IN THE MATTER OF	*	**BEFORE THE**
JAMES L. HARRY, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D20168		**Case Number: 2014-0254A**

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

CONSENT ORDER

On November 14, 2017, Disciplinary Panel A of the Maryland State Board of Physicians ("Disciplinary Panel A") charged **JAMES L. HARRY, M.D.**, (the "Respondent"), License Number D20168, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II §§ 14-101 *et seq.* (2014 Repl. Vol.).

The pertinent provisions of the Act under Health Occ. II § 14-404(a) provide as follows:

> **§ 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[.]

On February 28, 2018, a conference with regard to this matter was held before a panel of the Board's Disciplinary Committee for Case Resolution ("DCCR"). As a result of the DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on February 1, 1977. His license is scheduled to expire on September 30, 2018.

2. The Respondent is not board-certified in any medical specialty.

3. In 2009, the Respondent became employed by a group pain management practice ("the Practice")[1] in Towson, Maryland.

4. In a statement to the Board, the Respondent advised that he "work[s] closely with my employer, [the Practice's medical director] on all patients I see." When interviewed under oath by Board staff, the Respondent stated that he was "primarily trained by [the Practice's medical director] and his colleagues" and that he had completed several Continuing Medical Education credits in responsible opioid prescribing.

5. In or around September 2013, the Board received a complaint from an insurer regarding the Respondent's prescribing practices.

6. Thereafter, the Board initiated an investigation. In furtherance of its investigation, the Board obtained ten patient records from the Respondent for review. The Board referred the patient charts and related materials to a peer review entity for review. The peer reviewers found deficiencies in the Respondent's prescribing practices which constituted violations of the Act.

[1] The names of facilities, individuals and patients are confidential.

7. The peer reviewers noted the following general deficiencies with regard to the Respondent's prescribing practices:

a. The Respondent consistently prescribed excessively high dosages of highly addictive short-acting opioids and long-acting opioids over prolonged periods of time in the absence of clinical evidence to support the dosages prescribed;

b. The Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management;

c. The Respondent maintained patients on excessively high levels of opioids for months and even years despite lack of improvement of functionality or pain control;

d. The Respondent failed to adequately monitor patients for the potential risk of diversion or addiction;

e. The Respondent failed to significantly modify his treatment plan when patients demonstrated aberrant behavior including inconsistent urine drug tests ("UDTs"). Inconsistent results include positive results for drugs not prescribed, or illicit drugs, or negative tests for drugs that were prescribed, which would raise concern for diversion;

f. The Respondent failed to obtain updated imaging studies or other objective clinical indications of a patient's pain;

g. The Respondent consistently failed to check patients' past and ongoing medication history with the Chesapeake Regional Information System for

our Patients ("CRISP") or the Maryland Prescription Drug Monitoring Program ("PDMP");

h. The Respondent failed to taper or wean patients from excessive dosages of opioids in spite of the lack of functional improvement or pain control over extended periods of time;

i. The Respondent failed to refer patients for appropriate consultations, including interventional pain management, for non-opioid-based treatment; and

j. The Respondent continued to maintain or escalate opioid doses in spite of patient behavior indicating opioid use disorder where an addiction consult would be more appropriate.

8. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22) for reasons including those set forth in the following patient summaries.

PATIENT-SPECIFIC FINDINGS OF FACT

In addition to the general practice deficiencies, the peer reviewers found the patent-specific practice deficiencies that include those set forth below.

Patient 2[2]

9. Patient 2, a male in his mid- forties, was seen by other Practice physicians for neck and back pain starting in January 2008.

[2] Patient identification numbers correspond to those in the peer review reports.

10. In 2008, a physician other than the Respondent began prescribing oxycodone 30 mg to Patient 2, documenting decreased range of motion of his cervical and lumbar spine.

11. The Respondent began treating Patient 2 in December 2009. The Respondent maintained Patient 2 on oxycodone 30 mg prescribing up to two tablets every four to six hours.

12. In June 2010, a practitioner other than the Respondent documented in Patient 2's record: "Do not prescribe this patient any opioids, had 2 overdoses." At the next visit, the Respondent prescribed to Patient 2 the same quantity of oxycodone 30 mg as previously.

