IN THE MATTER OF	*	**BEFORE THE**
BRYAN J. KATZ, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D82445	*	**Case Number: 2221-0019**

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ORDER AFFIRMING CEASE AND DESIST ORDER

On November 30, 2021, pursuant to Md. Code Ann., Health Occ. § 14-206(e)(3), Disciplinary Panel B ("Panel B" or the "Panel") of the Maryland State Board of Physicians (the "Board") issued a Cease and Desist Order against Bryan J. Katz, M.D. (the "Respondent") for him to immediately cease and desist from treating chronic pain patients and from prescribing and all dispensing controlled dangerous substances ("CDS"), as defined in Md. Code Ann., Crim. Law §§ 5-401 *et seq.*, in the State of Maryland.

The pertinent statutory provisions of the Panel's action are as follows:

§ 14-206. Judicial Powers.

. . .

(e) A disciplinary panel may issue a cease and desist order . . . against an individual for:

. . .

(3) Taking any action:

(i) For which a disciplinary panel determines there is a preponderance of evidence of grounds for discipline under § 14-404 of this title; and

(ii) That poses a serious risk to the health, safety, and welfare of a patient.

§ 14-404.

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

. . .

(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; [and]

. . .

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

On December 30, 2021, pursuant to COMAR 10.32.02.11E(3)(a), the Respondent filed a written opposition challenging the Cease and Desist Order and included a request for a hearing. On January 26, 2022, pursuant to COMAR 10.32.02.11E(3)(b), Panel B held a hearing on the Respondent's opposition.

I. DISCUSSION OF RESPONDENT'S OPPOSITION

In his Opposition, the Respondent does not challenge the investigative findings contained in the Cease and Desist Order. The Panel has accepted those investigative findings as findings of fact. *See* Section II, below. The Respondent does argue, however, that the Cease and Desist Order was overbroad and does not comply with the Board's procedures.

The Respondent argues that the Cease and Desist Order was overbroad, first, contending that the prohibition on him treating chronic pain patients precludes the Respondent from treating non-chronic pain conditions of patients who also have chronic pain, and second, contending that the prohibition on prescribing and dispensing all CDS

unnecessarily prevents him from prescribing CDS that were not the subject of the deficiencies found by the peer reviewers.

First, the Panel finds that prohibition on treating chronic pain patients does not preclude the Respondent from treating the non-chronic pain conditions of patients who also have chronic pain. Thus, the Respondent can treat a patient who has chronic pain for non-chronic pain conditions, so long as the patient's chronic pain is not treated by the Respondent and the Respondent's treatment does not include him prescribing CDS for the patient.

Concerning the Respondent's argument that the Cease and Desist Order improperly prohibits the Respondent from prescribing and dispensing CDS that were not the subject of the peer reviewers' findings, the Respondent contends that the peer review reports concern the Respondent's prescribing of opioids, and not his prescribing of non-opioid CDS, such as stimulants and benzodiazepines. The Panel does not accept this argument. Non-opioid CDS present many of the same risks as opioids, such as abuse, dependence, addiction, and overdose.[1] Also, the deficiencies in the Respondent's practice are broader than his prescribing of only opioids. For example, the Respondent failed to conduct comprehensive history and physical examinations, failed to address inconsistent results of urine toxicology screens, failed to ensure compliance with the patients' medication regimens, and failed to document the medical justification for a prescription of Soma,[2]

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[1] The Panel has relied upon its experience, technical competence, and specialized knowledge. *See* State Gov't § 10-213(i).

[2] Soma is the brand name for carisoprodol, a muscle relaxer and Schedule IV CDS. *See* Crim. Law § 5-405(c)(7).

which is a non-opioid CDS (*see* Patient 3). In any case, the extent of the Respondent's deficiencies with opioids demonstrates a serious risk to patients with respect to all CDS prescribing and dispensing.

Lastly, the Respondent argues that there is a procedural error with the issuance of the Cease and Desist Order. Relying upon Health Occ. § 14-401.1(e)(2)(vi), the Respondent contends that peer reviewers for a Cease and Desist Order must use a standard format for peer review reports. The Panel does not accept this argument. Section 14-401.1(e) provides, in relevant part:

> (1) . . . the Board shall enter into a written contract with an entity or individual for confidential physician peer review of allegations based on § 14-404(a)(22) of this subtitle.
> (2) A peer reviewer shall:
> . . .
> (vi) Have a standard format for peer review reports.

The requirement for a standard format for peer review reports concerns allegations based on § 14-404(a)(22). The Cease and Desist Order, however, was based on § 14-206(e)(3). Underlying the Cease and Desist Order is the allegation that the Respondent violated § 14-404(a)(22), but the § 14-404(a)(22) allegations were peer reviewed using a standard format, as the Respondent noted in his opposition: "The [Cease and Desist] Order does not contain any indication that either original peer review report was in any way defective . . . ." Opposition, page 7, ¶ 36. The addendum the peer reviewer used for the Cease and Desist concerned the Cease and Desist Order, while § 14-401.1(e) concerns the underlying peer reviews of the § 14-404(a)(22) allegations, which as the Respondent acknowledges, were not procedurally defective.

II. FINDINGS OF FACTS

Based upon the investigatory material received by Panel B, Panel B finds the following facts by a preponderance of evidence:

A. BACKGROUND

1. At all times relevant, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on October 3, 2016, under License Number D82445. The Respondent's medical license is active and scheduled for renewal on September 30, 2022.

2. From approximately November 2018 to February 2020, the Respondent practiced pain medicine at a pain management practice in Maryland. Since then, the Respondent has been operating a private home-based telemedicine practice out of Baltimore, Maryland.

3. The Board initiated an investigation of the Respondent after receiving an anonymous complaint, on or about August 26, 2019, alleging that the Respondent, who had no specialized training in pain medicine, was prescribing oxycodone 30 mg to patients without imaging studies or workups.

B. BOARD INVESTIGATION

4. In furtherance of its investigation, the Board issued a subpoena to the Respondent for ten (10) patient records and supporting materials, with which the Respondent complied. The Board then submitted the subpoenaed materials to a peer reviewing entity for a peer review. The review was performed by two physicians who are board-certified in anesthesiology with subspeciality certification in pain medicine. After

review, both reviewers independently concluded that the Respondent failed to meet appropriate standards for the delivery of quality medical care in nine of ten patients and failed to keep adequate medical records in all ten patients ("Patient 1 to 10").[3] Based on Peer Reviewer 1's significant concerns regarding the Respondent's prescribing of CDS, Board staff asked Peer Reviewer 1 to submit an addendum addressing whether Dr. Katz could safely continue to prescribe CDS. Peer Reviewer 1 submitted an addendum to his report that stated that the Respondent lacks "advanced training in pain management, appears unfamiliar with the potency, titration methodologies and dose conversion for opiates." The Respondent, the peer reviewer opined, demonstrated "a consistent pattern of prescribing what appears to be templated, high-dose opioid regimen" and that the prescriptions were "indiscriminately prescribed . . . without regard to pain intensity, pain duration or primary diagnosis."

C. PATIENT-SPECIFIC SUMMARIES

Patient 1

5. Patient 1, a male born in the 1960s, saw the Respondent from on or about April 24, 2019, to on or about January 8, 2020, on generally monthly visits with complaints of back and bilateral knee pain as a result of multiple prior motor vehicle accidents. Patient 1's medication regime upon presentation was the opioid CDS oxycodone 10 mg three times a day. Throughout the treatment period, the Respondent failed to conduct and document

[3] For confidentiality reasons, the names of patients have not been disclosed in this document.

comprehensive history and physical examinations and at times increased Patient 1's oxycodone dosage without sufficient documented medical justification. The Respondent also failed to perform random pill counts to ensure medication compliance and to address inconsistent urine toxicology screens ("UDS").

