IN THE MATTER OF	*	**BEFORE THE**
ROBERT J. REILLY, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D24986	*	**Case Number: 2017-0095A**

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

CONSENT ORDER

PROCEDURAL BACKGROUND

On August 28, 2017, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **ROBERT J. REILLY, M.D.** (the "Respondent"), License Number D24986, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") §§ 14-101 *et seq.* (2014 Repl. Vol.).

Specifically, Panel A charged the Respondent with violating the following provisions of the Act under Health Occ. II § 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 November 15, 2017, the Respondent appeared before Panel A, sitting as a Disciplinary Committee for Case Resolution. As a result of negotiations occurring before Panel A, the Respondent agreed to enter into the following Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

FINDINGS OF FACT

Panel A makes the following Findings of Fact:

I. Background

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on or about June 19, 1980, under License Number D24986. The Respondent's license is currently active and is scheduled for renewal on September 30, 2017.

2. The Respondent is board-certified in family medicine.

3. At all times relevant to these charges, the Respondent maintained a medical office at 505 Main Street, Salisbury, Maryland 21804.

II. The complaint

4. The Board initiated an investigation of the Respondent after receiving a complaint, dated August 5, 2016, from a pharmacist (the "Complainant")[1] who reported

[1] For confidentiality purposes, the names of the Complainant, patients or other individuals have not been identified in this charging document. The Respondent is aware of the identity of all individuals referenced herein.

concerns about the Respondent's prescribing practices after one of the Respondent's patients fainted in the pharmacy's waiting room on August 4, 2016.

III. Board investigative findings

5. As part of its investigation, the Board obtained a series of patient charts from the Respondent for review. The Board referred the patient charts and related materials to its peer review entity for a practice review. The peer reviewers found deficiencies in the Respondent's prescribing practices and recordkeeping, which constituted violations of the Act.

6. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), as set forth in the following patient summaries.

Patient A

7. Patient A, a woman then in her late-50s, began seeing the Respondent for medical care in or around October 2015, with complaints of back and knee pain. The Respondent prescribed high dosages of pain medications for prolonged periods of time, including oxycodone 15 mg three times per day ("TID"); extended release morphine, MS Contin 15 mg TID; and in addition, a benzodiazepine, alprazolam, 30 tablets per month. The Respondent maintained Patient A on these medications for several months.

8. In or around July 2016, Patient A went to the emergency room with symptoms of a drug overdose and was diagnosed with drug dependency issues. The Respondent resumed prescribing high-dosage opioid medications to Patient A after this incident.

9. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient A. The Respondent prescribed high dosages of opioid pain medications for prolonged periods of time without appropriate justification. The Respondent inappropriately continued to prescribe high dosages of opioid pain medications after Patient A was treated for a drug overdose and was diagnosed with a "drug dependency problem." The Respondent failed to exercise appropriate clinical judgment or document an appropriate clinical rationale for maintaining Patient A on this medication regimen after her hospitalization for a drug overdose. The Respondent inappropriately prescribed high dosages of opioid medications in conjunction with benzodiazepines. The Respondent failed to order or document urine drug screening while maintaining Patient A on this drug regimen. The Respondent failed to document a detailed medical history or physical examination, and failed to document a specific description of Patient A's pain complaints, including location, character, severity, exacerbating or relieving factors and associated symptoms.

Patient B

10. Patient B, a man then in his late-40s, began seeing the Respondent for medical care in or around 2014. Patient B's medical conditions included hepatitis C, chronic neck and back pain secondary to degenerative disc disease, and spondylosis. A previous physician had reportedly prescribed oxycodone, prednisone, Valium, Skelaxin and Neurontin.

