IN THE MATTER OF	*	BEFORE THE
SAMPSON SARPONG, M.D.	*	MARYLAND STATE BOARD
Respondent	*	OF PHYSICIANS
License Number D39249	*	Case Number 2015-0174

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FINAL DECISION AND ORDER

On May 26, 2016, the Respondent Sampson Sarpong, M.D., an allergist, was charged under the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, for unprofessional conduct in the practice of medicine, *see* Health Occ. § 14-404(a)(3)(ii); grossly overutilizing health care services, Health Occ. § 14-404(a)(19); failing to meet the appropriate standards of quality medical care, *see* Health Occ. § 14-404(a)(22)[1]; and failing to keep adequate medical records, *see* Health Occ. § 14-404(a)(40). The case was forwarded to the Office of Administrative Hearings ("OAH") for an evidentiary hearing.

On October 27, 28, and 31, 2016, an evidentiary hearing was held at OAH before an Administrative Law Judge ("ALJ"). The State presented the testimony of Alpa Laheri Jani, M.D., and Jeremy Drelich, M.D., who were accepted as expert witnesses in allergy and immunology; Molly Dicken, a compliance analyst for the Maryland State Board of Physicians (the "Board"); and Patient 10, a former patient of the Respondent. The Respondent testified on his own behalf and did not present any other witnesses. On January 23, 2017, the ALJ issued a proposed decision, finding that the Respondent violated Health Occ. § 14-404(a)(3)(ii), (19), (22), and (40), and recommended that his license to practice medicine in Maryland be revoked.

[1] A violation of Health Occ. § 14-404(a)(22) is commonly referred to as a violation of the "standard of care."

The Respondent filed exceptions, and on March 22, 2017, an exceptions hearing was held before Board Disciplinary Panel B ("Panel B" or the "Panel").

FINDINGS OF FACT

Panel B finds that the following facts were proven by the preponderance of evidence:

The Respondent was initially licensed to practice medicine in Maryland since 1989, and he continuously renewed his license. His most recent license was issued in 2015 and had the expiration date of September 30, 2017. He is board-certified in pediatrics, and his practice has been in the field of allergy and immunology. In 1983, he received his medical degree from the University of Ghana Medical School and moved to the United States. He completed his internship and residency at Howard University Hospital. Following his residency, he was in private practice until he received a fellowship in allergy and immunology at Johns Hopkins Hospital. From 1995 to 2000, he was an assistant professor in pediatrics, allergy and immunology at the University of Chicago. He then returned to Howard University Hospital, where he remained until 2007. Since 2007, he has been in private practice, which is named the Center for Allergic Diseases. His private practice has been at two offices which are both located in Maryland.

On September 15, 2014, the Board received a complaint from a former patient (Patient 10) of the Respondent. Patient 10 complained that, after an initial appointment with the Respondent, which involved extensive testing, the Respondent failed to appear for two subsequent follow-up appointments. Patient 10 was also concerned about his billing and unnecessary testing.

On February 6, 2015, the Board sent a subpoena to the Respondent for the medical and billing records he maintained on 10 specific patients the Board investigators listed. The 10

patients were chosen randomly by the Board investigators. On March 9, 2015, the Board received records pertaining to eight patients (Patients 1-8) with a certification signed, on March 2, 2015, by the Respondent for each of the eight patients stating that he provided the Board with the "complete medical records which include all records pertaining to the care and treatment of the patient . . . in [the Respondent's] possession." (Emphasis omitted.) The Respondent also provided a written summary of his care for each of these patients.

On July 13, 2015, the Board sent another subpoena to the Respondent for the records of two additional patients (Patients 9 and 10).

On July 23, 2015, the Respondent met with Board investigators for an interview, where it became apparent that the Respondent had not submitted all of the patient records he possessed for the patients at issue. Thus, on July 24, 2015, the Board requested the full and complete records of all of the patients whose records were requested as part of the investigation.

From July 27, 2015, through July 30, 2015, the Respondent piecemeal provided the Board with additional records of Patients 1-8 and records of Patients 9 and 10 with a certification signed, on July 27, 2015, by the Respondent for each patient stating again that he has provided the "complete medical records which include all records pertaining to the care and treatment of the patient . . . in [the Respondent's] possession." (Emphasis omitted.) The Respondent also provided a written summary of his treatment for each of the 10 patients.

Two peer reviewers, Dr. Jani and Dr. Drelich, were forwarded the records for a review of the Respondent's practice. The two peer reviewers wrote reports on his practice based on the records of the 10 patients whose records were obtained. Their peer review reports are both dated February 29, 2016. Each peer reviewer found that the Respondent engaged in unprofessional conduct in the practice of medicine, grossly overutilized health care services, failed to meet the

standard of care, and failed to keep adequate medical records. The Respondent was sent copies of the peer review reports.

On March 22, 2016, the Respondent delivered additional medical records pertaining to the 10 patients at issue which were not included in either of his first two responses to the subpoenas. The Respondent also included documents he drafted in response to the Board's investigation. As he explained, "I translated those records that I had presented before in a format that they can see." (Tr. 490.)

On May 26, 2016, the Respondent was charged with violating Health Occ. § 14-404(a)(3)(ii), (19), (22), and (40).

On October 31, 2016, at the evidentiary hearing before the ALJ, the Respondent produced additional documents, which included additional records pertaining to Patient 4 (Resp. Ex. 7) and Patient 6 (Resp. Ex. 6).

CPT CODE 99245

Billing for Level 5 services indicates the visit involved the most complex services that can occur during a visit. CPT code 99245 is a billing code for Level 5 services that requires a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Dr. Jani explained, "level 5 is the most complex level of coding that can be applied." (Tr. 79.) Referring to CPT code 99245, Dr. Jani stated, "Physicians typically spend 80 minutes face-to-face with the patient and/or family." (Respondent's Ex. 1) She explained that CPT code 99245 generally applies to the initial visit and "requires a comprehensive history, comprehensive physical examination and then complex medical decision-making needed in forming an assessment and plan." (Tr. 80.)

TESTING

The Respondent tested his patients through a variety of procedures. The five tests at issue are the Skin Prick Test (SPT), Patch Testing (PT), Spirometry (SP), Radioallergosorbent Test (RAST), and the Open Food Challenge (OFC). Each of these is explained below.

SKIN PRICK TEST (SPT)

To identify a person's allergic disorder, a physician can perform the SPT. Using a skin puncture device, small amounts of allergens are loaded into pricks or needles which are then pricked into the patient's skin. A specific allergen is placed into an individual prick. Thus, if 40 allergens are tested, there are 40 pricks. After 15 to 20 minutes, the physician examines the skin. A wheal (hive) response to a prick is indicative of an allergic disorder.

The allergens tested should be guided by the patient's complaints and symptoms. The SPT can test for "environmental allergens, such as dust, pollens, animal danders, things that are inhaled, typically, . . . in the environment. And then there are other skins tests relevant to foods causing symptoms, others to insect venoms." (Tr. 120.) Positive and negative controls should also be tested to ensure the validity of the interpretations. Unless there is a consequential change in the patient's condition, the SPT should not be repeated if the results of SPT are valid.

A patient should not take antihistamines and certain other medications for a period before a SPT (generally three days, but it can be more depending on the half-life of the antihistamine). A histamine test can determine the usefulness or validity of a SPT. A negative histamine response means that the results of a SPT are, or would be, compromised by medication, such as an antihistamine, which would interfere with the reactions to the allergens tested. Thus, patients must be notified to discontinue antihistamines and certain other medications before a visit in which a SPT will be performed. Tr. 64-65. If an SPT is invalidated or cancelled due to the

patient taking an antihistamine or other medication, the SPT should not be repeated unless there is first a positive histamine response (a result showing the test will not be compromised by medication). Tr. 119-20.

