IN THE MATTER OF	*	**BEFORE THE MARYLAND**
ALPHONSUS EZIAGWU OKOLI, M.D.	*	**STATE BOARD**
RESPONDENT	*	**OF PHYSICIANS**
LICENSE NO.: D73032	*	**CASE NO.: 2016-0298 B**

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CONSENT ORDER

On March 2, 2018, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged Alphonsus Eziagwu Okoli, M.D. (the "Respondent"), License No. D73032, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §14-401 *et seq.* (2014 Repl. Vol. & 2017 Supp.)

The pertinent provisions of Health Occ. §14-404(a) under which Panel B voted to charge Respondent provide the following:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a licensee if the licensee:
>
> (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[.]

FINDINGS OF FACT

Panel B makes the following Findings of fact:

I. License and Medical Background

1. At all times relevant hereto, Respondent was, and is, licensed to practice

medicine in Maryland. Respondent was originally licensed to practice medicine in Maryland on September 9, 2011 under license number D73032. Respondent last renewed his license in September 2016 which will expire on September 30, 2018.

2. In 1996, Respondent was granted a license to practice medicine in North Carolina, which is currently active.

3. Respondent was initially board-certified in internal medicine in 1996 and was re-certified in 2006, which expired on December 31, 2016.

4. Since approximately 2013, Respondent has maintained an office for the solo practice of internal medicine in Prince George's County.

II. Complaint

5. On or about October 14, 2015, the Board received a complaint from of former patient of Respondent's ("Patient 1"[1]). Patient 1 stated that Respondent failed to release him after treatment following a motor vehicle accident (MVA), failed to provide him with a return to work note, and failed to provide him with copies of his medical records.[2]

III. Board Investigation

6. On November 6, 2015, Board staff sent correspondence to Respondent requesting Respondent to provide a response to the allegations of the Complaint and issued a subpoena for Patient 1's medical record.

7. On April 12, 2016, the Board issued a subpoena to Respondent for his appointment logs from April 1, 2015 to April 12, 2016.

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[1] Patient names are confidential and are not used in the Consent Order. Respondent has been provided a Confidential Patient Identification List containing the names of each of the patients referenced in the Consent Order.

[2] Patient 1 did not respond to correspondence sent to him by Board staff about his complaint.

8. On May 11, 2016, the Board issued a subpoena to Respondent for a complete copy of the medical records of 10 additional patients, selected from Respondent's appointment logs.

9. On July 13, 2016, the Board issued subpoenas to five pharmacies in the geographical area surrounding Respondent's practice, requesting a computer-generated printout of all controlled dangerous substances ("CDS") written by Respondent from January 1, 2015 to July 13, 2016. The printouts revealed multiple prescriptions for oxycodone 30 mg. 120 tablets, with occasional prescriptions for alprazolam, acetaminophen/codeine, Adderall, amphetamine salts, and Qsymia.[3] Most of the patients are from areas in Maryland, District of Columbia and northern Virginia in proximity to Respondent's office; but, a number are from a greater distance, such as Baltimore City and Baltimore County. One patient, who is from Rochester, New York, filled his prescriptions at national chain pharmacies in Conshohocken, Pennsylvania; Front Royal, Virginia; Wilmington, Delaware; and Greenbelt, Hyattsville and Greenbelt, Maryland.

10. On October 4, 2016, Respondent testified under oath to the following:

a. Most of his patients have illnesses such as diabetes, hypertension, and asthma;

b. Less than one-quarter of his patients are seen for pain management;

c. There was a delay in Patient 1 receiving his records. Respondent uses an outside billing service, the office was transitioning their service to incorporate ICD-10 (International Classification of Diseases) billing codes, version 10, and the person who handled billing for Respondent was not available due to being in training; and

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[3]Qsymia is the trade name for a combination of phentermine and topiramate, used for weight loss.

d. Patient 1 came to his office on October 14, 2015,[4] and Respondent gave Patient 1 his medical and billing records and a statement that Patient 1 has not been able to return to work since the MVA. Respondent has not been paid for his services rendered to Patient 1.