13. The Respondent continued Patient 2 on oxycodone 30 mg, albeit with a slight decrease in the quantity of pills prescribed despite Patient 2's multiple inconsistent urine drug tests ("UDTs") that were positive for marijuana and hydrocodone, the latter of which was not prescribed, and an inconsistent UDT that was negative for oxycodone but positive for morphine and Soma,[3] neither of which had been prescribed.

14. The Respondent failed to meet appropriate standards for the delivery of quality medical services with regard to Patient 2. The Respondent prescribed high dosages of short-acting opioids over several years without appropriate pathology or findings on physical examination, without a plan to transition Patient 2 off oxycodone 30 mg, a highly addictive opioid, and despite multiple inconsistent UDTs and information that Patient 2 had overdosed in the past. The Respondent

[3] Soma, a Schedule IV Controlled Dangerous Substance, is a muscle relaxant.

failed to obtain updated radiological studies and did not refer Patient 2 to physical therapy until 2014. The Respondent failed to refer Patient 2 for an interventional pain management consultation. Despite Patient 2's multiple violations of the Medication Agreement, the Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management.

Patient 3

15. Patient 3, a female in her late-forties, presented to the Practice in 2009 with low back pain.

16. Patient 3 was seen by other practitioners at the Practice prior to seeing the Respondent beginning in July 2012. Prior to seeing the Respondent, Patient 1 was prescribed oxycodone 15 mg one tablet every four to six hours (five/day maximum), methadone 10 mg one tablet every eight hours and Xanax, a benzodiazepine.

17. Prior to seeing the Respondent, Patient 3 had tested positive for heroin on two occasions and admitted to snorting heroin. She had also tested positive for non-prescribed morphine and hydrocodone.

18. Despite Patient 3's aberrant history, the Respondent continued to prescribe oxycodone 15 mg one tablet every four to six hours, methadone and Xanax.

19. The Respondent failed to meet appropriate standards for the delivery of quality care with regard to Patient 3. He prescribed high dosages of a short-acting opioid for a prolonged period of time in the absence of sufficient pathology to warrant such high doses. The Respondent inappropriately prescribed high dosages of

opioids in conjunction with a benzodiazepine. The Respondent failed to refer Patient 3 for an interventional pain consultation and failed to prescribe non-opioid adjuvants for nerve pain. Despite Patient 3's multiple violations of her Medication Agreement, the Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management.

Patient 4

20. Patient 4, a male in his late forties, was initially seen by the Respondent in March 2012. Patient 4's past medical history includes sacroiliac dysfunction, crush injuries to his lower extremities status post multiple surgeries and opioid dependency.

21. The Respondent prescribed Patient 4 oxycodone 30 mg five tablets/day, OxyContin 40 mg one tablet QID (four times a day), Xanax 1 mg BID (two times a day) and nortriptyline (an anti-depressant) and maintained him on that regimen for the entire review period (through December 2013).

22. The Respondent continued to prescribe high dosage opioids to Patient 4 despite two UDTs that were positive for methadone that had not been prescribed.

23. The Respondent failed to address the inconsistent UDTs.

24. The Respondent failed to meet appropriate standards for the delivery of quality care with regard to Patient 4. He prescribed high dosages of a short-acting opioid for a prolonged period of time in the absence of sufficient pathology to warrant such high doses. Despite Patient 4's multiple violations of his Medication Agreement, the Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management.

Patient 5

25. Patient 5, a male in his mid-thirties, presented at the Practice in 2006 with complaints of low back, leg, neck and shoulder pain. Imaging studies performed in 2007 revealed moderate arthritic changes of the AC joint,[4] likely avascular necrosis of the right hip, minimal retrolisthesis of the right hip,

26. Patient 5 was seen by practitioners at the Practice other than the Respondent for some visits.

27. The Respondent maintained Patient 5's medication regimen that included: methadone 10 mg TID (three times a day), oxycodone 15 mg maximum of five tablets/day, Valium, Ambien and ibuprofen.

28. The Respondent maintained Patient 5 on this regimen for several months despite multiple UDTs that were positive for alcohol and negative for oxycodone.

29. In 2013, the Respondent increased Patient 5's oxycodone 15 mg to a maximum of six tablets a day. The Respondent failed to document the medical necessity for the dosage increase.

30. The Respondent failed to meet appropriate standards for the delivery of quality care with regard to Patient 5. He prescribed high dosages of a short-acting opioid for a prolonged period of time without a plan to transition Patient 5 off the highly addictive medication. Despite Patient 5's multiple violations of his Medication Agreement, the Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management.

