealed hypertrophic AK involving appendageal structures, transected at the base. Dr. Barnett opined the Mohs surgery was inappropriate because AKs are benign lesions.

Patient Five Summary

The Respondent performed Mohs surgery to Patient Five's right medial eyebrow on November 29, 2016. The preliminary dermatopathology report revealed atypical squamous proliferation extending to the biopsy base; re-excision was recommended. Dr. Barnett opined this Mohs surgery was inappropriate because an atypical squamous proliferation is not synonymous with SCC. Again, Dr. Barnett stated non-malignant lesions are never treated with Mohs surgery.

Patient Six Summary

The Respondent performed a Mohs surgery to Patient Six's left dorsal hand on February 2, 2016. The preliminary dermatopathology report revealed atypical squamous proliferation extending to biopsy base; re-excision was recommended. Although atypical squamous proliferation is not SCC, Dr. Barnett considered a photograph of the lesion and given its pathology, size and location, he opined that removal by Mohs surgery was not inappropriate.

However, Dr. Barnett found an AUC score of three when considering the Respondent's January 26, 2016 Mohs surgery to Patient Six's left anterior thigh. The preliminary dermatopathology report revealed SCC, deep margin involved. Given there is a sufficient amount of skin on the thigh, Dr. Barnett opined Mohs surgery was not appropriate because it is very easy to pull the skin together, so a costlier Mohs procedure was not required; a simple excision would have sufficed.

Pertaining to a June 21, 2016 Mohs surgery the Respondent performed to Patient Six's right dorsal hand, the preliminary dermatopathology report revealed hypertrophic AK, transected at the base. Dr. Barnett opined Mohs surgery was inappropriate because Mohs surgery is not indicated for non-cancers.

On October 18, 2016 the Respondent performed Mohs surgery to Patient Six's left anterior ankle. The preliminary dermatopathology report revealed hypertrophic AK, transected at the base. Here again, Dr. Barnett opined Mohs surgery was inappropriate because Mohs surgery is not the standard of care for non-cancers.

Patient Eight Summary

On April 8, 2014, the Respondent performed Mohs surgery to Patient Eight's right mid upper forehead. The preliminary dermatopathology report revealed atypical squamous proliferation extending to biopsy base; re-excision was recommended. Dr. Barnett testified the

Mohs surgery was inappropriate because atypical squamous proliferations are not cancer and Mohs surgery is used in instances of skin cancer.

Pertaining to the Respondent's March 31, 2015 Mohs surgery to Patient Eight's right sideburn, the preliminary dermatopathology report revealed SK and atypical squamous proliferation extending to biopsy base; re-excision was recommended. Dr. Barnett opined Mohs surgery was not appropriate because there was no malignancy. He added that although the pathologist recommended re-excision, that could be done by a re-biopsy or small excision.

On December 15, 2015, the Respondent performed Mohs surgery to Patient Eight's left tricep. The preliminary dermatopathology report revealed BCC, superficial type, lateral margin involved. Dr. Barnett again concluded the Mohs surgery was not appropriate because the AUC score was three. The tricep contains sufficient skin to close a wound, and the skin cancer was noted to be a superficial type.

Pertaining to the Mohs surgery the Respondent performed to Patient Eight's right abdomen on January 19, 2016, the preliminary dermatopathology report revealed traumatized BCC, superficial type, lateral margin involved. Dr. Barnett concluded the Mohs surgery was not appropriate because the AUC score was three. He explained that the abdomen contains sufficient skin to pull from; the BCC was a superficial type; and most dermatologists would have simply sprayed the lesion with liquid nitrogen. Dr. Barnett testified that Respondent's decision to perform Mohs surgery was excessive.

On December 13, 2016, the Respondent performed Mohs surgery to Patient Eight's left elbow. The preliminary dermatopathology report revealed BCC, micronodular type with neuroendocrine features, deep margin involved. Dr. Barnett opined Mohs surgery was not appropriate after inputting patient information in the AUC algorithm and deriving a score of three.