A SPT is generally not indicated for a patient with dermographism (or dermatorgraphism), which is a skin condition in which scratching causes a rash or hives. The dermographism often makes the SPT more difficult and often futile, as the skin condition interferes with an interpretation of the SPT.

PATCH TESTING (PT)

PT is used to diagnose allergic disorders in a patient who has contact dermatitis. Indications for PT would be a rash that is suspect for contact dermatitis or a rash that develops from contact with an allergen. Additionally, another possible indication for PT is eosinophilic esophagitis, which is an esophageal disorder (an intestinal disorder thought to be related to food allergies).

Generally, PT involves placing seven to eight large patches on a patient. Each large patch has 10 individual patch tests. Thus PT generally involves approximately 70-80 individual patch tests. Each individual patch test concerns an individual allergen. PT generally requires three visits. The patches are applied during the first visit, and then, after two days, the patient returns for the patches to be removed and the skin is evaluated by the physician. The patient returns again, after three to seven days, for a third visit for a second reading.

SPIROMETRY (SP)

SP is a pulmonary function test to diagnose asthma and other lung conditions. SP is indicated if an upper airway disease is suspected. The test is performed by the patient exhaling into a machine for a measurement of the amount of air that is exhaled and the velocity of the air.

RADIOALLERGOSORBENT TEST (RAST)

RAST is a form of blood testing for allergic disorders.

OPEN FOOD CHALLENGE (OFC)

If the patient reports symptoms of an allergy to a certain food, but other forms of testing does not substantiate the allergy, then a physician may conduct an OFC. The physician will observe the patient ingesting the food and watch for symptoms to determine if it is a true food allergy.

PATIENT 1

The Respondent's records contain a Health Insurance Claim form indicating that the Respondent billed $250 under CPT code 99245, $2640 for SPT for 264 allergens tested, and SP for $100, totaling $2990, for services he provided Patient 1 on March 24, 2014. (State's Ex. 16 at 160.) The Respondent did not perform those tests or provide those services to Patient 1 nor did he even meet with Patient 1 on that date. The first time Patient 1 met with the Respondent was on April 15, 2014.

On April 15, 2014, Patient 1 initially visited the Respondent. Patient 1 is a teacher. She reported a history of asthma, seasonal allergies, and an allergy to nuts. She had a severe asthma attack while working at her school, which was undergoing renovations. She was treated at a hospital emergency room. The Respondent documented Patient 1's history, noting asthma, seasonal allergies, and an allergy to nuts. The patient was taking Albuterol every four hours, or as needed, and Spiriva daily. The Respondent examined the patient's head, eyes, ears, nose, and throat (HEENT), as well as lungs. He also noted, "Rest of Exam within normal Limits." On April 15, 2014, the Respondent performed SPT testing for 264 allergens (a full panel). The SPT included comprehensive food allergy testing and was not limited to testing for nuts. The SPT

results were uninterpretable because the patient had taken an antihistamine. The Respondent also performed SP, which was within normal limits. The Respondent billed $2640 for the SPT for 264 allergens tested, $100 for the SP, and $250 under CPT code 99245 for a total of $2990.

Patient 1 returned on April 18, 2014. The Respondent again performed a SPT of 264 allergens. The Respondent wrote, "She is not on any histamine since last visit." There, however, was again a negative histamine response, which was deemed caused by a "cough mixture" the patient had taken the previous night. The SPT results were deemed "inconclusive." The Respondent billed $2640 for the SPT for 264 allergens tested and $250 under CPT code 99245 for a total of $2890.

Patient 1 returned on April 24, 2014. The Respondent again performed a SPT. There was an "equivocal response to histamine." The Respondent also performed another SP, again with normal results. The Respondent scheduled another visit for May 1, 2014 for a follow-up and ordered that the patient temporarily discontinue her current medications (to prevent another antihistamine compromised SPT) and that, in the meantime, the patient take Prednisone for her allergies. The Respondent billed $250 under CPT code 99245, $2640 for the SPT for 264 allergens tested, and $100 for the SP for a total charge of $2890.[2]

On May 1, 2014, the Respondent's progress notes state that he performed another SPT. This time there was a positive histamine response. According to the Respondent's progress notes, the test showed a "negative response to Nuts." Other than this note, there were no test results documented in the record. The Respondent also performed another SP, again with normal results. The Respondent also performed patch testing (PT) with 300 patch tests. The

[2] The Respondent miscalculated the charges. The charges add to $2990.

Respondent billed $250 under CPT code 99245, $2640 for SPT for 264 allergens tested, $100 for the SP, and $3000 for PT for a total of $5990.

On May 3, 2014, Patient 1 was seen by the Respondent for a reading of the PT performed on May 1, 2014. The Respondent recorded 70 patch tests with the following results: "Patch Test reading – No reaction." He scheduled an OFC for Brazil nuts, and ordered that the patient resume her medications except for any antihistamine. The Respondent billed $250 under CPT code 99245.

On May 10, 2014, Patient 1 returned, and the Respondent performed another SPT. There was a positive histamine response. The Respondent's progress notes state, "Prick Skin Test to Brazil Nut negative." Other than this note, the test results of the SPT are not documented. The Respondent performed the OFC and reported that the patient was fit to take Brazil nuts since there was no reaction. The Respondent also performed two SPs, each with normal results. The Respondent billed for $250 under CPT code 99245, $2640 for the SPT for 264 allergens tested, and $100 for the SP for a total of $2990 for the May 10, 2014, visit.

PATIENT 2

The Respondent's medical records contain a health insurance billing form for services he purportedly provided Patient 2 on March 31, 2014. (State's Exhibit 18 at 207.) The claim form lists SPT billed at $2640 for 264 allergens tested and $250 under CPT code 99245 for a total charge of $2890. The Respondent, however, did not provide services to Patient 2 on that date.

On April 2, 2014, Patient 2 saw the Respondent for the first time. Patient 2 is a mechanic who suffered from hives for two years prior to seeing the Respondent. He had seen other physicians, but his hives had not been successfully treated. On April 2, the Respondent performed a SPT for 264 antigens. The histamine test was negative; the Respondent noted,

"Poor histamine response." The Respondent also conducted a SP; the results were normal. In addition, the Respondent ordered RAST. Another appointment was scheduled, and the Respondent's notes state that the patient should "[s]top all antihistamines by mouth." The Respondent billed $250 under CPT code 99245, $2640 for a SPT for 264 allergens tested, and $100 for the SP for a total of $2990 for the visit.

On April 16, the Respondent performed another SPT for 264 allergens, which showed "generalized prick response to all allergens including saline control." RAST results were obtained, which showed a response to cockroaches. The Respondent also performed a SP. The results were normal. In a bill that incorrectly provided the service date as April 17, 2014, the Respondent wrote $250 under CPT code 99245, $2640 for the SPT, and $100 for the SP for a total of $2990.

On April 30, 2014, RAST was repeated, showing a moderate response to dust mite. The Respondent billed for $250 under CPT code 99245.

On May 7, 2014, the Respondent performed another SPT. The Respondent wrote in his progress notes the SPT had an "equivocal result" (although he wrote unequivocal result on the SPT result form). He also performed another SP and noted normal results and "poor effort." The Respondent billed $250 under CPT code 99245, $2640 for SPT for 264 allergens tested, and $100 for SP for a total of $2990.

On May 13, 2014, the Respondent performed another SPT, which, according to his progress notes had an "equivocal response." The Respondent also performed another SP, which had a disposition of "poor effort." The Respondent billed $250 under CPT code 99245, $2640 for a SPT for 264 allergens tested, and $100 for SP for a total of $2990.