[4] The abbreviation for acromioclavicular joint; the joint at the top of the shoulder.

The Respondent failed to obtain updated imaging studies or to refer Patient 5 for an interventional pain consultation.

Patient 6

31. Patient 6, a female in her early fifties, was initially seen at the Practice in October 2009 and was treated for residual status post knee replacement. Nerve studies of Patient 6's knee were normal.

32. The Respondent maintained Patient 6 for years on a medication regimen that included OxyContin 30 mg one tablet BID, oxycodone 5 mg every four to six hours and ibuprofen.

33. The Respondent failed to meet appropriate standards for the delivery of quality care with regard to Patient 6. He prescribed high dosages of a short-acting opioid for a prolonged period of time without a plan to transition Patient 6 off the highly addictive medication. The Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management. The Respondent failed to monitor Patient 6 adequately.

Patient 7

34. Patient 7, a male in his early forties, resided in a state other than Maryland. He presented to the Practice in December 2010 for low back pain and total body pain. He was status post amputation of his right great toe.

35. The Respondent initially prescribed Patient 7 Roxicodone 30 mg one tablet every four to six hours and methadone 10 mg BID.

36. Patient 7 tested positive for heroin on two occasions and tested negative for all prescribed medications on multiple occasions. Nonetheless, the Respondent

escalated Patient 7's Roxicodone 30 mg to one tablet every three or four hours in the absence of a significant change in Patient 7's condition. The Respondent failed to document his treatment rationale.

37. The Respondent failed to meet appropriate standards for the delivery of quality care with regard to Patient 7. He prescribed high dosages of a short-acting opioid for a prolonged period of time without a plan to transition Patient 7 off the highly addictive medication. The Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management. The Respondent failed to monitor Patient 7 adequately and escalated Patient 7's dosage of short-acting opioids after UDTs that were positive for heroin.

Patient 8

38. Patient 8, a male in his mid-fifties, was initially seen at the Practice in 2009. Patient 8's medical history included multiple back surgeries with a diagnosis of Failed Back Surgery Syndrome, chronic pain syndrome and opioid dependency. Patient 8 had been disabled since a work-related accident in 1990.

39. The Respondent maintained Patient 8 for most of the review period (through 2013) on a medication regimen that included MS Contin 30 mg four tablets every 12 hours and Percocet 10/650, maximum eight tablets per day.

40. The acetaminophen dosage contained in the Percocet as prescribed equals 5200 mg/day; this exceeds the recommended dosage and put Patient 8 at risk for hepatoxicity.

41. The morphine dose for this medication regimen equals 360 mg/day.

42. Patient 8 had had several pain management consultations and Independent Medical Examinations. Each had recommended that Patient 8 undergo detoxification; however, Patient 8 consistently expressed his reluctance. Also noted was Patient 8's failure to make any functional improvement on the above regimen.

43. In February 2013, the Respondent documented his plan to decrease Patient 8's medication by one tablet a week. The Respondent further noted that he had discussed the plan with Patient 8 who "is not interested in pursuing any goals as his pain is limiting him to do anything."

44. The Respondent did not thereafter taper Patient 8's medication.

45. In April 2013, the Respondent documented that he had explained to Patient 8 the risks of the high level of acetaminophen and that Patient 8 had signed the note.

46. In September 2013, Patient 8 underwent an Independent Medical Examination. The examining physician noted the very high levels of morphine and acetaminophen that Patient 8 was being prescribed.

47. In November 2013, the Respondent decreased Patient 8's acetaminophen dosage from Percocet 10/650 to 10/325 five to six tablets/day. The Respondent increased Patient 8's morphine dosage from MS Contin 30 mg two every 12 hours to MS Contin 60 mg two every 12 hours.

48. The Respondent failed to meet appropriate standards of care with regard to Patient 8. The Respondent prescribed excessively high dosages of both short-acting and long-acting opioids for an extended period of time without a plan to transition Patient 8 off the dosage levels. The Respondent prescribed high dosages of

oxycodone that were in excess of the morphine equivalent recommended for chronic pain management and prescribed dosages of acetaminophen that were potentially toxic.