The preliminary dermatopathology report also referenced a biopsy performed on Patient Eight's right chin, which revealed sebaceous adenoma with a positive Muir-Torre immunohistochemical screening test, margins involved. As a result, the Respondent performed a Mohs surgery on December 27, 2016. Dr. Barnett explained that sebaceous adenomas are benign growths, and as such, are not appropriate for Mohs surgery. Regarding the positive immunohistochemical screening test, Dr. Barnett stated people who have sebaceous adenomas may be at increased risk for a syndrome which can increase their risk for certain internal malignancies. Thus, a referral to an internist to perform necessary screenings is appropriate.

Patient Nine Summary

Dr. Barnett calculated an AUC score of three for the Respondent's Mohs surgery to Patient Nine's left tricep on January 17, 2017. The preliminary dermatopathology report revealed BCC, superficial type, lateral margins involved. Dr. Barnett opined Mohs surgery was not appropriate because the cancer was a superficial type in an area where there is plenty of skin in order to perform a regular excision, but at the same time other methods such as a destruction, like cryosurgery or electro-desiccation and curettage could be performed in the area as well.

Under the same rationale, Dr. Barnett opined the Respondent's Mohs surgeries to Patient Nine's right mid back on January 31, 2017 and left mid back on February 14, 2017 were not appropriate.

On February 7, 2017, the Respondent performed Mohs surgery to Patient Nine's right mid abdomen. The preliminary dermatopathology report revealed BCC, superficial type, deep margin focally involved. Dr. Barnett scored an AUC score of three and opined that the Mohs surgery was not appropriate.

Finally, with regard to the Respondent's Mohs surgery to Patient Nine's left clavicle as a result of a June 8, 2017 biopsy, the preliminary dermatopathology report revealed BCC, superficial type, lateral margin involved. Dr. Barnett applied the AUC and determined the score of three rendered the Mohs surgery inappropriate. He explained the skin cancer was superficial and located in an area with plenty of skin to make a closure with a simple excision.

I found Dr. Barnett credible. His expert testimony was consistent and persuasive. He testified clearly and in detail, and he explained the various sources that formed his opinion on the standard of care, overutilization of health care, and professionalism. Although not a Mohs surgeon, he refers patients to Mohs surgeons when appropriate. I credited his candor in stating his belief that, at times, the Board over-reaches and can be unreasonable. With that belief in mind, Dr. Barnett stated that he was hoping to find rationale which could help the Respondent – that perhaps there was some misunderstanding. However after careful review and consideration, he could find no such rationale or misunderstanding in this case. Dr. Barnett's approach was clear: a dermatologist should not treat something as a skin cancer unless it is known to be a skin cancer. Dr. Barnett spoke not only of the costs associated with unnecessary procedures, but also the resulting physical, and psychiatric, psychologic effects on the patients.

The Respondent

The Respondent testified regarding his curriculum vitae and that he is Fellowship-trained in Mohs surgery. He explained the Mohs surgery procedure, and said the 2012 Mohs AUC guidelines came about after he completed his fellowship. Prior to that time, the Respondent said, there was no algorithm and scoring record for Mohs surgeries and they were performed based upon a judgment call. He estimated that ten to twenty percent of the Mohs surgery cases he saw during his Fellowship would not fulfill AUC criteria. He testified that when he began his practice, many

cases sent to him were not stringent in Mohs criteria, and he concluded there is "some wiggle room . . . in terms of patient preference, cosmetic indications, patient balance." (Test. Respondent, Transcript Vol. 1, p. 159.) The Respondent testified that he has never encountered a billing issue, whereby any insurers rejected reimbursement; therefore, he explained that until this case, he had no knowledge that anyone might perceive his decisions as inappropriate.