On May 28, 2014, the Respondent performed another SPT. The progress notes state that the SPT had a generalized response including a saline control reaction. The SPT test results form states, "Unequivocal response." The Respondent's summary says that the results were "equivocal." The Respondent diagnosed the patient with dermatographism and prescribed Hydroxine HCl 2. The Respondents records do not contain a health insurance claim form for this visit, although the Respondent circled CPT codes 99245 (Level 5/HC/80), 95004 (Pricks, inhalants), 95004 (Pricks, food), and 94060 (Spirometry w/ Bronchodilator) on the form listing the billing codes.

The Respondent's records contain a health insurance claim form for services provided to Patient 2 on June 6, 2014, for Level 5 services under CPT code 99245 for $250. (State's Ex. 18 at 201.) There is no progress note pertaining to that date or other medical records indicating he provided services to Patient 2 on that date.

On July 2, 2014, the patient returned for a follow-up visit. The progress notes state that the patient has dermatographism, a dust mite allergy, and a cockroach allergy and that the patient's symptoms have shown a marked improvement with the Hydroxine HCl. The Respondent performed a SP, which had normal results. The plan was to "continue medication." Although the only service listed on the billing claim form was for CPT code 99245 for $250, the total charge was $2990.

PATIENT 3

Patient 3 saw the Respondent for the first time on April 24, 2014. At this visit, the Respondent documented in his progress notes that the patient complained of facial pain, sinus pressure, and seasonal allergies, and the Respondent wrote in his summary that the patient had occasional hives. She had previously seen another allergist without success. The Respondent

wrote in his summary that the patient admitted to taking antihistamine medication. The Respondent performed a SPT with a "poor histamine response." The Respondent wrote under the plan for the patient to be "off antihistamines." The Respondent performed a SP with normal results. The Respondent also ordered RAST which showed normal total IgE but abnormal responses to cat hair, cat dander, dog dander, dust mites, and cockroaches. The Respondent billed $250 under CPT code 99245, $100 for a SP, and $2640 for the SPT for 264 allergens tested for a total charge of $2990.

On May 1, 2014, the Respondent wrote in the progress notes that the patient presented with "chronic rhinosinusitis." He performed another SPT, which showed late-phase reactions. The Respondent checked on his SPT form reactions to Cat Pelt, German Cockroach, Cat Hair, Dock/Sorrel Mix, Dog Epithelium, Meadow Fescue Grass, Mite D.P., Mouse Epithelium, Neurospora, Mosquito, Black Locust, Melaleuca Pollen, and Mullberry White. The Respondent also performed another SP, which again had normal results. The Respondent also performed a PT. The Respondent's summary states, "She was instructed to take the patch off after 48 hours and take a picture after removal." The Respondent billed $250 under CPT code 99245, $2640 for the SPT for 264 allergens tested, and $100 for the SP for a total of $2990.

On May 15, 2014, Patient 3 visited the Respondent. The Respondent's progress notes state that the patient had a late phase reaction to the SPT performed on May 1, 2014. There is no form recording the results of a SPT performed on May 15, 2014. His summary states that the patient "reported a late phase reaction to some of the skin prick test but could not identify the kind of allergen." He performed a SP with normal results. With respect to the PT, the Respondent wrote, "The patches on her back fell of[f] within a day." The patient was prescribed Allegra D. The Respondent's records do not contain a health insurance claim form for this date

but his records contain a billing code form with the CPT codes circled: 99245 (Level 5/HC/80), 95004 (Pricks, inhalants), 95004 (Pricks, food), and 94060 (Spirometry w/ Bronchodilator).

PATIENT 4

Patient 4 visited the Respondent for the first time on July 11, 2011. Patient 4, who was 57 years old, has chronic lung disease, presented with a persistent cough, shortness of breath, rash, swelling of her feet, possible food allergy, and allergic rhinitis. She became itchy after eating crab. She had previously met with other physicians without improvement. The Respondent performed a physical examination, which included an evaluation of the patient's vital signs, cognitive functioning, HEENT, lungs, heart, musculoskeletal, extremities. The progress notes state, "[the patient] is off Allegra for 1 week." The Respondent performed SPT for environmental skin and food allergy testing which had only equivocal results due to poor histamine response. He performed SP without bronchodilation showing a possible mixed restrictive or obstructive pattern. A RAST was conducted that was negative to crab and several other foods. The Respondent ordered a chest X-ray and started the patient on Advair 500/50 twice a day, a burst of Prednisone, and an EpiPen for possible anaphylaxis from crab. The patient had an elevated IgE discovered upon testing. The Respondent billed $1200 for SPT, $250 under CPT code 99245, and $100 for a SP, for a total of $1550.

According to the Respondent, the Patient was "Lost to follow up."

Approximately one year later, however, on August 17, 2012, Patient 4 returned to the Respondent after having difficulty breathing for one week. He performed a physical examination and found papular rash and exacerbation of lung disease. He performed a SP which showed an increasing restrictive pattern. The patient was evaluated for allergic bronchopulmonary aspergillosis (ABPA) which was negative. He placed the patient on a short

burst of Prednisone and referred her to dermatology. The Respondent billed $250 for CPT code 99245 and $100 for a SP for a total of $350. He wrote that he would see the patient in one week.

Patient 4 again became lost to follow-up, but had a walk in visit on June 5, 2013. She had a SP which was back to her "baseline" of her initial visit. The Respondent billed $100 for a SP with a date of service of June 5, 2013. (State's Ex. 23 at 384.)

On June 17, 2013, the Respondent performed a physical evaluation and an SPT which had a "poor histamine response." Because of a rash, the Respondent performed PT, which showed "No reaction" to 66 patch tests. The patient was continued on medications. The Respondent billed SPT for $2640 for 264 allergens tested, PT for $2000 for 200 patch tests, and $250 for CPT code $99245 for a total of $4890.

On July 29, 2013, the Respondent assessed the patient, performed a SP, which was found "unchanged." No specific SP testing results are noted. He continued the patient on her medications. The Respondent billed $250 under CPT code 99245 and $100 for SP for a total of $350.

On August 26, 2013, the Respondent wrote that the patient was improving. The SP was "unchanged." No specific SP testing results are noted. He continued the patient on her medications. The Respondent billed $250 under CPT code 99245 and $100 for SP for a total of $350.

On November 11, 2013, the Respondent performed a SPT with a good positive control. He wrote, "negative for a fumigatus," SP was "unchanged," and that the medication should continue. No specific SP testing results are noted. The Respondent billed $250 under CPT code 99245 and $2640 for SPT for 264 allergens tested for a total of $2890.

On September 30, 2014, the patient visited complaining of a two week cough. He performed a SP with normal results and ordered a chest CT. The Respondent billed $250 under CPT code 99245 and $100 for SP for a total of $350.

On October 21, 2014, the Respondent noted the results of the chest CT, which confirmed the patient's lung disease. Respondent billed $250 under CPT code 99245 and $100 for a SP for a total of $350. The progress notes do not mention a SP.

PATIENT 5

Patient 5 was a 14 year old female who saw the Respondent for the first time on April 15, 2014. The Patient reported seasonal allergies (runny nose, itchy eyes, hives), food allergies to seafood and peanuts, and anaphylactic reaction. The Respondent performed a SPT, but the histamine response was negative. The Patient stated that she had taken some allergy medicine two days prior to the visit. The SP was normal. The Respondent billed $2640 for SPT for 264 allergens tested and $250 under CPT code 99245 for a total of $2890.

On April 19, 2014, the SPT was repeated, with a good histamine response. The SPT showed reactions to the following: Bermuda Grass, Eucalyptus, Furarium, Johnson Grass, Mixed Feathers, Meadow Fescue Grass, Black Locust, Oak Read, white Oak, Queen Palm, Pine Australian, Wide Pollen Oak, and Virginia Live Oak. The Respondent also ordered the RAST. The RAST showed reactions to peanuts, green peas, almonds, green bean, and maple sugar. The Respondent billed $2640 for the SPT for 264 allergens tested and $250 under CPT code 99245 for a total of $2890.

On May 1, 2014, the patient returned and reported some late phase reactions to the SPT performed on April 19. The Respondent conducted another SPT. A SP was performed again with normal results again. And the Respondent performed a PT. The Respondent billed $2640

for SPT 264 allergens tested, $250 under CPT code 99245, and PT for $3000 for 300 patches for a total bill of $5890.

On May 3, 2014, the Respondent evaluated the PT, finding no reaction. There is no form documenting the allergens tested for the PT. The Respondent billed $250 under CPT code 99245.

On May 13, 2014, the Respondent conducted an OFC for green peas. The Respondent determined from the OFC that Patient 5 has no allergy. Two SPs were normal. The Respondent also wrote in his progress notes, "Skin Test to Shrimp negative." The Respondent billed $2640 for SPT for 264 allergens tested, $100 for SP, and $250 under CPT code 99245 for a total of $2990.

On May 29, 2014, the patient returned for an OFC for shrimp. The patient had no reaction to the Shrimp. Two SPs were normal. The Respondent wrote, "Can eat shrimp." He prescribed an EpiPen in case of accidental ingestion of peanuts. The Respondent billed $100 for Ingestion Challenge (CPT code 95075), $100 for the SP, and $250 under CPT code 99245 for a total of $450.

PATIENT 6

Patient 6, a 53 year old woman, initially saw the Respondent on March 24, 2014. The patient complained of snoring, pain in her knee, and seasonal allergies. The full panel of SPT was positive for dust mite. He recommended environmental controls for the dust mites. He conducted a SP. He also performed PT. He billed $2640 for SPT for 264 allergens tested, $100 for SP, PT for $1000 for 100 patch tests, and $250 under CPT code 99245 for a total of $3990.

On March 31, 2014, the Patient arrived for an evaluation of the PT. The PT assessment form listed only 70 allergens tested, despite the Respondent billing for 100. The PT showed a

reaction to nickel. The plan was for Flonase nose spray twice a day and for the patient to make a follow up appointment as needed. The Respondent billed $250 under CPT code 99245.

The Respondent's records of Patient 6 also contain a health insurance billing form for services the Respondent claims he provided Patient 6 on April 15, 2014. It shows the Respondent billed $250 for CPT code 99245, $100 for SP, and $2640 for a SPT (264 allergens tested) for a total of $2990. For his summary of care, however, the Respondent identified the dates of his treatment of this patient as "3/24/ to 3/31/14." And the Respondent does not mention in his summary any visit or services provided on April 15, 2014. Further, supplemental records the Respondent provided the Board after the peer review reports included a note he signed, regarding Patient 6 stating, "Patient was not seen in April 2014 and therefore no medical records or billing to the insurance company." (Resp. Ex. 17, at 464.) The Respondent, however, submitted into evidence at the ALJ hearing several documents purporting to document services he provided Patient 6 on April 15, 2014, including SPT results and progress notes.

PATIENT 7

The Respondent's records contain a Health Insurance Claim Form for Patient 7 for services provided on April 24, 2014, which states that he billed $2640 for SPT (264 allergens), $100 for a SP, and $250 under CPT code 99245 for a total of $2990. There is no indication from any other record that the Respondent provided services to Patient 7 on that date. The document states that the patient's authorization for the release of medical records for processing the claim is on file with the date July 18, 2014. The billing form is signed by the Respondent with the signature date of April 24, 2014.

Patient 7 was 27 years old when she initially saw the Respondent on July 18, 2014. The patient reported snoring, headaches, postnasal drainage, and season allergies. She was taking

Zyrtec and Flonase with minimal success. The Respondent performed a SPT ("good histamine response") that showed positive reactions to the following: Short Ragweed, Hickory Shagbank, Hackberry, Live Pollen, Pecan Pollen, Orchard Grass, Redtop Grass, Ruba Rhodotorula, Rhe Grass Perrenial, Bermuda Grass, Cat Pelt, Cat Hair, Eucalyptus, Epococcum Nigrum, Juniper Western, Neurospora, Dust Mite, White Oak, Australia Pine, and Pigweed Spiny. The Respondent also performed PT. He diagnosed the patient with severe allergic rhinosinusitis. He recommended an antibiotic (Z-Pak) and the patient as a candidate for immunotherapy. The Respondent billed $2640 for SPT (264 allergens), $100 for a SP, $1000 for PT for 100 patch tests, and $250 under CPT 99245 for a total of $3990. There is no reference to a SP in his progress notes or summary.

On July 21, 2014, the patient returned. The Respondent noted that the PT was negative. The PT form states "no positive reaction" for 60 patch tests. The Respondent continued the Flonase and that the patient was a candidate for allergy shifts and to make any further appointments on an as needed basis. The Respondent billed $250 for CPT code 99245 for the visit.

PATIENT 8

Patient 8 was 85 years old when she initially visited the Respondent on February 7, 2014. The patient reported postnasal drainage and seasonal allergies. She had taken Atrovent, eye drops, and Flonase with minimal success. The Respondent performed a SPT (for 80 pricks) which showed a reaction to mustard seed and spinach. He also performed a PT for 80 patches. He also performed a SP with normal results. He assesses the patient with allergic rhinitis and sinusitis. He suggested a referral to an ENT and antibiotics. He billed $800 for SPT for 80

allergens, $800 for the PT for 80 patch tests, $100 for the SP, and $250 under CPT code 99205 (Level 5/HC/60) for a total of $1950.

On February 21, 2014, Patient 8 returned. The Respondent documented no reaction to the PT. He performed another SPT, which showed a reaction to Virginia Oak. He changed the patient's Flonase prescription to Nasonex and recommended seeing the patient after her visit to an ENT. He billed $800 for the SPT for 80 allergens, $250 for CPT code 99205, and $100 for another SP for a total of $1150. There is no reference to a SP in either the progress notes or his summary.

PATIENT 9

Patient 9 was 25 years old when he saw the Respondent for the first time on May 29, 2014. The patient complained of sneezing, cough, rash, and seasonal and perennial allergies. He was also diagnosed with AIDS. The Respondent performed a SPT (good histamine response) which showed reactions to the following: Acacia, Bermuda Grass, Grass Bahia, Meadow Fescue Grass, Neurospora, Black Locust, Melaleuca Pollen, White Oak, Queen Palm, Pine Australia, and Peanut. The patient stated he could eat peanuts without a problem. The Respondent also performed PT. The Respondent also ordered a RAST. The Respondent diagnosed the patient with hives and rhinitis and prescribed hydroxyzine. He also instructed the patient to return with a list of his medications to see if any related to his rash. The Respondent billed $2640 for the SPT for 264 allergens, PT for $3000 for 300 patch tests, and $250 for CPT code 99245 for a total of $5890.

On June 3, 2014, the Respondent documents no response to 70 patch tests for the PT. The RAST showed a negative response to peanut. The patient reported a late phase reaction on the SPT. On a repeat SPT, the patient had a reaction to the following: Meadow Fescue Grass,

Oak Red, White Oak, Wide Pollen Oat, Virginia Live Oak, Rhe Grass Perennial, Velvet Grass, Timothy Standard, and Stemphyiium. The Respondent also checked a reaction to unnamed allergens 3 and 4 under column U. The Respondent noted that the patient seemed to have a reaction to Sulfa drugs. The Respondent billed $2640 for SPT of 264 allergens and $250 for CPT code 99245 for a total of $2890.

On June 30, 2014, the patient returned for a follow-up visit. The Respondent noted that the rash has subsided and that the patient should see him on an as needed basis. The Respondent billed for $250 for CPT code 99245.

PATIENT 10

Patient 10 was 63 years old woman when she visited the Respondent for the first time on August 23, 2014. The patient complained of snoring, barking cough, plugging in ear, itchy eyes, and a runny nose. Her symptoms worsened despite taking Lasix. The Respondent performed a SPT, there was no histamine response. The Respondent instructed the patient to stop all medications for a repeat SPT, and prescribed a five day dosage of Prednisone. The Respondent also placed patches on the patient for a PT. He billed $2640 for the SPT for 264 allergens, $1000 for PT of 100 patch tests, and $250 for CPT code 99215 (Level 5/HC/40) for a total of $3890.

The patient was scheduled for an appointment for August 25, 2014. The Respondent, however, was not at the office, and the office was locked. The Respondent telephoned the patient, and she agreed to return the following day.

On August 26, 2014, the patient returned. The Respondent again was not present. An office assistant removed the patches. The Respondent wrote that the patches could not be

interpreted because the patches stayed the patient's back for 72 hours instead of 48 hours. The Respondent billed for $250. (State's Ex. 52.)

THE STATE'S EXPERTS

Dr. Jani and Dr. Drelich testified for the State, and each was accepted as an expert in allergy and immunology. The Respondent did not present any expert testimony. The Panel adopts the following description of the professional background and credentials of the State's experts:

> Dr. Jani received her medical degree from Johns Hopkins University School of Medicine in 1998. She was a resident at Barnes-Jewish Hospital in St. Louis, Missouri, from 1998 to 2001. She was a Fellow in allergy and immunology at the Washington University School of Medicine from 2001 to 2003. Dr. Jani was certified by the American Board of Allergy and Immunology in 2003, and recertified in 2012. She was certified by the American Board of Internal Medicine in 2001. She has been in private practice in Frederick, Maryland, since February 2005. She has also been employed by the Johns Hopkins University School of Medicine, Division of Allergy and Clinical Immunology, Assistant Professor of Clinical Medicine, [from] January 2005 to July 2006, and April 2010 to the present. Dr. Jani has been licensed to practice medicine in Maryland since 2004.
>
> Dr. Drelich received his medical degree from Rutgers Medical School, Piscataway, New Jersey, in 1981. He was a pediatric resident at the Michael Reese Hospital in Chicago, Illinois, from 1981 to 1984. He was a fellow in Allergy and Clinical Immunology at the Henry Ford Hospital, Detroit, Michigan, from 1991 to 1993. Dr. Drelich has been certified by the American Board of Allergy and Immunology in 1993, 2003, and 2013. He is board-certified in pediatrics. He has been licensed to practice medicine in Maryland since 1994.

The ALJ found the testimony of both experts reliable. The ALJ explained that both of the State's experts testified in an "understandable and straightforward manner." The ALJ found significant that, while there was "some variation in their opinions," they were "consistent in their opinion that patterns in the Respondent's practice demonstrate the violations alleged in the charges," noting that there was no evidence the experts ever met and discussed standards.

According to the ALJ, both experts found "excessive SPT, excessive repeat SPT without a histamine control, PT without indication, billing for visits and procedures not documented in the record, and inadequate medical records."

A careful review of the evidentiary record and the testimony of the experts confirms the ALJ's description of their testimony. By no means was their testimony identical. At times they relied upon on or emphasized different details. But, in general, they both found the same patterns of misconduct. Their opinions were well-reasoned, well-founded, and consistent with fundamental medical principles. Their clear explanations of the intricacies of the field of allergies and immunology were decidedly helpful. Dr. Jani and Dr. Drelich were reliable expert witnesses, and the Panel relied heavily upon their testimony and opinions in forming its findings and conclusions.

EXCEPTIONS

The ALJ succinctly summarized the Respondent's conduct:

> the State demonstrated that the Respondent routinely administered excessive SPT not supported by patient history, repeated SPT without first finding a [positive] histamine response, used PT without indication in some instances, and billed for consultations and tests not documented in the record. [ALJ's Proposed Decision at 22.]

The Respondent filed extensive exceptions, but the exceptions generally do not focus on the conduct summarized by the ALJ and which is central to this case. The core of the case is the Respondent's unprofessional conduct and gross overutilization. The Respondent instead focuses his exceptions on the issue of the standard of care. Although there is certainly some overlap in this case between the standard of care and unprofessional conduct and gross overutilization, the nature of the grounds are quite different. Ultimately, though, the most serious concerns of the Panel and the crux of this case pertain to unprofessional conduct and gross overutilization.

The standard of care requires that a physician is held to that degree and skill expected of a reasonably competent physician in the same class acting in the same or similar circumstances. *See Shilkret v. Annapolis Emergency Hospital Association,* 276 Md. 187, 200 (1975). The Respondent's main argument is that there was insufficient expert testimony to support a finding of a standard of care violation for seven out of 10 patients, contending that both peer reviewers did not find a standard of care violation for three of the patients and they disagreed on four other patients. There is merit to the Respondent's exception that a standard of care violation is not indicated for his treatment of most of the patients at issue. The Panel thus finds a violation of the standard of care concerning only Patients 1 and 9, as explained later in this decision. But, as already stated, standard of care issues were not the driving force in this case.

The Respondent also argues on exceptions that the ALJ improperly failed to give any weight to records the Respondent produced in response to the peer reviewer reports. The Panel does not accept this exception. There are several serious concerns about these records and other records of the Respondent which were his exhibits and admitted into evidence. First, many of these documents were not included in the documents the Respondent, in March and July 2015, produced and certified were all of the records in his possession concerning the patients at issue. Regarding Patients 1-8, the Respondent *twice* certified he was producing all of the records in his possession. Yet, numerous records he later produced concerning these patients were not included in the first two productions. Second, there is no question that the Respondent wrote many of these documents long after the services were provided or purportedly provided. The Respondent's exceptions state, "Respondent reformatted the original patient records from the original format his office used." One document (Resp. Ex. 7 at 304) purports to record the results of a SPT for Patient 4 from July 11, 2011. But there is another form recording the results

of the SPT from July 11, 2011, for Patient 4 (State's Exhibit 23 at 399) for the same allergens, and the Respondent provided the Board this form in July 2015. And these documents contain different writings on them. Then, the Respondent admitted that one document (Resp. Ex. 7 at 304) was written "several years after the actual visit." (Tr. 506.) Another example is Patient 6's results for the PT of March 24, 2014. There is one version from the documents he submitted to the Board in July 2015 (State's Ex. 27 at 511-13) and a different version in Respondent's Exhibit 6 at 209-10. And third, the records contradict themselves. For example, the supplemental records contain a signed statement from the Respondent stating that he did not see Patient 6 in April 2014. (Resp. Ex. 17 at 464.) Notwithstanding his representation that he did not provide services to Patient 6 in April 2014, the Respondent later admitted into evidence several purported medical records of his treatment of Patient 6 for treatment purportedly provided on April 15, 2014 (*e.g.,* Resp. Ex. 6 at 192-95, 219). What is clear is that these later produced records are not what they purport to be. It should be clear from the documents when the documents were actually written. These records do not. These records were written years after the services were provided or purportedly provided but that is not mentioned in the records. The information contained in the supplemental documents is not trustworthy and, in some cases, outright false. In any case, the supplemental records the Respondent belatedly produced are not reliable indicators of his purported treatment.[3] The exception is denied.

The Panel has carefully considered the Respondent's other exceptions, which take issue with numerous details in the ALJ's decision. There are several instances in which the Respondent's exceptions are correct; that is, the ALJ did at times misstate certain dates, number

[3] The Panel deems the supplemental records to be the documents the Respondent provided the Board in March 2016 after the peer review reports were issued and the records concerning Patients 6 and 4 in Respondent's Exhibits 6 and 7.

of tests, and other details. Most of these misstatements are of minor significance, however. And there were several concerns of the Respondent's practice that the ALJ found rose to the level of a violation where the Panel does not. But overall, the ALJ did correctly find that State proved significant violations of the Maryland Medical Practice Act. The Panel has thus written this decision to focus on the most profound violations.

CONCLUSIONS OF LAW

I. BILLING FOR SERVICES NOT PROVIDED

1. BILLING FOR DAYS IN WHICH THERE WAS NO PATIENT VISIT OR ENCOUNTER.

The Respondent billed on several occasions for testing and services that were not provided, as demonstrated by the fact that his records contain billing forms indicating he billed for testing and services on days in which there was no patient visit or encounter.

The Respondent billed for a **March 24, 2014**, visit with Patient 1, even though there was no visit with Patient 1 that day. (St. Ex. 16 at 160.) The Respondent billed $250 under CPT code 99245, $2640 for a SPT for 264 allergens tested, and $100 for a SP with bronchodilator for a total charge of $2990. The Respondent signed the billing form with the signature date of March 24, 2014. The Respondent testified, however, "Patient 1 came into my care April the 15th of 2014." (Tr. 392.) And the Respondent wrote in his summary that Patient 1 was first seen in his office on April 15, 2014. The progress notes make no reference to a visit on March 24, 2014. As Dr. Drelich stated in his report, "There is also the billing on March 24, 2014 for 264 skin tests, although there is no notation in the chart of this encounter." The ALJ correctly found that the Respondent billed for a SPT and SP for March 24, 2014, with a total bill of $2990. With respect to this finding, the Respondent's exceptions only state, "the record does not support the finding of a 3/24/14 encounter for Patient 1." This further makes clear that the Respondent did

not meet with Patient 1 on March 24, 2014. The billing form also states that the authorization for the release of records to process the claim is dated March 24, 2014, and is "on file," although the records do not contain an authorization from that date. Despite billing for $2990 for services to Patient 1 on March 24, 2014, the Respondent did not provide services to Patient 1 that day.

The Respondent billed for **April 15, 2014,** visit with Patient 6, even though there was no visit with Patient 6 that day. (St. Ex. 26, at 489.) The Respondent billed $250 under CPT code 99245, $2640 for a SPT for 264 allergens tested, and $100 for a SP with bronchodilator for a total of $2990. The Respondent's signature is on the billing with the signature date of April 15, 2014. The Respondent's summaries do not reference a visit by Patient 6 on April 15, 2014. And the records he produced in response to the Board's subpoenas in March and July 2015 do not contain any medical records confirming this visit. In fact, in the supplemental records the Respondent produced in response to the peer review reports is a note signed by the Respondent concerning Patient 6, stating, **"Patient was not seen in April 2014 and therefore no medical records or billing to the insurance company."** (Resp. Ex. 17, at 464.) The Respondent, nonetheless, entered into evidence at the ALJ hearing several documents purporting to be medical records from April 15, 2014. The Respondent submitted SPT results (Resp. Ex. 6 at 192-195) and progress notes (Ex. 6 at 218-219) concerning April 15, 2014. These documents were not included in the medical records he submitted on either March 2, 2015, or in July 2015, despite certifying on both those occasions that the records he submitted with each of those certifications were the patient's complete medical records. Nor were they even part of the supplemental documents he produced in response to the peer review reports. These are false medical records. The Respondent billed for services for Patient 6 for April 15, 2014, although the Respondent did not provide services to Patient 6 on that date.

The Respondent's records contain a billing form for services for Patient 7 for services on April 24, 2014. (St. Ex. 28, at 517.) The billing form delineates $250 under CPT code 99245, $2640 for a SPT of 264 allergens, and $100 for a SP for a total of $2990. Patient 7's first visit to the Respondent, however, was on July 18, 2014. There are no notes to show that a visit on April 24, 2014, occurred, and the Respondent's summary does not mention a visit for that date. The Respondent's exceptions state, "The record does not support finding Respondent billed Patient 7 for 4/24/14 visit." The Respondent cites his own testimony in which he stated that the bill form contains the date, "7/18/14" after "on file," which pertains to patient's authorization to release medical records necessary to process the claim. July 18, 2014, was the date of the patient's initial visit with the Respondent. He testified that the billing form was not submitted for billing, explaining that "the insurance company would not even look at it because of the discrepancy." It should be noted that an inconsistency between the date of the patient's authorization for release of records for processing and the dates of service is not present on the other billing forms with false dates of service, such as March 24, 2014, for Patient 1 or April 15, 2014, for Patient 6. It is possible that the Respondent recognized the discrepancy in the April 24, 2014, billing form prior to submitting it and decided not to submit this false document. The Panel will accept the Respondent's assertion that he did not bill for treatment or services for Patient 7 on April 24, 2014.[4] But it must also be noted that this billing form has the Respondent's signature on it with the signature date of April 24, 2014. (St. Ex. 28 at 517.)

In sum, the Panel concludes that the Respondent did bill for medical services he did not perform for Patients 1 and 6, as described above. The billing forms at issue for Patients 1 and 6

[4] Likewise, concerning Patient 2, the Panel does not find that the Respondent submitted to the insurance company billing forms for services on March 31, 2014, and June 6, 2014, as neither of these forms was signed by the Respondent.

have multiple false dates that align with each other. These false dates were not mere accidents or aberrations. They were deliberately made to deceive. The Respondent's billing for services not provided, as described above, constitutes unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

2. BILLING FOR SPs THAT WERE NOT PERFORMED

The Respondent billed $100 for a SP performed on Patient 4 on October 21, 2014. The records indicate that he did not perform a SP on Patient 4 on that date. There are no SP results documented and there is no mention of a SP in the progress notes for October 21, 2014.

The Respondent billed $100 for a SP performed on Patient 7 on July 18, 2014. The records indicate that he did not perform a SP on Patient 7 on that date. There are no SP results documented; there is no mention of a SP in the progress notes for July 18, 2014; and the Respondent does not mention a SP for that date in his summary.

The Respondent billed $100 for a SP performed on Patient 8 on February 21, 2014. The records indicate that he did not perform a SP on Patient 8 on that date. There are no SP results documented and no mention of a SP in the progress notes for October 21, 2014, and the Respondent does not mention a SP for that date in his summary.

The Respondent's billing for SPs that were not performed constitutes unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

3. BILLING FOR MORE PATCH TESTS THAN HE PERFORMED

The Respondent routinely billed for more patch testing than he actually performed. Dr. Drelich testified, "the numbers of patch tests were way in excess of anything I've ever seen. And I'm not even sure it's physically possible to perform on a patient, for example, 200 patch tests in one visit. We do patch testing, and I don't think I could fit 200 or 300 patch tests on a patient in

a visit. It's not physically possible." He explained that generally PT involves between 65 and 80 patch tests at a time. (Tr. 222.)

The Respondent billed $3000 for PT on Patient 1 for 300 patch tests on May 1, 2014. On May 3, 2014, the Respondent, however, wrote "no reaction" for the results of 70 patch tests. As Dr. Delich explained, "there's documentation for 70 patch tests, but there's billing for 300." (Tr. 227.)

The Respondent billed $2000 for PT on Patient 4 for 200 patch tests on June 17, 2013. The Respondent wrote "no reaction" for the results of 66 patch tests (although the results form is missing a page (page three of three, which generally has four allergens listed)).

The Respondent billed $1000 for PT on Patient 6 for 100 patch tests on March 24, 2014. The Respondent marked the results of 70 patch tests, which showed a reaction to nickel.

The Respondent billed $1000 for PT on Patient 7 for 100 patch tests on July 18, 2014. On July 21, 2014, the Respondent marked "no positive reaction" for the results of 70 patch tests.