6. Examples of the Respondent's failure to meet quality medical and record keeping standards include, but are not limited to:

A. Failing to conduct and document comprehensive history and physical examinations, including neurological examination documenting motor function, sensory function, strength and reflexes in the lower extremities;

B. Increasing Patient 1's CDS opioid dosage at the initial visit on April 24, 2019, to oxycodone 15 mg three times a day without sufficient documented medical justification;

C. Increasing Patient 1's CDS opioid dosage on May 22, 2019, to oxycodone 15 mg three times a day and Oxycontin 15 mg two times a day without sufficient documented medical justification;

D. Increasing Patient 1's dosage on June 19, 2019, to oxycodone 15 mg four times a day and Oxycontin 15 mg two times a day without sufficient documented medical justification;

E. Failing to conduct routine pill counts to ensure medication compliance; and

F. Failing to address Patient 1's inconsistent UDS.

Patient 2

7. Patient 2, a male born in the 1980s, saw the Respondent from on or about April 2, 2019, to on or about December 23, 2019, on generally monthly visits with complaints of back pain from a work-related fall in 2016. Patient 2's medication regime upon presentation was oxycodone 30 mg every four to six hours (#100). Throughout the treatment period, the Respondent failed to conduct and document comprehensive history and physical examinations and maintained Patient 2 on high-dose CDS without sufficient documented medical justification. The Respondent also failed to perform random pill counts to ensure medication compliance and to address inconsistent UDS.

8. Examples of the Respondent's failure to meet quality medical and record keeping standards include, but are not limited to:

A. Failing to conduct and document comprehensive history and physical examinations, including neurological examination documenting motor function, sensory function, strength and reflexes in the lower extremities;

B. Prescribing to Patient 2 at his initial visit on April 2, 2019, and subsequently maintaining him on Oxycontin 15 mg every 12 hours and oxycodone 20 mg (#120) despite Patient 2 having an essentially normal MRI from 2016;

C. Increasing Patient 2's dosage on September 18, 2019, and subsequently maintaining him on oxycodone 30 mg every four to six

hours (#100) and the CDS oxymorphone 15 mg every twelve hours (#60) without sufficient documented medical justification;

D. Failing to conduct routine pill counts to ensure medication compliance; and

E. Failing to address Patient 2's inconsistent UDS.

Patient 3

9. Patient 3, a male born in the 1970s, saw the Respondent from on or about July 24, 2019, to on or about December 11, 2019, with complaints of left flank/lower back pain. Patient 3 had a history of near fatal traumatic accident involving a tree stump removing machinery that resulted in traverse process and spinous process factures in the lower back, right tibia and humerus fractures, a left femur fracture, as well as severe trauma to the left flank and abdominal wall. Patient 3's medication regime upon presentation was the CDS Methadone 10 mg three times a day (#90) and oxycodone 30 mg 4 times a day (#120). At the initial visit, the Respondent increased Patient 3's dosage to Methadone 10 mg (#90) and oxycodone 30 mg (#180) and subsequently maintained Patient 3 on such high-dose medication regime without first attempting to address Patient 3's potential underlying psychiatric issues.

10. Examples of the Respondent's failure to meet quality medical and record keeping standards include, but are not limited to:

A. Increasing Patient 3's medication dosage at his initial visit to Methadone 10 mg (#90) and oxycodone 30 mg (#180) and subsequently maintaining him on such high-dose regime without first

attempting to address Patient 3's potential underlying psychiatric issues;

B. Failing to document a comprehensive physical examination at the initial visit, especially with respect to Patient 3's back;