During his testimony, the Respondent acknowledged reading the AUC thoroughly when it was published. He recognized the expertise of Dr. Coldiron and its other co-authors. He also stated that he read the disclaimers. The Respondent expressed concern regarding patient backlash if he were to tell someone he would not perform a Mohs surgery because of the AUC score. The Respondent questioned how an algorithm can properly quantify cosmesis, i.e. individual patient cosmetic concerns, or whether someone lives an active lifestyle or lives alone, such that return office visits or wound-care may be of greater concern. The Respondent also testified that prior to being involved in this case, he was not aware of anyone AUC scoring lesions as Dr. Barnett had in his peer review. The Respondent lamented patient dissatisfaction with burn and freeze methods of treatment, because of scarring, longer healing timeframes, and their cure rates not being as effective as Mohs surgery.

The Respondent stated that as a skin cancer specialist, many of his patients have had voluminous incidents of skin cancer. He stated one of his patients had sixty-five Mohs surgeries prior to becoming his patient. Many of his patients know what procedure they want performed. The Respondent testified,

> And I tell my patients all the time, I'm not here to tell you what to do. My responsibility to you is for you to understand what I know. This is what you have. Here are the five treatments. Treatment A has this recurrence rate, Treatment B has this recurrence rate, this is how it's going to play out.

(Test. Respondent, Transcript Vol. 1, p. 159.)

> Doing Mohs on every case is not the answer. But at the end of the day, I have to concede, Mohs is superior to all other treatments, and that's something that we have to concede. Does that mean we can use it all of the time? No. In a utopia where things didn't cost anything, would we? Probably. Probably we would.

(Test. Respondent, Transcript Vol. 1, p. 168/169.)

The Respondent stated that there is a .25% to 20% percent chance that AK will evolve into a SCC in one year. He explained that when a report reveals AK, transected at the base, there is a one in five chance of a skin cancer. The Respondent said the cure rate is highest using a Mohs surgery and he argued that often times, it is more cost-effective to perform the Mohs surgery as opposed to the costs of a re-biopsy, then further procedures, if necessary.

The Respondent testified that ultimately, he and Dr. Barnett "are at different ends of the spectrum" and added,

> a lot of times that's how medicine is practiced. In a gray zone, you are going to get some people on one side and you're going to get some people on the other side. What I hope is that we can at least agree that we are in a gray zone.

(Test. Respondent, Transcript Vol. 1, p. 194.)

The Respondent explained that he recommends a freezing treatment for AK; however, he views AK transected at the base differently than Dr. Barnett. Another biopsy may yield the same result. Patients lead busy lives. Rather than having patients return for multiple office visits, the Respondent said many of his patients simply ask for Mohs surgery. And the Respondent argued that performing the Mohs surgery immediately is more cost-effective than billing multiple office visits, biopsies, and necessary treatments. However, now that he understands the firm stance on the AUC many of his colleagues hold, the Respondent testified that he has changed his practice pattern. Using Patient Two as an example, the Respondent explained that in a similar situation today, he would repeat the biopsy and would not perform Mohs surgery, even if requested by a patient. (Test. Respondent, Transcript Vol. 1, p. 187.)

The Respondent testified that Patient Three lives alone and has no one to care for his wounds, had a previous positive experience with Mohs surgery, and preferred not to return to the office multiple times.

The Respondent testified Patient Five suffers with fibromyalgia and maintains a busy lifestyle with grandchildren and running a children's summer camp. The Respondent testified that an excision would result in a complex repair procedure, which would not be indicated for someone with a low pain threshold.

The Respondent disagreed with Dr. Barnett's AUC score for Patient Six. The Respondent explained that Patient Six has Crohn's disease and has been on immune-suppressant medicine for decades. Factoring Patient Six's background, the Respondent said the AUC rating significantly changes and Patient Six is appropriate for Mohs surgery.

The Respondent testified that Patient Eight drives a tractor and was interested in the least amount of healing time possible. With regard to the Mohs surgery performed to Patient Eight's chin, the Respondent stated:

> It was kind of like off label use of the medication. Sometimes we step outside the box and we use a [technique] that we know is good or a medicine that is good for something else, and then we apply it to a certain situation where practically it makes a lot of sense. Was the patient harmed? No. If we can agree that the spot should have been re-excised, then absolutely not. You've got a good result. You've got a great result.