11. On January 25, 2017, the Board referred the case to a peer review agency, requesting independent peer review by two physicians who are board-certified in internal medicine.

12. On June 13, 2017, the Board received the peer review reports. The peer reviewers concurred that regarding ten of the eleven patients reviewed,[5] Respondent failed to meet the appropriate standards for the delivery of quality medical care, and in eleven out of eleven cases, Respondent failed to maintain adequate medical records.

13. On June 14, 2017, the Board sent copies of the peer review reports to Respondent with the names of the reviewers redacted requesting Respondent to provide a Supplemental Response.

14. On July 3, 2017, the Board received Respondent's Supplemental Response, which was subsequently reviewed by the two peer reviewers, prior to the issuance of Charges. Respondent stated, among other comments, that since mid-2015, he has stopped accepting new patients who he believes in an initial telephone screening would be seeking chronic opioid therapy, he has closed a website for patient scheduling and appointments through which most of the patients seeking opioid therapy have come to his office, and he has been discharging the patients who require opioid therapy.

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[4] October 14, 2015 is the date Patient 1 filed his complaint.
[5] There are no standard of care violations pertaining to Patient 1. Patient 1 is the complainant.

IV. Summary of Findings of Fails to Meet Standards of Quality Medical Care[6] and Fails to Keep Adequate Medical Records Pertaining to Patients 2 - 11.[7]

15. In the ten cases reviewed in which the peer reviewers concurred that Respondent failed to meet standards for quality medical care and failed to maintain adequate documentation, Respondent:

a. Initially prescribed the same high dose (30 mg., 120 tablets) of oxycodone for all ten patients, all of whom stated that they had not been previously taking opioids, with refills given every month, regardless of the nature, severity or chronicity of the pain and the individual characteristics, rather than starting at a low dose, if indicated, and adjusting the prescriptions based on patient response;

b. Treated patients for pain with the prescription of opioids, without the appropriate training and experience;

c. Failed to incorporate the findings of the patients' subjective responses to Respondent's "Pain Assessment Questionnaire" into his documentation of the office visit;

d. Failed to document any assessment of the patients' response to oxycodone and/or physical therapy;

e. Failed to enforce pain contracts;

f. Failed to review the CRISP (Chesapeake Regional Information System for our Patients) database to determine whether patients were receiving opioids from another provider;

g. Consistently ignored, or was unaware of "red flags", which suggested the possibility of misuse or diversion of opioids, such as cash payments for visits, patients who traveled great distances to see him solely for the refill of oxycodone, UDS which showed the use of illicit substance, and familial

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

[7] The Peer Review Reports contain detailed discussions of the basis for the peer reviewers' opinions pertaining to each of the ten patients that Respondent failed to meet standards of quality medical care and failed to keep adequate medical records.

relationships;[8]

h. Continued to prescribe oxycodone to patients who declined to accept his referral to pain management clinics or were unsuccessful in obtaining an appointment;

i. Failed to review records of prior care and treatment; and

j. Failed to obtain urine drug screens.

V. Summary of Findings of Fails to Keep Adequate Medical Records

Patient 1

16. Respondent failed to keep adequate medical records regarding his care and treatment of Patient 1, for reasons including but not limited to that he:

a. In his initial assessment of Patient 1, failed to provide basic details about the possible severity of the injury from the MVA the day prior such as the speed of the vehicles, whether there was any loss of consciousness, whether Patient 1 was wearing a seatbelt, and whether there were any fatalities;

b. Failed to adequately document the results of his physical examination of Patient 1's areas of pain, other than the mere descriptive of "tenderness;"

c. Failed to adequately document whether Patient 1 was improving over the course of the four visits, Patient 1's response to the pain medication and other therapies prescribed; and

d. Failed to document in the office visit notes that he prescribed Tylenol #3 or maintain in his medical records a copy of the prescription.

VI. Summary of Findings

17. Respondent's failure to meet standards of quality medical care constitutes evidence of violation of Health Occ. §14-404(a)(22).

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[8] In April 2015, Patient 8 and Patient 9, who are father and son, traveled from Baltimore to Respondent's office seeking opioid prescriptions. Respondent treated both with opioids on an ongoing basis.

