IN THE MATTER OF	*	**BEFORE THE**
JASON GOODMAN, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D55846	*	**Case Number: 2218-0055**

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AMENDED ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE[1]

Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of Jason Goodman, M.D., (the "Respondent"), license number D55846, to practice medicine in the State of Maryland. Disciplinary Panel A takes such action pursuant to its authority under Md. Code Ann., State Gov't II ("State Gov't") § 10-226(c)(2) (2014 Repl. Vol. & 2017 Supp.) and Md. Code Regs. 10.32.02.08B(7)(a), concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to Panel A and the investigatory information obtained by, received by and made known to and available to Panel A and the Office of the Attorney General, including the instances described below, Panel A has reason to believe that the following facts are true:[2]

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[1] This amended Order supersedes the Order of Summary Suspension dated March 30, 2018.

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

1. At all times relevant hereto, the Respondent has been licensed to practice medicine in Maryland. The Respondent was initially licensed to practice medicine in Maryland on April 5, 2000. His license is scheduled to expire on September 30, 2018.

2. The Respondent is board-certified in Internal Medicine.

3. On or about April 4, 2017, the Respondent began employment at a medical office (the "Practice")[3] in Anne Arundel County, Maryland.

4. On or about October 13, 2017, the Board received a complaint from a partner in the Practice (the "Complainant"), who stated that after the Respondent joined the Practice, he offered to take over prescribing narcotics for several patients who already had pain management doctors.

5. The Complainant alleged that a patient ("Patient A") reported that she found some of her oxycodone[4] missing after the Respondent made a home visit, and an audit of several patients determined that at least one other patient ("Patient B") was missing pain medication.

6. Another patient ("Patient C") reported that the Respondent called her on the same day that he prescribed oxycodone to schedule a home visit.

7. Board Staff interviewed the Complainant, who reported she was downsizing her practice, and that her practice partner contracted with the

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[3] To ensure confidentiality, the names of individuals, hospitals, medical offices, and health care facilities are not disclosed in this document. The Respondent may obtain the identity of the referenced individuals and entities by contacting the assigned administrative prosecutor.

[4] Oxycodone is a semisynthetic opioid synthesized from thebaine, an opioid alkaloid found in the Persian poppy, and one of the many alkaloids found in the opium poppy. It is a moderately potent opioid pain medication (orally roughly 1.5 times more potent than morphine), generally indicated for relief of moderate to severe pain.

Respondent in a cost sharing arrangement, where the Respondent agreed to share expenses and assume the care of certain patients in the concierge practice. The Practice had a concierge arrangement with certain patients who paid a yearly fee.

8. The Complainant reported that she was surprised when the Respondent took over narcotic prescribing for Patient A, who was already being followed by a pain management specialist.

9. According to the Complainant, the Respondent wrote a prescription for Patient A for Oxycodone (20 mg), 1-2 every four hours PRN,[5] and Opana ER (20 mg)[6] to be taken three times a day, and he gave her 90 pills with no refills.

10. Later, the Complainant received a phone call from Patient A, who complained that the Respondent made frequent visits to her home, and after a visit she discovered that medication was missing. The Complainant wrote Patient A another prescription to replace the missing medication and advised her to return to the pain management practice.

11. The Complainant contacted Patient B, who also reported that the Respondent made visits to her home. The Complainant then asked Patient B to review her medications, and she discovered that pain medication was also missing.

12. Board staff interviewed the Complainant's Practice partner, "Witness A," who stated that she became concerned about the Respondent's access to

[5] PRN is a medical abbreviation, which means when necessary or as needed.
[6] Opana (Oxymorphone) extended release is a long acting opioid analgesic used to treat moderate to severe pain.

patients after Patient A reported the frequency of the Respondent's home visits and her concerns that he may have been stealing her medication. Witness A also stated that it was not a routine practice for physicians in the Practice to make home visits. Witness A agreed that under the circumstances, the Practice needed to terminate the Respondent's cost sharing agreement with the Practice.

13. On or about October 4, 2017, the Practice informed the Respondent that it was terminating his office sharing agreement due to the prescribing irregularities and the missing medications.

14. Board Staff also subpoenaed Prescription Drug Monitoring Program (PDMP) records for the Respondent, which documented that he prescribed large amounts of oxycodone to patients who were not patients at the Practice.

15. In furtherance of its investigation, Board staff interviewed Patients A, B, and C and subpoenaed their medical records.

A. Patient Specific Allegations

Patient A

16. In an interview with Board staff, Patient A reported that the Respondent contacted her and asked that she bring her medications with her for a "meet and greet" scheduled for September 13, 2017, at the Practice. She reported that during the meeting, the Respondent took her medications and went in another room and took pictures of the medications. She reported that the Respondent was alone with the medication.

17. Patient A reported that after the meeting with the Respondent she discovered that about 40 of her oxycodone tablets were missing. She was unsure about why the pills were missing so she contacted her pharmacy to determine whether a mistake was made at the pharmacy. The Pharmacy staff confirmed that records did not indicate that the pharmacy made an error that resulted in a shortage of medication in Patient A's prescription.

18. Patient A reported that after her initial meeting with the Respondent he visited her home four times in a ten-day period. She stated that he called her several times on his mobile phone and said that he would be at her house within 15-20 minutes. He claimed that he was in her neighborhood because he had patients to see in a nearby residential facility.

