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

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

CEASE AND DESIST ORDER

Pursuant to the authority granted to Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") under Md. Code Ann., Health Occ. ("Health Occ.") § 14-206(e)(3)(2014 Repl. Vol. & 2020 Supp.), Panel B hereby orders **BRYAN J. KATZ, M.D.** (the "Respondent") to immediately **CEASE AND DESIST** from treating chronic pain conditions and from prescribing opiates and other concurrent Controlled Dangerous Substances ("CDS") in the State of Maryland, as defined in Criminal Law § 5-401 *et seq*.

The pertinent provisions of the Maryland Medical Practice Act (the "Act"), Health Occ. §§ 14-101 *et seq.*, under which Panel B issues this Order provide the following:

§ 14-206. Judicial Powers.

...

(e) A disciplinary panel may issue a cease and desist order or obtain injunctive relief 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. Denials, reprimands, probation, suspensions, and revocations.

(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[.]

INVESTIGATIVE FINDINGS[1]

Based on the investigatory information received by, made known to, and available to Panel B, there is reason to believe that the following facts are true:

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.

[1] The statements regarding the Board's investigative findings are intended to provide the Respondent with reasonable notice of the basis of the Board's action. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

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.[2] 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 Dr. Katz's prescribing of CDS, Board staff asked Peer

[2] 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.

[3] For confidentiality reasons, the names of patients have not been disclosed in this document. The Respondent may obtain the identity of any patient referenced herein by contacting the administrative prosecutor.

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. 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 foregoing Investigative Findings, Panel B concludes as a matter of law that a preponderance of evidence supports a conclusion that the Respondent failed to meet appropriate standards of quality medical care and failed to keep adequate medical records with regard to his CDS prescribing practices and treatment of chronic pain patients in violation of Health Occ. § 14-404(a)(22) and (40). Because the Respondent's deficient CDS prescribing practices pose a serious risk to the health, safety and welfare of patients, Panel B is authorized to issue this cease and desist order under Health Occ. § 14-206(e)(3).

ORDER

Based on the foregoing Investigative Findings and Conclusions of Law, it is, by a majority of the quorum of Panel B, hereby:

ORDERED that pursuant to the authority under the Maryland Medical Practice Act, Health Occ. § 14-206(e)(3), the Respondent, Brian J. Katz, M.D., shall **IMMEDIATELY CEASE AND DESIST** from treating chronic pain patients and

prescribing and dispensing all CDS; thus, the Respondent shall not prescribe or dispense CDS to any person; and it is further

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

ORDERED that this order is **EFFECTIVE IMMEDIATELY** pursuant to COMAR 10.32.02.11E(1)(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

11/30/2021
Date

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

NOTICE OF OPPORTUNITY FOR A HEARING

The Respondent may challenge the factual or legal basis of this initial order by filing a written opposition, which may include a request for a hearing, within 30 days of its issuance. The written opposition shall be made to:

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

A copy shall also be mailed to:

K. F. Michael Kao
Assistant Attorney General
Maryland Office of the Attorney General

Health Occupations Prosecution and Litigation Division
300 West Preston Street, Suite 201
Baltimore, Maryland 21201

If the Respondent files a written opposition and a request for a hearing, the Board shall consider that opposition and provide a hearing if requested. If the Respondent does not file a timely written opposition, the Respondent will lose the right to challenge this Initial Order to Cease and Desist and this Order will remain in effect.