(Test. Respondent, Transcript Vol. 1, p. 210/211.)

The Respondent testified Patient Nine is an executive with depression who "keloids" easily.[19] Given these facts, and Patient Nine's travel schedule, the Responded explained his concern was to create as small a scar as possible and avoid multiple office visits.

[19] A keloid is a type of raised scar. https://www.aad.org/public/diseases/bumps-and-growths/keloids

As a result of this action by the Board, the Respondent testified he has changed his practice significantly. He explained that he now scores every lesion, and if Mohs surgery is not appropriate, the Respondent stated that he does not perform the Mohs surgery. The Respondent said although this takes a burden off of him, he feels robotic at times. He added,

> A lot of times I feel bad about it. A lot of times I wish I wonder, I've done all this training, I have this expertise, we have an office, it's set up efficiently, but I'm denying people a higher cure rate, a smaller scar, a superior procedure based on a document and an investigation that quite frankly my biggest concern is I don't, I'm not sure what the standard of care is.

(Test. Respondent, Transcript Vol. 1, p. 217.)

I found the Respondent contradictory. He acknowledged reading the AUC thoroughly when it was published and stated that he recognized the expertise of its authors, but then noted how the article contains disclaimers. The Respondent argued that his practice area in dispute is a "gray zone," but Dr. Barnett testified the AUC is so well-known that an app[20] exists to allow practitioners to quickly and conveniently score lesions. I question how much interaction the Respondent has with his fellow professionals to not have been aware of the app. The Respondent said cosmesis is an important factor not considered under the AUC and lamented patient backlash if he refused to perform Mohs surgery, then said Mohs surgery is not the answer in every case. He testified he informs his patients that he is not there to tell them what to do, that he believes his responsibility to convey to patients what he knows, what techniques are available, and what they cure rates are. However, the Respondent later testified that Mohs is the superior treatment, and in a utopia it would be utilized all the time. The Respondent argued that he never harmed a patient, but at no point in his testimony did he address what I find to be Dr. Barnett's legitimate concerns

[20] App is short for "application," which is the same thing as a software program. While an app may refer to a program for any hardware platform, it is most often used to describe programs for mobile devices, such as smartphones and tablets. https://techterms.com/definition/app

that the Respondent was over-treating them by treating them as though they had cancer, and what physical, and psychiatric, psychologic effects that may bring. With conflicts such as these, I had strong reservations about the Respondent's credibility.

Dr. Coldiron

Dr. Coldiron's practice is in Cincinnati, Ohio. He began his testimony reviewing his credentials, which included a Fellowship in Mohs micrographic surgery. He has published articles and written book chapters in skin cancer patient safety and the epidemiology of skin cancer. He testified regarding the evolution in Mohs surgery training as well as application of the surgery. Dr. Coldiron explained Mohs surgeries have higher cure rates and smaller scars. He explained that he helped to develop the AUC to decrease the inappropriate utilization of Mohs surgery, with a disclaimer that every patient and situation is unique. He stated that the AUC has generally been accepted as reasonable criteria in the professional community. He is aware that an app exists to help dermatologists derive an AUC score, but explained he does not use the app in his practice because his electronic medical record computes the AUC scores. Dr. Coldiron further explained that he has billed Mohs surgeries with an AUC score of three; he sees nothing wrong if that is what the patient wants. He added,

> I think, you know, the standard of care is defined by how you handle it in the community. It's not necessarily based on the appropriate use criteria. Appropriate use criteria is an education tool, and a billing tool. You may not get it paid for, that's a different issue.

(Test. Dr. Coldiron, Transcript Vol. Two, p. 264.)

Dr. Coldiron said a diagnosis of AK transected is not useful because it does not offer a definitive report of what is underneath the sample. He added that if he had a dermatopathologist who made that report regularly, he would either change dermatopathologists or change his biopsy technique. Dr. Coldiron explained that transected AKs are not covered in the AUC.