C. Failing to document his medical decision-making regarding opioid dose increase;

D. Failing to document his medical decision-making regarding prescribing of Soma; and

E. Failing to conduct routine pill counts to ensure medication compliance.

Patient 4

11. Patient 4, a female born in the 1970s, saw the Respondent from on or about March 19, 2019, to on or about October 30, 2019, with complaints of low back pain radiating to lower extremities. Patient 4 had a history of L5/S1 spinal fusion in 2014 and right total knee replacement in 2018. Patient 4's medication regime upon presentation was oxycodone 15 mg four times a day and oxymorphone 15 mg twice a day. During the treatment period, the Respondent maintained Patient 4 on high-dose short acting opioid without sufficiently documented physical examinations and based on questionable opioid risk assessments that failed to fully consider Patient 4's concomitant anxiety, emotional lability and trauma and inconsistent UDSs. The Respondent also failed to perform pill counts to ensure medication compliance.

12. Examples of the Respondent's failure to meet quality medical and record keeping standards include, but are not limited to:

A. Failing to conduct and document comprehensive history and physical examinations, including neurological examination documenting motor function, sensory function, strength and reflexes in the lower extremities;

B. Increasing Patient 4's medication dosage at initial visit to oxycodone 30 mg (#90) and oxymorphone ER 30 mg (#30) based on questionable opioid risk assessment and without sufficiently documented physical examination;

C. Increasing Patient 4's medication dosage at second visit to oxycodone 30 mg (#120) and oxymorphone 30 mg (#60) and maintaining her on such high-dose CDS based on questionable opioid risk assessment and without sufficiently documented physical examination;

D. Failing to address Patient 4's inconsistent UDSs; and

E. Failing to perform pill counts to ensure medication compliance.

Patient 5

13. Patient 5, a male born in the 1970s, saw the Respondent from on or about February 28, 2019, to on or about December 5, 2019, with complaints of low back pain radiating to bilateral lower extremities. Patient 5 had a history of motor vehicle accident in 1988. Patient 5 presented with an MRI from 2016 showing herniated disc at L5/S1, which is inconsistent with the Respondent's assessment of Degenerative Joint Disease.

Patient 5's medication regimen upon presentation was oxycodone 30 mg (#90). During the treatment period, the Respondent maintained Patient 5 on high-dose short acting CDS without sufficiently documented physical examinations and despite a 2016 MRI, which showed only herniated disc at L5/S1. Moreover, the Respondent failed to perform pill counts to ensure medication compliance.

14. Examples of the Respondent's failure to meet quality medical and record keeping standards include, but are not limited to:

A. Failing to conduct and document comprehensive history and physical examinations, including neurological examination documenting motor function, sensory function, strength and reflexes in the lower extremities;

B. Maintaining Patient 5 at initial visit on oxycodone 30 mg (#90) without sufficiently documented physical examination and despite a 2016 MRI showing only herniated disc at L5/S1;

C. Adding Oxycontin 15 mg (#60) at Patient 5's March 28, 2019, visit at Patient 5's request and without sufficiently documented medical justification;

D. Increasing Patient 5's medication dosage to oxycodone 30 mg (#120) and maintaining him on such high-dose short acting opioid without sufficiently documented physical examination and medical justification;

E. Failing to refer Patient 5 to a back specialist; and

F. Failing to perform pill counts to ensure medication compliance.

Patient 6

15. Patient 6, a female born in the 1960s, saw the Respondent from on or about February 12, 2019, to on or about December 17, 2019, with a 12-year history of right ankle pain, bilateral shoulder pain and low back pain. Patient 5's medical history was significant for bipolar, depression and anxiety. During the treatment period, the Respondent maintained Patient 6 on high-dose short acting opiate analgesics without sufficiently documented comprehensive physical examinations.