11. The Respondent initially placed Patient B on Methadone 10 mg twice per day ("BID"), then discontinued it and placed him on OxyContin 60 mg BID. The Respondent added oxycodone 30 mg four time per day ("QID"). The Respondent maintained Patient B on this regimen for many months. The Respondent added Dilaudid 8 mg every four hours. The Respondent increased Patient B's OxyContin 60 mg from BID to TID while maintaining him on oxycodone 30 mg QID. The Respondent then increased Patient B's OxyContin to 80 mg BID and increased his oxycodone 30 mg from QID to six times per day. The Respondent also prescribed a benzodiazepine, clonazepam 1 mg TID.

12. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient B. The Respondent inappropriately prescribed escalating dosages of opioid medications, despite Patient B's co-morbid conditions. The Respondent inappropriately prescribed high-dosage opioid medications in conjunction with benzodiazepines. The Respondent, although noting that he ordered urine drug screening, did not maintain the reports of such screening in his chart. The Respondent failed to document a detailed medical history or physical examination, and failed to document a specific description of Patient B's pain complaints, including location, character, severity, exacerbating or relieving factors and associated symptoms.

Patient C

13. Patient C, a man then in his early-50s, began seeing the Respondent for medical care in or around 2016, with complaints of facial pain resulting from a motor

vehicle accident. Patient C's medical history included oxycodone abuse, alcohol abuse, multiple psychiatric disorders, extensive facial trauma with prior reconstructive facial surgeries, and traumatic brain injury. The Respondent prescribed Patient C oxycodone 15 mg QID, MS Contin 15 mg TID, and Amitriptyline 50 mg, and maintained him on these medications for a few months.

14. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient C. The Respondent inappropriately placed Patient C on an initial trial of high dosage opioid medications. The Respondent failed to order or document ordering urine drug screening, or document other forms of medication compliance measures. The Respondent did not document an adequate risk assessment or attempt to employ other pain management strategies in view of Patient C's prior alcohol abuse/opioid abuse issues. In some progress notes, the Respondent failed to explain his rationale for medical decision-making. The Respondent failed to document a detailed medical history or physical examination, and failed to document a specific description of Patient C's pain complaints, including location, character, severity, exacerbating or relieving factors and associated symptoms.

Patient D

15. Patient D, then a woman in her late-30s, began seeing the Respondent for medical care in or around 2012. Patient D's medical conditions include morbid obesity, chronic obstructive pulmonary disease, psychiatric disorders, hypertension, diabetes mellitus and osteoarthritis. In 2015, Patient D began complaining of increasing pain in

her back and knees. The Respondent started Patient D on hydrocodone QID, and then switched her to oxycodone 10 mg QID. The Respondent added MS Contin 15 mg in 2016, and alprazolam TID plus Ativan and Trazadone. The Respondent maintained Patient D on this regimen for many months.

16. The Respondent failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient D. The Respondent failed to document urine drug screening for medication compliance. In his progress notes, the Respondent, although briefly mentioning the patient's diagnoses, failed to adequately document Patient D's pain complaints and his rationale for opioid prescriptions. The Respondent failed to document a detailed medical history or physical examination, and failed to document a specific description of Patient D's pain complaints, including location, character, severity, exacerbating or relieving factors and associated symptoms.

Patient E

17. Patient E, a woman then in her mid-50s, began seeing the Respondent for medical care in or around 2015. Patient E's medical history included hypertension, chronic cough and non-specific back pain. The Respondent started Patient E on Tylenol with codeine 100 tablets per month then changed her medication to hydrocodone 10 mg five times per day. The Respondent maintained Patient E on these medications for many months.

18. The Respondent failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient E. The Respondent failed to document urine drug screening for medication compliance. The Respondent failed to consistently record his rationale for prescribing opioid medications. The Respondent

failed to document a detailed medical history or physical examination, and failed to document a specific description of Patient E's pain complaints, including location, character, severity, exacerbating or relieving factors and associated symptoms.