19. Patient A reported that the Respondent came to her home on September 18, 2017, at 8:15 a.m. On that date he wrote Patient A new prescriptions, including increasing the oxycodone from 5 tablets per day to 8 tablets per day.

20. Patient A reported that on Saturday, September 30, 2017, the Respondent came to her house early in the morning. She described him as unshaven, disheveled looking, casually dressed, and she commented that he "almost looked desperate." He asked her to produce her medication and she complied.

21. During that visit, Patient A stated that the Respondent asked her to show him a fossil from a fossil collection she kept in her home because his son

was interested in fossils. Patient A left the room to retrieve the fossil and the Respondent was left alone with her medication.

22. After the Respondent left her home Patient A discovered that 80-90 oxycodone tablets were missing. Patient A reports that she lives alone and no one else has access to her medication.

23. Patient A discussed her concerns about the Respondent with a friend, who advised her not to allow the Respondent to return to her home for medical visits. Patient A also reported her concerns to the physicians at the Practice.

Patient B

24. In an interview with Board staff, Patient B reported that she met the Respondent at a "meet and greet" at the Practice on September 12, 2017. At that time, Patient B stated that she was taking Tramadol[7] and sertraline.[8] The Respondent told her that she should not take those medications together and he prescribed oxycodone instead. Patient B reported that the Respondent assured her that oxycodone was better for her than Tramadol.

25. The Respondent wrote her a prescription for 150 oxycodone on September 12, 2017 and delivered it to her home on September 13, 2017. Patient B reported that during the home visit, the Respondent kept asking

[7] Tramadol is an opioid-like medication used to treat moderate to severe pain.
[8] Sertraline, commonly sold under the trade name Zoloft, is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. It is primarily used for major depressive disorder, obsessive compulsive disorder, panic disorder, and social anxiety disorder.

her questions about the medications and followed her into her bedroom where she kept her medication.

26. On one of the home visits, Patient B mentioned to the Respondent that she kept old medication in the cabinets in her bathroom. The Respondent took the medications with him, advising Patient B that he planned to dispose of the medication. Patient B stated that some of the medications, included pain medication, which had been prescribed for prior dental procedures.

27. Patient B reported that the Respondent followed her around in her home, which made her uncomfortable. The Respondent asked to see her current medications, which were stored in her bedroom and bathroom. The Respondent dumped the medications out on the sink and examined them.

28. On September 26, 2017, the Respondent prescribed 150 oxycodone tablets for Patient B.

29. According to Patient B, on October 3, 2017, the Respondent contacted her to make an appointment to discuss some laboratory results. Patient B states that she tried to discourage the Respondent, but he insisted on coming over.

30. The Respondent came over and delivered the laboratory results. He asked to use the bathroom and left quickly afterwards.

31. The Complainant contacted Patient B to express her concerns about the Respondent and asked Patient B to count her pain medication. Patient B reported that she found pain medication missing.

Patient C

32. On July 11, 2017, Patient C had a "meet and greet" with the Respondent at the Practice. Patient C complained that she was having pain in her liver, and that she was not getting any relief from Tramadol or ibuprofen. The Respondent prescribed oxycodone and ordered an x-ray.

33. On or about October 3, 2017, the Respondent called Patient C and stated that he wanted to stop by with another order for an x-ray. The Respondent then asked her if she had picked up her order for oxycodone. After Patient C told him that she had not picked up the prescription, the Respondent said that he would drop off the order for the x-ray on another day.

B. Toxicology Screening Results

34. The Respondent was subpoenaed to the Board for an interview on March 7, 2018. The Subpoena required the Respondent to appear at the Board and give testimony in the form of an interview. The Respondent arrived at the Board with counsel, but he refused to answer any questions under oath. The Respondent's counsel advised him not to respond to the interview questions.

35. After the March 7th meeting with the Board, the Respondent went for a toxicology screen per the Board's instructions. The results of the screening indicated that the Respondent tested positive for opiates and various opioid medications.

CONCLUSION OF LAW

Based on the foregoing investigative findings, Panel A concludes that the public health, safety or welfare imperatively requires emergency action in this case, pursuant to State Gov't § 10-226(c)(2) and Md. Code Regs. 10.32.02.08B(7)(a).

ORDER

It is, by a majority of the quorum of Panel A, hereby:

ORDERED that pursuant to the authority vested by State Gov't § 10-226(c)(2), the Respondent's license to practice medicine in the State of Maryland is hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that a post-deprivation Summary Suspension Hearing in accordance with Md. Code Regs. 10.32.02.08 B(7), C & E has been scheduled for **Wednesday, April 11, 2018, at 1:00 p.m.** before Panel A at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and be it further

ORDERED that at the conclusion of the post-deprivation Summary Suspension Hearing held before Panel A, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) calendar days an evidentiary hearing, such hearing to be held within thirty (30) calendar days of the request, before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and be it further

ORDERED that a copy of this Order of Summary Suspension shall be filed by Panel A in accordance with Md. Code Ann., Health Occ. II § 14-407 (2014 Repl. Vol. & 2017 Supp.); and be it further

ORDERED that this is a Final Order of Panel A and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4–101 *et seq.*

April 4, 2018
Date

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