Dr. Coldiron concluded that the Respondent met the appropriate standard of care with regard to Patient One because: Mohs surgery was never performed on Patient One, and the Responded "adequately explained" his change in treatment recommendation from Mohs surgery to cryosurgery. (Jt. Ex. 1.) I did not find Dr. Coldiron's opinion persuasive. First, it was Patient One who stopped the Mohs surgery from taking place by cancelling the procedure, so I do not credit the Respondent for that fact. Second, I do not find the Respondent's explanation for recommending a "lesser invasive treatment" logical. (State Ex. 32; Test. Respondent.) Essentially, the Respondent stated that changing to a lesser invasive treatment recommendation may increase the chance of a patient choosing to get some treatment. However, between changing his treatment recommendation from Mohs surgery to cryosurgery, the Respondent had had no communication with Patient One. He had no understanding why it was that Patient One had cancelled her appointment and fallen out of contact. Had the Respondent believed his original treatment recommendation of Mohs surgery was appropriate, lack of contact with a patient would not warrant a change.

Dr. Coldiron was asked in his opinion whether the Respondent acted below the standard of care in cases where he performed Mohs surgeries with an AK transected at the base report. Dr. Coldiron responded, "Well, it depends." (Test. Dr. Coldiron, Transcript Vol. Two, p. 265.) He went on to explain that some patient photographs clearly supported a conclusion of cancer. Other patient photographs were not so obvious. And when asked whether the Respondent behaved unreasonably using Mohs surgery when the application is not within the AUC criteria, Dr. Coldiron stated:

> No, it's not unreasonable. I expect that from now on, he'll do another biopsy or do something else, or ask the pathologist to reinvent it and cut it at a different angle, but usually you'd like to have a definitive pathologic diagnosis before you do

> anything, before you do anything, you know? But you don't do that with AK. With AK, if we freeze them all day long and you don't have any idea what you're really freezing. It is based on a clinical impression. I suspect that we freeze squamous cell carcinoma in situ's all the time, and cure them. I don't know. Sometimes they come back and then you have to biopsy. But you can't treat every actinic keratosis with Mohs, or you'd have to skin the general public alive. They're all over the place. So you, you have to use some clinical judgment there.

(Test. Dr. Coldiron, Transcript Vol. Two, p. 266/267.)

Dr. Coldiron added that in all of these patient cases, some course of action was necessary. "It's just did they need Mohs surgery? Did they need all the edges checked? Maybe, maybe not. But they all needed something done to these lesions. . . ." (Test. Dr. Coldiron, Transcript Vol. Two, p. 267.) However, regarding Patient Eight's sebaceous adenoma, Dr. Coldiron stated that sebaceous adenoma are benign and do "not necessarily need the margins checked microscopically" through Mohs surgery. (Jt. Ex. 1.)

While Dr. Barnett testified that squamous proliferations are not prima facie evidence of skin cancer, Dr. Coldiron stated that with the exception of warts, squamous proliferations are probably cancerous. Dr. Coldiron expressed concern that the biopsies may have masked an underlying tumor.

Regarding patient cases with low AUC scores, Dr. Coldiron stated that there have been times when he opted for application of Mohs surgery and explained,

> Because it has come back a couple of times and I need to check the edges. You can, you know, and Mohs is the best way to check the edges and make it not come back, because you don't, you don't want to make them come back. Sometimes they say, doctor, I'm not coming back, and so you can cut it out and send it out and if it's positive, what are you going to do? I mean, so, you know, it happens every now and then. Again, I think that that is a clinical judgement. I wouldn't do it routinely, I wouldn't do it, you know, often, but I think it can happen.