Patient F

19. Patient F, then a man in his mid-50s, began seeing the Respondent for medical care in or around 2012. Patient F had a medical history that included a rotator cuff tear and surgical repair of the left shoulder, occurring in 2011; chronic, active hepatitis C; alcohol abuse; psychiatric issues; and cervical and lumbar spondylosis. In 2014, Patient F sustained another rotator cuff injury and underwent a right shoulder repair. Patient F reportedly underwent treatment with a pain medicine specialist in 2013 and underwent facet denervation. The specialist recommended that Patient F not receive benzodiazepines with opioid medications. From 2012 to 2016, the Respondent maintained Patient F on hydrocodone 5 mg QID, Ativan 1 mg BID and Meloxicam 15 mg.

20. The Respondent failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient F. The Respondent failed to document a detailed medical history or physical examination, and failed to document a specific description of Patient F's pain complaints, including location, character, severity, exacerbating or relieving factors and associated symptoms. The Respondent failed to document urine drug screening for medication compliance. The Respondent's progress notes frequently fail to adequately document his medical decision-making in treating this patient, who had a history of alcohol abuse and hepatitis C, with a combination of opioids, benzodiazepines and non-steroidal anti-inflammatory medications for a prolonged time period. The Respondent failed to document the results of liver function tests.

Supplemental response from the Respondent

21. The Board provided the Respondent with the reports from the reviewers. The Respondent submitted a response to the Board, which it received on or about June 9, 2017. The Respondent stated that his office was implementing an electronic medical records system and that "many of the concerns in the reviews will be corrected." The Respondent further stated that in the past year, his office was performing more urine drug screens, and that in the past several months, he was weaning his patients who were on opioids and benzodiazepines off the benzodiazepine medications.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent violated the following provision of the Act: Health Occ. II § 14-404(a)(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 Health Occ. II § 14-404(a)(40), Fails to keep adequate medical records as determined by appropriate peer review.

ORDER

It is, on the affirmative vote of a majority of the quorum of 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 **ONE (1) YEAR**,[2] to begin upon the effective date of this Consent Order, subject to the following probationary terms and conditions:

1. The Respondent shall not treat patients for chronic pain;

2. Within six (6) months, the Respondent shall successfully complete a Board disciplinary panel-approved course in the appropriate prescribing of opioid medications. The 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 panel that the Respondent has successfully completed the course;

3. Within six (6) months, the Respondent shall successfully complete a Board disciplinary panel-approved course in the appropriate medical recordkeeping. 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;

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

5. During the probationary period, the Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agents at

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

the Board's discretion. An unsatisfactory chart and/or peer review will constitute a violation of probation.

AND IT IS FURTHER ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or of this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings. 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 after the appropriate hearing, if the Board or Board disciplinary panel determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board or Board disciplinary panel may reprimand the Respondent, place Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or Board disciplinary panel 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 shall not apply for early termination of probation; and it is further

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

ORDERED that after **ONE (1) YEAR,** the Respondent may submit a written petition to the Board or Panel A 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 comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. II §§ 14-101 -- 14-702, and all laws, statutes and regulations governing the practice of medicine.

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 the Panel A; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* (2014).

11/28/2017
Date

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

CONSENT

I, Robert J. Reilly, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact, Conclusions of Law and Order.

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 as provided by law. I acknowledge the legal authority and the jurisdiction of Panel A to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of Disciplinary Panel B that might have followed any such hearing.

I sign this Consent Order after having had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

11/22/17
Date

Robert J. Reilly, M.D.
Respondent

Read and approved:

Catherine W. Steiner, Esquire
Counsel for Dr. Reilly

NOTARY

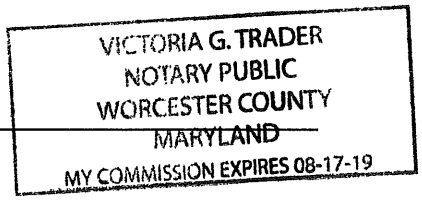
STATE OF Maryland

CITY/COUNTY OF Worcester

I HEREBY CERTIFY that on this 22nd day of November, 2017, 2017, before me, a Notary Public of the foregoing State and City/County, did personally

appear Robert J. Reilly, 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 notary seal.



Notary Public

My commission expires: