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

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

CONSENT ORDER

On December 2, 2021, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged Bryan J. Katz, M.D. (the "Respondent"), License Number D82445, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2014 Repl. Vol. & 2020 Supp.). Panel B charged the Respondent under the following provisions of the Act:

> **Health Occ. § 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (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 February 23, 2022, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on the negotiations occurring as a result of this

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

FINDINGS OF FACT

Panel B makes the following findings of fact:

I. BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent originally was licensed to practice medicine in Maryland on October 3, 2016, under License Number D82445. The Respondent's medical license is 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 workup.

II. BOARD INVESTIGATION

4. In furtherance of its investigation, the Board issued a subpoena to the Respondent for ten (10) patient records and supporting materials, 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.[1] 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").[2] Based on Peer Reviewer 1's significant concerns regarding Dr. Katz'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 Dr. Katz lacks "advanced training in pain management, appears unfamiliar with the potency, titration methodologies and dose conversion for opiates." Dr. Katz, the peer reviewer opined, demonstrated "a consistent patterns 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."

III. 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 oxycodone 10 mg three times a day.

[1] The specific findings of both reviewers pertaining to the ten patients reviewed are set forth completely in the Peer Review Reports which have been provided to the Respondent.

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

Throughout the treatment period, the Respondent failed to conduct and 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 narcotic 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 narcotic 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 narcotic 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 narcotics 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 narcotic dosage on September 18, 2019, and subsequently maintaining him on oxycodone 30 mg every four to six

hours (#100) and 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 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 narcotic 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 opiate 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 opiate without sufficiently documented physical examinations and based on questionable opiate 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 opiate 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 narcotics based on questionable opiate 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 narcotics 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 opiate 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 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 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 narcotics; 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 opiates, the Respondent increased Patient 8's total opiate 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 opiate risk assessment;

C. Failing perform opiate 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 opiate 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 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:

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 opiate analgesics to Patient 10 despite inconsistent UDS and other red flags; and

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

CONCLUSIONS OF LAW

Based on the forgoing Findings of Fact, Panel B concludes as a matter of law that: the Respondent failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical or surgical care 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, thus, by Disciplinary Panel B of the Board, hereby:

ORDERED that the Cease and Desist Order against the Respondent, issued by Panel B on November 30, 2021, and affirmed by Panel B on February 23, 2022, is terminated as moot based upon the issuance of this Consent Order; and it is further

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

ORDERED that the Respondent is permanently prohibited from prescribing and dispensing opioid medications; and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **TWO YEARS**.[3] During probation, the Respondent shall comply with the following terms and conditions of probation:

1. During probation, the Respondent shall not prescribe or dispense any Controlled Dangerous Substances ("CDS"). The CDS are identified in Health Occ. §§ 5-401—5-406. In addition, the following terms apply:

(a) The Respondent shall not delegate to any physician assistant the prescribing of CDS;

(b) The Respondent is prohibited from certifying patients for the medical use of cannabis;

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

(d) The Respondent agrees that the CDS Registration issued by the Office of Controlled Substances Administration will be restricted to the same categories of CDS or opioid medications as limited by this Consent Order;

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

2. Within **ONE YEAR,** the Respondent is required to take and successfully complete courses in: (i) the appropriate prescribing of CDS medications, and (ii) medical record-keeping. The following terms apply:

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

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

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

(d) the Respondent is responsible for the cost of the courses; and

3. Within **SIX MONTHS,** the Respondent shall pay a civil fine of **$500.00.** The payment shall be by money order or bank certified check 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 the Respondent's license if the Respondent fails to timely pay the fine to the Board; and it is further

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

ORDERED that a violation of probation constitutes a violation of this Consent Order;

ORDERED that, after the Respondent has complied with all terms and conditions and the minimum period of probation imposed by the Consent Order has passed, the Respondent may submit a written petition for termination of probation. After consideration of the petition, the Respondent's probation may be administratively terminated through an

order of the disciplinary panel if the Respondent has complied with all probationary terms and conditions and there are no pending complaints related to the charges; and it is further

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

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

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

ORDERED that, after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent's license to practice medicine

in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

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

Signature On File

03/29/2022
Date

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

CONSENT

I, Bryan J. Katz, M.D., acknowledge that I have consulted with counsel before signing this document.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq.* concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

3/26/2022
Date

Signature On File

Bryan J. Katz, M.D.

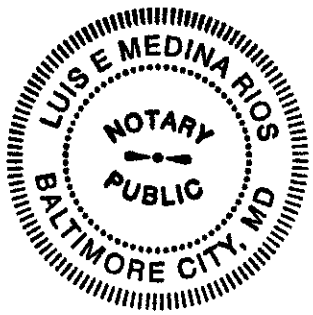
NOTARY

STATE OF Maryland

CITY / COUNTY OF Baltimore

I HEREBY CERTIFY that on this 26 day of March 2022, before me, a Notary Public of the foregoing State and City/County, personally appeared Bryan J. Katz, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.



Notary Public

Commission expires: 10/04/2025