(Test. Dr. Coldiron, Transcript Vol. Two, p. 269/270.) I am unsure what he meant when he prefaced his explanation by stating "because it has come back a couple of times." If Dr. Coldiron

meant that he had performed multiple biopsies and the dermatopathology reports had come back inconclusively several times, that is a different scenario than these patient cases involving the Respondent. The Respondent did not perform re-biopsies; he made treatment recommendations based from the first and only dermatopathology report. If Dr. Coldiron meant that the lesions came back several times, that is also a different scenario than these patient cases involving the Respondent. There was no evidence offered that the Respondent was treating a regrown lesion in any of the patient cases.

When asked about the sebaceous adenoma on Patient Eight's chin, Dr. Coldiron said,

> Well, his notes said he was worried about a sebaceous carcinoma at the base, so you want to make sure that you, you didn't have cancer at the base of it, and, and that would make sense to check it. But, you know, routinely we don't do Mohs on benign lesions.

(Test. Dr. Coldiron, Transcript Vol. Two, p. 271.) In his report, Dr. Coldiron wrote, "sebaceous adenoma are benign." (Jt. Ex. 1.)

Ultimately, Dr. Coldiron opined that when a pathology report is ambiguous, a doctor must make the clinical decision whether to re-biopsy, treat, or not treat the lesion. He added that a re-biopsy and return office visits increase costs. When asked whether, in his opinion, the Respondent breached standards of care, grossly over utilized medical services, committed professional misconduct or had inappropriate record keeping, Dr. Coldiron concluded that the Respondent "generally met the standard of care, though I think that he'll, he'll, you know, probably, those transected actinic keratosis, he'll probably re-biopsy them more often." (Test. Dr. Coldiron, Transcript Vol. Two, p. 274.) This conclusion differed somewhat from his supplemental report, undated, wherein he opined that the Respondent "met the standard of care of a reasonably prudent dermatologist in his care and treatment of the patients at issue." (Joint Ex. 1.) During his hearing testimony, Dr. Coldiron's opinion was conditioned – adding that the

Respondent "generally" met the standard of care, and the Respondent will probably perform more re-biopsies. In his supplemental report, Dr. Coldiron wrote the Respondent "may have used Mohs more intensely for margin control in some cases, but unnecessary surgery was not done." (Joint Ex. 1.)

When asked about the disappearance of the Mohs surgery recommendation on Patient One's dermatopathology report and its replacement with a cryosurgery recommendation, Dr. Coldiron stated that he is not an expert regarding the keeping of medical records.

I found Dr. Coldiron credible. He is one of the authorities on Mohs surgery. He created the AUC criteria, and his electronic medical record system scores patient lesions in accordance with the AUC. However, his testimony was less supportive of the Respondent than was his report. As a result of this inconsistency, I found Dr. Coldiron less persuasive than Dr. Barnett whom I found to be consistent. During testimony, Dr. Coldiron conditioned his opinion with regard to the Respondent's conduct. When asked his opinion whether the Respondent acted below the standard of care in cases where he performed Mohs surgeries with an AK transacted report, Dr. Coldiron responded, "Well, it depends." (Test. Dr. Coldiron, Transcript Vol. Two, p. 265.) He suspects the Respondent will now re-biopsy or ask the pathologist to reinvent or cut the sample from a different angle. "It's just did they need Mohs surgery? Did they need all the edges checked? Maybe, maybe not. But they all needed something done to these lesions . . ." (Test. Dr. Coldiron, Transcript Vol. Two, p. 267.) Dr. Coldiron stressed that ideally, one wants a definitive pathologic diagnosis before taking an action. He also began his testimony by stating, "the standard of care is defined by how you handle it in the community." (Test. Dr. Coldiron, Transcript Vol. Two, p. 264.)

While clearly an expert in his field, Dr. Coldiron's opinions during the hearing were conditional. Furthermore, I find Dr. Barnett is more familiar with the relevant standard of care in Maryland. Dr. Coldiron focused on the fact that something needed to be done in the patients' cases and no one was physically harmed by the Respondent's actions. Dr. Barnett focused on the actual charges, i.e. what was recommended or performed, was it appropriate, and was there a breach in professional conduct. For these reasons, I placed greater weight on the opinions of Dr. Barnett.