16. Examples of the Respondent's failure to meet quality medical and record keeping standards include, but are not limited to:

A. Failing to conduct and document comprehensive history and physical examinations, including neurological examination documenting motor function, sensory function, strength and reflexes in the lower extremities;

B. Prescribing to Patient 6 at the initial visit oxycodone 30 mg (#90) without sufficiently documented comprehensive physical examination;

C. Increasing Patient 6's medication dosage on April 9, 2019, to oxycodone 30 mg (#120) at the patient's request and without sufficiently documented physical examination or medical justification;

D. Failing to prescribe or document prescribing Naloxone;

E. Failing to address inconsistent UDSs; and

F. Failing to perform pill counts to ensure medication compliance.

Patient 7

17. Patient 7, a male born in the 1970s, saw the Respondent from on or about February 7, 2019, to on or about December 18, 2019, with complaints of low back pain and left sciatica due to a work-related injury. Patient 5's medication regimen upon presentation was oxycodone 30 mg four times a day, Methadone 10 mg twice a day and Lyrica 150 mg three times a day. During the treatment period, the Respondent maintained Patient 7 on high-dose short acting opiate analgesics despite: a lack of sufficiently documented physical examinations; a 2016 MRI showing that Patient 7 had a herniated disc at L5/S1, which is treatable without using such high-dose CDS; and inconsistent UDSs. Moreover, the Respondent failed to perform pill counts to ensure medication compliance.

18. Examples of the Respondent's failure to meet quality medical and record keeping standards include, but are not limited to:

A. Failing to conduct and document comprehensive history and physical examinations, including neurological examination documenting motor function, sensory function, strength and reflexes in the lower extremities;

B. Maintaining Patient 7 at the initial visit on oxycodone 30 mg (#120) without sufficiently documented comprehensive physical examination and despite a treatable disc herniation;

C. Increasing Patient 7's medication dosages to oxycodone 30 mg (#120) and Methadone 10 mg (#90) without sufficiently documented medical justification;

D. Failing to refer Patient 7 for specialist consultation despite a 2016 MRI showing a treatable L5/S1 disc herniation;

E. Failing to address Patient 7's inconsistent UDSs; and

F. Failing to perform pill counts to ensure medication compliance.

Patient 8

19. Patient 8, a female born in the 1970s, saw the Respondent by Videoconference from on or about May 7, 2020, to on or about October 27, 2020, with complaints of low back and bilateral knee pain. Patient 8 was a referral from a medical cannabis referral service and her medication regimen on presentation included oxycodone 10 mg three to four times a day and Methadone 5 mg twice a day. During the treatment period, despite noting a treatment strategy to minimize opioids, the Respondent increased Patient 8's total opioid burden from 60 MME on initial consultation to 120 MME after three visits.

20. Examples of the Respondent's failure to meet quality medical and record keeping standards include, but are not limited to:

A. Maintaining Patient 8 at the initial visit on oxycodone 10 mg (#120) without sufficiently documented background verification and evaluation, including an opiate risk assessment;

B. Increasing Patient 8's medication dosages on July 8, 2020, to oxycodone 20 mg (#90) and Methadone 5 mg (#60) and maintaining her on such high-dosages subsequently without sufficiently documented evaluation, including an opioid risk assessment;

C. Failing perform opioid risk assessments or check Prescription Drug Monitoring Program; and

D. Failing to order UDS or perform pill counts to ensure medication compliance.

Patient 9

21. Patient 9, a male born in the 1990s, saw the Respondent from on or about January 30, 2019, to on or about January 9, 2020, with complaints of neck, low back and upper and lower extremities pain. Patient 9 had a history severe burn trauma from an accident in 2011. Patient 9 presented with a medication regimen that included unspecified chronic opioid treatment from various previous providers. During the treatment period, the Respondent maintained Patient 9 on high-dose opiate analgesics, including oxycodone 30 mg (#120) and Xtampza[4] 27 mg, without sufficiently documented physical examinations and medical justification. Moreover, the Respondent continued to prescribe high-dose opiate analgesics to Patient 9 despite repeated inconsistent UDSs.