The Respondent billed $3000 for PT on Patient 9 for 300 patch tests on May 29, 2014. On June 3, 2014, the Respondent wrote "Negative Response" for results of 70 patch tests. As Dr. Drelich testified, "And then there was, for example, billing for 300 patch tests, but the evidence in the record is for only 70 patch tests." (Tr. 248.)

The Respondent billed $1000 for PT on Patient 10 for 100 patch tests on August 23, 2014. The Respondent wrote that the test was "incomplete" for the results of 70 patch tests. Dr. Drelich testified, "the record indicates 70 patch tests, but the patient was billed for 100."

The Respondent's exceptions for Patients 1 and 7 state that he "no longer bills for patches that fall off a patient or are otherwise unable to use once opened for a patient." For none of the patients discussed above, however, did the Respondent record that patches fell off or were

otherwise unable to use once opened for a patient, nor did the Respondent specify or detail any mishaps for any patients that would explain the discrepancies between the number of patch tests billed and the number recorded as performed. The Respondent routinely billed for more patch tests than he actually performed, constituting unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

II. UNNECESSARY AND UNINDICATED TESTING

1. UNINDICATED PT AND EXCESSIVE ALLERGENS TESTED ON STPs

The Respondent routinely performed testing that was unnecessary, unindicated, and excessive. He often performed PTs when there was no indication. On numerous occasions with the SPTs, the Respondent unnecessarily tested a full panel of allergens (264). This was evident with his testing of food allergens when there were no complaints, symptoms, or indicators for these tests.

The Respondent billed for a full panel SPT (264 allergens) on Patient 1 on six occasions. A full Panel was unnecessary and not indicated. On each of these SPTs there was "no indication for SPT for food allergens beyond nuts." (Dr. Jani, Tr. 36.) As Dr. Drelich explained, there may have been justification to test for nuts "but not for 100-and-some-odd other foods." (Tr. 229.)

On at least two occasions the Respondent billed for a full panel SPT on Patient 3, which included extensive testing of food allergies. The testing for food allergens was not indicated: "there's no history of food allergy." (Dr. Drelich, T. 234.)

On July 18, 2014, the Respondent performed PT on Patient 7. Both experts for the State testified PT was not indicated. Dr. Jani testified, "There was no documentation to support the need for patch testing." (Tr. 87.) Dr. Jani further testified in support of her opinion that the Respondent engaged in gross overutilization that "in the case of patch testing, it being applied

when it was not indicated." (*Id.*) Dr. Drelich testified, "And the patient was tested for an excessive number of patch tests for contact dermatitis, but there is no history to suggest contact dermatitis." (Tr. 244-45.) The ALJ found, "there was no patient history or presentation to support the PT." (ALJ's Proposed Decision at 47.) The Respondent's exceptions contend, "The record does not support finding Respondent did not document need for PT. The use of Nexium may indicate acid reflux and may therefore indicate for PT. (R-2 at 445-46)." (Exceptions at 6.) There is, however, no documentation that Patient 7 was taking Nexium. The transcript pages the Respondent references concern Patient 6, not Patient 7. In fairness, the ALJ also incorrectly wrote, "The Respondent administered PT because Patient 7 took Nexium." (ALJ's Proposed Decision at 16, ¶ 80.) In any case, the Panel does not find that Patient 7 was taking Nexium. PT was not indicated for Patient 7. Thus, in addition to billing for more patch tests than performed for Patient 7, the PT in general was unjustified. Moreover, on two occasions the Respondent billed for full panel SPTs on patient 7, which were unnecessary. Dr. Drelich explained, "the patient was tested for an excessive number of food allergens which there [is] no [ ] history to suggest it." (Tr. 244.)

There was no indication for PT for Patient 8. Both experts for the State correctly testified that PT was unindicated and unnecessary. Thus, in addition to billing for more patch tests than performed for Patient 8, there was no justification for any PT.

There also was no indication for PT for Patient 9. In explaining the basis for her opinion that the Respondent engaged in gross overutilization, Dr. Jani included, "patch testing not being indicated, but performed." (Tr. 92.) Thus, in addition to billing for more patch tests than performed for Patient 9, no PT was needed. Furthermore, the Respondent twice billed for full

panel STPs for Patient 9, which included tests that were excessive and irrelevant. (Dr. Jani, Tr. 92; Dr. Drelich, Tr. 249.)

The Respondent billed for a full Panel STP on Patient 10, which included an excessive number of unnecessary testing for specific allergens. Dr. Drelilch testified, "I do not see an indication for food allergy testing." (Tr. 251.) Dr. Jani testified, "Again, an excessive number of skin tests not supported by the patient complaints." (Tr. 94.) Additionally, there was no indication for the PT the Respondent performed on Patient 10. And, as mentioned previously, the Respondent billed for more PT than he actually performed. The Respondent then failed to show up for the subsequent two follow-up appointments, thus, the Respondent was not able to read the results of the PT.

Performing the unnecessary and unindicated testing, as described above, constitutes gross overutilization of health care services, in violation of Health Occ. § 14-404(a)(19).

2. UNNECESSARY REPEAT SPTs

Patient 2 complained of chronic hives, which the patient had for approximately two years prior to his first visit with the Respondent. The Respondent, nonetheless, performed SPT on at least five occasions, and billing $2640 for SPTs on five occasions for a total of $13,200. Dr. Drelich correctly explained that a patient with hives "would, in fact, make skin testing very difficult to perform or interpret." He further testified, there was "both excessive and unnecessary allergy skin testing for environmental and food allergies in a patient with two years of chronic urticarial [hives] which he – ultimately, dermographism does not merit any of that testing." The SPT results, in fact, were equivocal or generalized. During the first visit, the Respondent performed a SPT with equivocal results, and RAST testing was obtained. After this visit, as Dr. Drelich explained in his peer review report, "any further skin testing would not be necessary."

(Drelich's peer review report at 6.) After that visit, the Respondent performed SPTs on four more occasions. The Panel finds the repeat SPTs were unnecessary and unjustified.

The Respondent billed for SPTs for Patient 5 on four occasions. The first SPT had a poor histamine response, but the second SPT (April 19, 2014) had adequate results. Nonetheless, the Respondent documented that he performed two more SPTs (May 1, 2014, and May 13, 2014). There was no justification for repeating the SPTs after an adequate response. The Respondent noted that the patient had a late phase reaction from the SPT from April 19, 2014, but this would not justify repeat testing.

On May 29, 2014, the Respondent performed a full panel SPT on Patient 9. The Respondent then unnecessarily repeated the SPT on June 3, 2014. A late phase reaction did not justify repeat the SPT.

The unnecessary and unindicated testing described above constitutes unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), and gross overutilization of health care services, in violation of Health Occ. § 14-404(a)(19).

3. SPT HISTAMINE RESPONSES

Taking antihistamines within a short period before a SPT will invalidate the SPT, thus a patient must discontinue taking antihistamines before a SPT. If testing shows a negative histamine response (an antihistamine was taken too close to the SPT), one does not know if negative responses to the allergens tested are due to the antihistamine or to the patient being non-allergic. If there is an invalidated SPT because of a negative histamine response, the physician should obtain a positive histamine response prior to performing a subsequent SPT, which the Respondent did not do.

Patient 1's first visit, on April 15, 2014, included a SPT which was uninterpretable because the patient took an antihistamine before the visit. The Respondent billed $2640 for the SPT. On the second visit, April 18, 2014, the Respondent did not perform a histamine test prior to conducting another SPT, and the SPT was again uninterpretable, because the patient had taken "cough medicine" before the visit. The Respondent billed $2640 for the SPT. On April 24, 2014, the Respondent performed another SPT without first testing for a histamine response. The results of the test were "equivocal response to histamine." The Respondent billed $2640 for the SPT. On May 1, 2014, the Respondent performed another SPT, again without first testing for an antihistamine, but this time, fortunately, there was a positive histamine response indicated from the SPT, so the SPT was adequate. The Respondent billed $2640 for the SPT.[5] Both of the State's experts found that it was improper for the Respondent to conduct a SPT after the first SPT was invalidated due to a negative histamine response without conducting a histamine test prior to any subsequent SPT. The Respondent's failure to do so resulted in two further invalidated SPTs for which he billed a combined $5,280.