The Charges

The Respondent testified he knew no colleague in the community AUC scoring lesions, while Dr. Barnett was utilizing the AUC app and Dr. Coldiron's electronic medical record was reporting AUC results. Rather than read the AUC and apply it to his practice, the Respondent focused on its disclaimers and placed cosmesis and patient preference above what his own expert, Dr. Coldiron, stated has generally been accepted as reasonable criteria in the professional community. (Test. Dr. Coldiron, Transcript Vol. Two, p. 276.) Both Dr. Barnett and Dr. Coldiron testified that one wants a definitive pathologic diagnosis before taking an action. Instead, whether with an inconclusive dermatopathology report or an inappropriate AUC score, the Respondent enthusiastically endorsed Mohs surgery to his patients, its near 100 percent cure rate, and its ability to reduce office visits. When presented with methods other than Mohs surgery in the manner the Respondent testified, it is inconceivable who would not request the Mohs surgery, even if it was not clinically indicated or medically necessary. In this regard, the Respondent failed to offer appropriate counsel to his patients and his conduct was unprofessional.

The State has established by a preponderance of the evidence that the Respondent recommended and performed Mohs surgeries on pre-cancerous and pre-invasive skin conditions in

the absence of pathology results supporting the surgeries. [Recommended: Patient One; Performed: Patients Two, Three, Five, Six, and Eight.] Furthermore, the State established by a preponderance of the evidence that the Respondent performed Mohs surgery on lesions that failed to conform with the AUC. [Patients Two, Three, Eight, and Nine.[21]] Thus, the Respondent failed to meet the standards of quality care, overutilized Mohs surgeries, and his behavior constituted unprofessional conduct in the practice of medicine in violation of sections 14-404(a)(22), (a)(19), and (a)(3)(ii) of the Business Occupations Article. Furthermore, the Respondent failed to keep adequate medical records in violation of section 14-404(a)(40) of the Business Occupations Article when his digital stamp recommending cryosurgery on Patient One's dermatopathology report removed his prior Mohs surgery recommendation completely from the dermatopathology report. The Respondent argued that it could be gleaned from telephone records that there had been a prior recommendation of Mohs surgery. I do not find the argument persuasive because regardless of that fact, the dermatopathology report had been altered.

Sanctions

The relevant regulations for sanctioning physicians are as follows:

Ground	Maximum Sanction	Minimum Sanction	Maximum Fine	Minimum Fine
14-404 (a)(3)(ii)	Revocation	Reprimand	$50,000	$5,000
14-404 (a)(19)	Revocation	Reprimand and probation for 2 years	$50,000	$10,000
14-404(a)(22)	Revocation	Reprimand	$50,000	$5,000
14-404(a)(40)	Suspension for 1 year	Reprimand	$50,000	$2,500

COMAR 10.32.02.10B.

[21] I gave the Respondent the benefit of the doubt and did not include Patient Six because the Respondent testified that including the patient's Crohn's disease in the AUC algorithm as he had, Mohs surgery was appropriate. Dr. Barnett's report does not reference the patient's Crohn's disease. The State did not offer rebuttal evidence regarding the effect Crohn's disease may have on the AUC.

The State has stated it seeks to impose a disciplinary reprimand against the Respondent with an eighteen-month probationary period wherein the Respondent shall be assigned a practice supervisor to review, minimally, ten patient records on a monthly basis and communicate with the Respondent to ensure that Mohs surgeries are performed when medically and clinically appropriate. Additionally, within the first six months of probation, the State seeks for the Respondent to successfully complete a Board-approved, intensive course in the appropriate use of Mohs surgery. Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2018); COMAR 10.32.02.09A-B; COMAR 10.32.02.10. The State presented no evidence the Respondent has ever been the subject of any prior disciplinary actions. By all accounts, the Respondent has had an otherwise unblemished medical career thus far in Maryland. In addition, the Respondent testified that he has begun applying the AUC criteria in his practice. The regulations allow for a reprimand and probation to include course-work and peer review which serves a valuable rehabilitative component to ensure the Respondent understands the appropriate application of Mohs surgery in his practice. Given the recommendations are lesser in severity in the regulatory ranking of sanctions, I see no reason to deviate from the Board's recommendation with the exception of extending the supervisory period from eighteen months to a period of two years. Reprimand and probation for two years constitute the minimum sanction for a violation of section 14-404(a)(19) of the Health Occupations article. *See* COMAR 10.32.02.10.