18. Respondent's failure to keep adequate medical records constitutes evidence of violation of Health Occ. §14-404(a)(40).

CONCLUSIONS OF LAW

Based on the Findings of Fact, Panel B concludes as a matter of law that the Respondent failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care performed in this State, in violation of 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).

ORDER

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

ORDERED that Respondent is Reprimanded; and it is further

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

1. Respondent's prescribing of opioids in his solo outpatient medical practice shall be supervised for the duration of probation by a panel-approved peer supervisor who is board-certified in pain medicine. Within 30 days of the effective date of the Consent Order, Respondent shall provide the panel with the name and professional background information of the supervisor whom he is offering for approval. The panel-approved supervisor must familiarize himself or herself with the relevant Board and panel orders and peer review reports concerning Respondent. Respondent consents to the release of these documents to the supervisor. Each month the supervisor shall review the patient

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

records, chosen by the supervisor, of at least 10 of Respondent's patients for whom Respondent is prescribing opioids. The supervisor shall meet in-person with Respondent at least one time each month. Discussion at the in-person meetings shall include the care Respondent has provided for specific patients and detailed feedback from the supervisor on the Respondent's practices. The supervisor shall be available to Respondent for consultations on any patient and have access to Respondent's patients' records and patient information. Additionally, Respondent shall ensure that the supervisor provides the Board with quarterly reports concerning whether there are any concerns with Respondent's management of pain patients. If there are indications that Respondent poses a substantive risk to patients, the supervisor shall immediately report his or her concerns to the Board. An unsatisfactory supervisory report may constitute a violation of the terms and conditions of this Consent Order. After a minimum of one year of supervision, Respondent may petition the Board or panel to reduce the frequency of supervision, but only on the recommendation of the supervisor. If the supervising physician discontinues supervision at any time during the probationary period, Respondent is responsible for obtaining another panel-approved supervising physician to fulfill the supervision requirements;

2. Within six months, Respondent shall successfully complete a Board disciplinary panel-approved course in opioid prescribing. The Board disciplinary panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. Respondent must provide documentation to the Board that Respondent has successfully completed the course;

3. The Panel will issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program ("PDMP") immediately and on a quarterly basis for Respondent's CDS prescriptions. The administrative subpoenas will request a review of Respondent's CDS prescriptions immediately and from the beginning of each quarter;

4. Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agents. An unsatisfactory chart and/or peer review will constitute a violation of this Consent Order;

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

ORDERED that, after two years, Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or disciplinary panel. Respondent may be required to appear before the Board or disciplinary panel to discuss his petition for termination. The Board or disciplinary panel will grant the petition to terminate the probation if Respondent has complied with all the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

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

ORDERED that after the appropriate hearing, the Board or disciplinary panel determines that Respondent has failed to comply with any term or condition of this Consent Order, the Board or disciplinary panel may reprimand Respondent, place Respondent on probation with appropriate probationary terms and conditions or suspend or revoke Respondent's license to practice medicine in Maryland. The Board or disciplinary panel may, in addition to one or more of

the sanctions set forth above, impose a civil monetary fine upon Respondent; and it is further

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

ORDERED that, unless stated otherwise in the order, any time prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of Panel B; and

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

06/21/2018
date

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

CONSENT

I, Alphonsus E. Okoli, M.D., License No. D73032, by affixing my signature hereto, acknowledge that:

I am represented by counsel, Kevin Dunne, Esquire, and have consulted with counsel before entering this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I am waiving those procedural

and substantive protections. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

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

06/14/18
Date

Alphonsus E. Okoli, M.D., Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Prince George's

I HEREBY CERTIFY that on this 14th day of June, 2018 before me, a Notary Public of the State and County aforesaid, personally appeared Alphonsus E. Okoli, M.D., License number D73032, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Luisa Natali Mata
Notary Public

My commission expires 05/24/2021

06/14/2018
Date

LUISA NATALI MATA
NOTARY PUBLIC
PRINCE GEORGE'S COUNTY
MARYLAND
My Commission Expires 05-24-2021