Patient 9

49. Patient 9, a male in his mid-forties, was referred to the Practice by his primary care physician in March 2011. Patient 9's medical history included mechanical low back pain, shoulder pain and knee pain.

50. The Respondent continued Patient 9's medication regimen and prescribed oxycodone 30 mg one to two tablets every four to six hours.

51. In 2012, the Respondent documented that Patient 9's dosage was to be tapered by one pill a day. The Respondent, however, continued to prescribe the same quantity of oxycodone with the same usage instructions throughout the review period (January 2014).

52. In June 2012, Patient 9's UDT was positive for Xanax that was not prescribed by the Respondent. Patient 9 stated that his primary care physician had prescribed the Xanax to him over a year earlier. The Respondent then prescribed Xanax 0.5 mg to Patient 9.

53. In June 2014, the Respondent discontinued Patient 9's Xanax and started Klonopin, a benzodiazepine, at Patient 9's request.

54. The Respondent failed to meet appropriate standards of care with regard to Patient 9. Patient 9 had the requisite pathology for a substantial level of opioid management; however, the Respondent prescribed excessively high dosages of both short-acting and long-acting opioids for an extended period of time without a

plan to transition Patient 9 off the dosage levels. The Respondent inappropriately prescribed high doses of opioids in conjunction with a benzodiazepine. The Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management

Patient 10

55. Patient 10, a male in his seventies, initially presented to the Practice in September 2010. The Respondent diagnosed Patient 10 with mechanical back and shoulder pain.

56. Patient 10's medication regimen prior to being treated by the Respondent had not included opioids. A practitioner other than the Respondent documented that Patient 10 had been prescribed hydrocodone and oxycodone after heart surgery about four years earlier. Patient 10 stated that he had felt better on that medication and asked for "something strong."

57. At the first visit, the Respondent prescribed oxycodone 10 mg one tablet TID- QID as needed and Naprosyn, a non-opioid analgesic.

58. In October 2010, the Respondent increased Patient 10's oxycodone to 15 mg TID – QID and added methadone 10 mg one tablet at bedtime.

59. Thereafter, the Respondent increased Patient 10's methadone 10 mg to three times a day.

60. In July 2013, the Respondent escalated Patient 10's dosage of oxycodone from 15 mg to 30 mg QID.

61. The Respondent failed to meet appropriate standards of care with regard to Patient 10, who previously had not been prescribed opioids on a regular basis. In the

absence of radiological studies, the Respondent prescribed excessively high dosages of both short-acting and long-acting opioids for an extended period of time without a plan to transition Patient 10 off the dosage levels. The Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, Disciplinary Panel A concludes as a matter of law that the Respondent failed to meet standards of care for the delivery of quality medical or surgical care, in violation of H.O. § 14-404(a)(22).

ORDER

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

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

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS** with the following conditions:[5]

1) The Respondent is prohibited from prescribing CDS during the probationary period;

2) Within THREE (3) MONTHS, the 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. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;

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

3) The 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 a minimum of two years, the 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 Panel A. The Respondent may be required to appear before the Board or Panel A to discuss his petition for termination. The Board or Panel A will grant the petition to terminate the probation if the Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

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

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

ORDERED that if the Board or Panel A determines, after notice and an opportunity for a hearing before an Administrative Law Judge of the Office of Administrative Hearings if there is a genuine dispute as to a material fact or a show cause hearing before the Board or Panel A if there is no genuine dispute as to a material fact, that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board or Panel A may reprimand the Respondent, place the Respondent on probation

with appropriate terms and conditions, impose a civil monetary fine upon the Respondent, or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or Panel A may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; 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, unless stated otherwise in the order, any time period 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 A; and it is further.

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., General Provisions, §§ 4-101 *et seq.* (2014 & Supp. 2015).

May 24, 2018
Date

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

CONSENT

I, James L. Harry, M.D., acknowledge that I have been represented by counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by Disciplinary Panel A, 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 into 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 own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of Disciplinary Panel A 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 a disciplinary panel of the Board that I might have filed after any such hearing.

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

Signature on File

May 22, 2018
Date

James L. Harry, M.D.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 22nd day of May 2018, before me, a Notary Public of the foregoing State and City/County, personally appeared James L. Harry, 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.

Toni Willey
Notary Public

My commission expires: 11/14/21

TONI WILLEY
Notary Public
Montgomery County, Maryland
My Commission Expires 11/14/2021