In addition to Patient 1, Patients 2, 3, 4, 5, and 10 also had negative histamine responses on their initial SPTs. Based upon the number of patients with negative histamine responses, the ALJ determined that the Respondent failed to notify his patients to stop taking antihistamines prior to the visit. The ALJ did not accept the Respondent's testimony that he did instruct his patients to stop taking antihistamine before their visits. The Panel accepts the ALJ's finding that the Respondent did not instruct his patients to stop taking antihistamines before their visits.

[5] As described above, the Respondent again performed another SPT on May 10, 2016, billing for $2640 for that STP, and billed $2640 for a SPT on March 24, 2016, although no visit occurred or SPT actually occurred on that date.

The Respondent's failure to obtain valid SPT results due to negative histamine responses resulted in numerous repeated tests that otherwise would have been unnecessary and fits within his pattern of unjustified testing and billing. As Dr. Jani testified, "There is also a pattern of reporting negative histamine response to the initial excessive number of tests to justify repeat testing." (Tr. 64.) The Respondents actions and omissions which resulting in poor or negative histamine responses on SPTs constitutes unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); and gross overutilization of health care services, Health Occ. § 14-404(a)(19).

III. UPCODING

On almost every patient visit, the Respondent billed under the highest billing level (CPT code 99245), which Dr. Drelich explained is meant for an "initial consultation, and in none of the records is there the level of complexity documented in the record to bill for that level of complexity." (Tr. 244.) The ALJ specifically found that the Respondent unjustifiably billed under CPT code 99245 for Patients 1, 2, 5, 7, and 9. The Panel accepts the ALJ's determination that the Respondent upcoded (billed under Code 99245 when the level of services required for that Code were not provided) for those patients. The Panel does not consider the initial visits for these patients to have been upcoded. The subsequent visits for Patients 1, 2, 5, 7, and 9 that were billed under CPT code 99245 were improperly upcoded and constitute unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

IV. STANDARD OF CARE

While the focus of this decision is the Respondent's unprofessional conduct and his gross overutilization, his conduct also constitutes a violation of the standard of care, as described here.

Concerning Patient 1, according to the experts for the State, the Respondent's repeated unnecessary testing violated the standard of care. The Panel accepts the testimony of the experts.

Concerning Patient 9, the State's experts agreed that the Respondent's excessive and unnecessary testing violated the standard of care. The Panel agrees with the State's experts.

Based on the above findings, with respect to Patients 1 and 9, the Respondent failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care performed in this State, in violation of Health Occ. § 14-404(a)(22).

V. FAILURE TO KEEP ADEQUATE RECORDS

The State's experts often considered the lack of documentation for testing which the Respondent billed to be both a violation of Health Occ. § 14-404(a)(40) (failure to keep adequate records) and Health Occ. § 14-404(a)(3)(ii) (unprofessional conduct). In many cases, the lack of documentation helped demonstrate that the Respondent billed for testing that he did not perform. The Panel considers these instances unprofessional conduct, as opposed to failure to keep adequate records. There were, however, several instances in which the Respondent's records clearly demonstrate a straightforward recordkeeping violation, under of Health Occ. § 14-404(a)(40).

The Respondent failed to document an adequate history of Patient 1's asthma and food allergies. The Respondent did not record medications, symptoms, triggers, onset, or frequency. The Respondent disputes that there was not a full history of the patient's asthma and points to paragraph 11 of the ALJ's findings of fact, but this paragraph appears to concern the patient's seasonal allergies, not asthma. The Respondent also refers in general to his progress notes, but, again, the Panel cannot identify the necessary history specific to asthma, as opposed to the seasonal allergies. Additionally, the Respondent billed $2640 for 264 allergens on six occasions,

but there are only three forms with test results. Each time a SPT is performed there should be documentation of allergens tested, the results for each allergen tested, and the date the test was performed. One form has two dates on it: 4/15/14 and 4/18/14. Each page has one signature of the Respondent. It is unclear when the Respondent completed this form. That should have been clear. His documentation of SPTs was substandard.

The Respondent billed for four SPTs for Patient 5 purportedly performed on April 15, 2014; April 19, 2014, May 1, 2014, and May 13, 2014. The Respondent billed for the testing of 264 allergens with each of these SPTs. Each SPT should be documented with each of the allergens tested, the results, and the date of the test. The records, however, contain only three forms with SPT results. One results form pertains to April 15, 2014 ("poor histamine response"). Another results form is dated April 19, 2014, and lists 96 allergens tested, although he billed for 264. The other results form is dated "4/15/14 – 5/29/15," which were the dates of the first and last of the six patient visits. This form does not distinguish the dates of any of the tests, and one cannot discern when any of these allergens were tested. In addition, on May 1, 2014, the Respondent billed $3000 for 300 patch tests, but there is no results form for the PT, which should list the allergens tested, the results, the date of the test, and the date of the reading. The Respondent only wrote "negative – (no reaction)" in the progress notes.

Based upon the findings described above, the Respondent failed to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40).

Summary of Conclusions of Law

As described above, the Respondent: is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); grossly overutilized health care services,

in violation of Health Occ. § 14-404(a)(19); failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care performed 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).

SANCTION

The ALJ recommended the revocation of the Respondent's license. The ALJ found that the Respondent's over-billing was deliberate and included billing for testing he did not perform. The ALJ also emphasized that his over-billing was not isolated and that he made no efforts to rectify it. According to the ALJ, his "offenses were part of a pattern of detrimental conduct."

The Respondent filed an exception to the ALJ's recommended sanction. The Respondent states that the Respondent has no prior disciplinary history and that "no patient was harmed." The Respondent argues he has rehabilitative potential and his conduct "was not committed in the deliberate fashion with which the ALJ concluded." The Respondent claims that his poor recordkeeping skills "undeniably contributed to the ALJ's finding of deliberate conduct." The Respondent contends that his practice could improve through a comprehensive recordkeeping course and a supervisor for his billing and medical records. The Panel finds this inadequate.

The Panel finds the Respondent's practices disturbing and intolerable. Certainly, the Respondent's over-billing was not isolated. It consumed his practice. His practice was replete with different schemes to bill for services that were not performed and for services that were performed but not indicated. And there is no doubt his conduct was deliberate. The Panel also finds unacceptable the number of inaccurate, contradictory, and false documents he produced. The Panel agrees with the ALJ that revocation is appropriate.

ORDER

Based upon the Findings of Fact and Conclusions of Law, it is, by an affirmative vote of a majority of the quorum of Board Disciplinary Panel B, hereby

ORDERED that the license of Sampson Sarpong, M.D. to practice medicine in Maryland (License No. D39249) is **REVOKED;** and it is further

ORDERED that this is a public document.

August 8, 2017
Date

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

NOTICE OF RIGHT TO APPEAL

Pursuant to § 14-408(a) of the Health Occupations Article, Dr. Sarpong has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review must be filed within 30 days from the date this Final Decision and Order was sent to the Respondent. The petition for judicial review must be made as directed in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If Dr. Sarpong petitions for judicial review, the Board is a party and should be served with the court's process. In addition, Dr. Sarpong should send a copy of his petition for judicial review to the Board's counsel, David Wagner, Assistant Attorney General, Office of the Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland 21201. The administrative prosecutor is not involved in the circuit court process and does not need to be served or copied on pleadings filed in circuit court.