22. Examples of the Respondent's failure to meet quality medical and record keeping standards include, but are not limited to:

[4] Xtampza is a brand name for oxycodone.

A. Failing to conduct and document comprehensive history and physical examinations, including neurological examination documenting motor function, sensory function, strength and reflexes in the lower extremities;

B. Prescribing at Patient 9's initial visit oxycodone 30 mg (#120) without a sufficiently documented comprehensive physical examination;

C. Adding Oxycontin 10 mg (#60) on July 18, 2019, and later substituting Xtampza ER 27 mg (#30) on August 15, 2019, without a sufficient documented physical examination or medical justification;

D. Continuing to prescribe high-dose short acting oxycodone despite repeated UDS showing absence of opiate or presence of illicit drug; and

E. Failing to perform pill counts to ensure medication compliance.

Patient 10

23. Patient 10, a male born in the 1980s, saw the Respondent from on or about January 31, 2019, to on or about January 2, 2020, with complaints of low back pain radiating into the thighs from a fall in 2009 and right leg pain from a gunshot wound in 2005. Patient 10's medication regimen on presentation included oxycodone 30 mg and Methadone 5 mg from various previous providers. During the treatment period, the Respondent maintained Patient 10 on high-dose narcotics, including oxycodone 30 mg (#120) and Methadone 10 mg (#30) without sufficiently documented physical examinations and despite a nearly normal lumbar MRI from 2015. Moreover, the

Respondent continued to prescribe high-dose narcotics to Patient 10 despite inconsistent UDS and other red flags.

24. Examples of the Respondent's failure to meet quality medical and record keeping standards include, but are not limited to:

A. Failing to conduct and document comprehensive history and physical examinations, including neurological examination documenting motor function, sensory function, strength and reflexes in the lower extremities;

B. Prescribing and maintaining Patient 10 on oxycodone 30 mg (#120) and Methadone 10 mg (#30) without sufficiently documented physical examinations and despite a near normal lumbar MRI from 2015;

C. Continuing to prescribe high-dose opioid analgesics to Patient 10 despite inconsistent UDS and other red flags; and

D. Failing to perform pill counts to ensure medication compliance.

III. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel B concludes as a matter of law that a preponderance of evidence supports a conclusion that the Respondent failed 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, 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). Because the Respondent's deficient CDS prescribing practices pose a serious risk to the health, safety and welfare to patients, a disciplinary panel is authorized to issue a cease and desist order. Health Occ. § 14-206(e)(3).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by Panel B, hereby

ORDERED that the Cease and Desist Order, issued by the Panel on November 30, 2021, against Respondent, Bryan J. Katz, M.D., is affirmed; and it is thus further

ORDERED that the Respondent, Bryan J. Katz, M.D., shall continue to cease and desist from treating chronic pain patients and from prescribing and dispensing CDS, thus the Respondent shall not prescribe or dispense CDS to any person; and it is further

ORDERED that, if the Respondent violates this Order Affirming Cease and Desist Order, a Board disciplinary panel may impose a civil fine pursuant to COMAR 10.32.02.11E(4)(a); and it is further

ORDERED that this order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of Panel B; and it is further

ORDERED that this is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* and COMAR 10.32.02.11E(1)(a).

Signature on File

02/23/2022
Date

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

NOTICE OF OPPORTUNITY FOR EVIDENTIARY HEARING

The Respondent may request a full evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings. The request will be granted if the Board receives a written request for the hearing within 10 days of the date of this Order. Any request shall be made to:

Christine A. Farrelly, Executive Director
Maryland State Board of Physicians
4201 Patterson Avenue, 4th Floor
Baltimore, Maryland 21215

A copy of any request shall also be mailed to:

K. F. Michael Kao, Assistant Attorney General
Office of the Attorney General
Health Occupations Prosecution and Litigation Division
300 West Preston Street, Suite 201
Baltimore, Maryland 21201