Under the applicable law, the Board also may impose a fine instead of or in addition to disciplinary sanctions against a licensee who is found to have violated section 14-404. Health Occ. § 14-405.1(a) (2014); COMAR 10.32.02.09. In this case, the Board is seeking a fine of $35,000 to be paid within one year.

I do not adopt the Board's sought-after fine. Considering mitigating factors such as the absence of a prior disciplinary record, the Respondent's communication and cooperativeness during the investigation, and the Respondent's testimony regarding corrective action he has taken in his practice, I recommend a $20,000 fine.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude the following:

1. The Respondent violated section 14-404(a)(3)(ii) of the Health Occupations Article of the Annotated Code of Maryland. Md. Code Ann., § 14-404(a)(3)(ii) (Supp. 2018).

2. The Respondent's misconduct subjects him to a sanction from a minimum of a reprimand to a maximum of a revocation of his license to practice medicine, and a fine from a minimum of $5,000.00 to a maximum of $50,000.00. *Id.*; COMAR 10.32.02.09A, B; COMAR 10.32.02.10B(3)(c).

3. The Respondent violated section 14-404(a)(19) of the Health Occupations Article of the Annotated Code of Maryland. Md. Code Ann., § 14-404(a)(19) (Supp. 2018).

4. The Respondent's misconduct subjects him to a sanction from a minimum of a reprimand and probation for two years to a maximum of a revocation of his license to practice medicine, and a fine from a minimum of $10,000.00 to a maximum of $50,000.00. *Id.*; COMAR 10.32.02.09A, B; COMAR 10.32.02.10B(19).

5. The Respondent violated section 14-404(a)(22) of the Health Occupations Article of the Annotated Code of Maryland. Md. Code Ann., § 14-404(a)(22) (Supp. 2018).

6. The Respondent's misconduct subjects him to a sanction from a minimum of a reprimand to a maximum of a revocation of his license to practice medicine, and a fine from a

minimum of $5,000.00 to a maximum of $50,000.00. *Id.*; COMAR 10.32.02.09A, B; COMAR 10.32.02.10B(22).

7. The Respondent violated section 14-404(a)(40) of the Health Occupations Article of the Annotated Code of Maryland. Md. Code Ann., § 14-404(a)(40) (Supp. 2018).

8. The Respondent's misconduct subjects him to a sanction from a minimum of a reprimand to a maximum of a suspension of his license to practice medicine for one year, and a fine from a minimum of $2,500.00 to a maximum of $50,000.00. *Id.*; COMAR 10.32.02.09A, B; COMAR 10.32.02.10B(40).

PROPOSED DISPOSITION

I **PROPOSE** the following:

1. The Charges filed by the Maryland State Board of Physicians against the Respondent on April 17, 2018, be **UPHELD** consistent with this Decision.

2. The Respondent be sanctioned by a reprimand and two-year period of probation, wherein the Respondent shall be assigned a practice supervisor to review, minimally, ten patient records on a monthly basis and communicate with the Respondent to ensure that Mohs surgeries are performed when medically and clinically appropriate. In addition, within the first six months of probation, the Respondent shall successfully complete a Board-approved, intensive course in the appropriate use of Mohs surgery.

3. The Respondent be ordered to pay a $20,000 fine.

January 10, 2019
Date Decision Issued

Tracey Johns Delp
Administrative Law Judge

TJD/dlm
#177336

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) (2014); 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 (2014); COMAR 10.32.02.05C. The OAH is not a party to any review process.

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