IN THE MATTER OF	*	**BEFORE THE**
BENJAMIN LEE, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D57974	*	**Case Number: 2016-0631 A**

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CONSENT ORDER

On December 29, 2017, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **Benjamin Lee, M.D.** ("Respondent"), License Number D57974, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. & 2017 Supp.). The pertinent provisions of the Act provide the following:

Health Occ. § 14-404. Denials, reprimands, probations, suspensions, and revocations -- Grounds.

(a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

...

(3) Is guilty of:

...

(ii) Unprofessional conduct in the practice of medicine;

...

(19) Grossly overutilizes health care services;

...

(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 March 14, 2018, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring because of the DCCR, Respondent agreed to enter this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Panel A makes the following findings of fact:

I. Background

1. At all times relevant hereto, Respondent was and is licensed to practice medicine in the State of Maryland. Respondent was originally licensed to practice medicine in Maryland on August 24, 2001. Respondent last renewed his license in September 2016, which will expire on September 30, 2018.

2. At all times relevant, Respondent was and is board-certified in Anesthesiology with sub-specialty certification in Pain Medicine. On September 26, 1997, Respondent was granted lifetime certification in Anesthesiology. On September 9, 2006, Respondent was certified in Pain Medicine, which he renewed on January 1, 2017. Respondent's Pain Medicine certification expires on December 31, 2026.

3. Respondent maintains a solo practice, known as, "Chesapeake Pain Center," for the practice of pain medicine in Bel Air, Maryland. One of the modalities that Respondent utilizes for pain management is the injection of steroids,[1] an interventional technique for pain relief.

4. Respondent holds privileges at several hospitals in Maryland.[2]

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[1] Steroids include drugs used to relieve swelling and inflammation, such as prednisone and cortisone.
[2] To ensure confidentiality, the names of individuals, patients, and institutions involved in this case are not disclosed in this document. Respondent was provided with a Confidential Identification List with the identity of all individuals, patients, and institutions referenced in this document.

5. Respondent also holds active licenses to practice medicine in Delaware and Georgia.

II. Complaint and Investigation

6. On or about February 9, 2016, the Board received a complaint from a patient of Respondent ("Patient 1"). The complaint alleges, among other issues, that Patient 1 was "misled and needlessly subjected to multiple painful procedures." Patient 1 attached correspondence between her and Respondent in which she detailed the decline in treatment level she received from Respondent, including receiving unnecessary procedures and having minimal communication with Respondent.

7. As part of its investigation, the Board issued a subpoena for Respondent's patient appointment logs from April 1, 2015 to April 28, 2016.

8. On or about May 23, 2016, the Board sent Respondent a subpoena for the complete medical and billing records of Patient 1 and nine additional patients (Patients 2 -10) whose names were selected by Board staff from the logs submitted by Respondent.

9. On or about July 7, 2016, the Board sent the ten medical and billing records to a peer review entity, which provided the records to two physicians, both board-certified in anesthesiology with sub-specialty certification in pain medicine, for independent peer reviews. Upon review of the records, the peer reviewers concurred that Respondent engaged in unprofessional conduct in the practice of medicine by the gross overutilization of steroid injections and failed to meet appropriate standards of care with respect to five of the ten patients.[3] Additionally, the peer reviewers concurred that Respondent failed to maintain adequate medical records for five of the ten patients.[4]

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[3] Patients 1, 2, 3, 8 and 9.
[4] Patients 1, 2, 4, 6, and 7.

III. Patient Specific Allegations

Patient 1

10. On January 9, 2014, Respondent saw Patient 1, the complainant, a female, then in her late 60s, for lower back, neck, and right knee pain. From January 9, 2014 to October 27, 2015, Respondent saw Patient 1 approximately once a month for medication management and injections.[5] Respondent diagnosed Patient 1 with cervical spondylosis[6] and cervical disc degeneration.

11. From March 18, 2014 to December 30, 2014, over approximately ten months, Respondent administered the following epidural steroid injections[7]:

a. 3/18/14 and 4/10/14 - cervical epidural injection C[8]6-7 and right and left cervical facet[9] injections C3-4, C4-5, C5-6. Respondent's records on 3/18/14 did not include an informed consent form for this procedure;

b. 4/17/14 - lumbar epidural injection L4-5 and right and left lumbar facet injections L3-4, L4-5, L5, S1;

c. 5/01/14 - thoracic epidural injections T10-11 and bilateral facet injections T8, T9, 10, T10, 11;

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[5] Patient 1 was scheduled to return in three weeks for lumbar facet and epidural injections but there are no records beyond October 27, 2015. On January 28, 2016, Patient 1 sent a letter of complaint to Respondent, stating that she "finally refused additional cervical epidurals", which suggests that Patient 1 terminated her care with Respondent after the October 27, 2015 visit.

[6] Cervical spondylosis is degeneration of the bones in the neck (vertebrae) and the disks between them, putting pressure on (compressing) the spinal cord in the neck. Osteoarthritis is the most common cause of cervical spondylosis.

[7] An epidural steroid injection is a minimally invasive procedure that can help relieve neck, arm, back, and leg pain caused by inflamed spinal nerves.

[8] The anatomy of the spine is described by dividing up the spine into three major sections: the cervical ("C"), the thoracic ("T"), and the lumbar ("L") spine. (Below the lumbar spine is a bone called the sacrum, which is part of the pelvis). Each section is made up of individual bones, called vertebrae. Cervical spine makes up the neck and has 7 vertebrae. The top two bones are known as the atlas and axis and are different from the others to allow rotation of the skull as well as forwards and backwards. Thoracic spine has 12 vertebrae which the ribs attach to. They are larger than the cervical vertebrae as they must support more of the bodies weight. Lumbar spine has 5 vertebrae which make up the lower back. Sacrum consists of 5 bones which are fused or stuck together and the coccyx is made up of 4 tiny bones and used to be a tail.

[9] A facet joint injection combines a local anesthetic and corticosteroid anti-inflammatory medications. This mixture relieves both pain and inflammation from the joint. A facet joint injection serves several purposes including immediate pain relief which then helps to confirm or deny the spinal joint as the pain source. F*acet joints* allow for small movements between adjacent vertebrae in the spine.

d. 5/27/14 – right and left cervical facet injections C3-4, C4-5, C5-6;

e. 7/29/14 – thoracic epidural injection T11-12 and bilateral facet injections T8-9, T9, 10, T10, 11;

f. 8/12/14, 10/16/14, 12/02/14 – cervical epidural injection C6-7 and right and left cervical facet injections C3-4, C4-5, C5-6;

g. 9/9/14 – thoracic epidural injection T11-12 and bilateral facet injections T8-9, T9, 10, T11, 12;

h. 11/14/14 and 11/21/14 –parathoracic trigger point injections.[10] There is no informed consent form and no procedure note for either date; and

i. 12/30/14 – cervical epidural injections C7, T1 and right and left cervical facet injections C5-6, C6-7, C7, T1.

12. From January 27, 2015 to September 8, 2015, over seven months, Respondent administered the following steroid injections to Patient 1 as summarized below:

a. 1/27/15 – thoracic facet and epidural (illegible) as evidenced by the informed consent but there is no procedure note;

b. 2/20/15 – a set of paracervical trigger point injections was described in the progress note but there is no informed consent and no procedure note;

c. 2/24/15 – cervical epidural injection C6-7 and right and left cervical facet injections C4-5, C5-6, C6-7;

d. 4/21/15, 8/11/15 and 9/8/15– right and left lumbar facet injections L3-4, L4-5, L5, S1 and lumbar epidural injections L4-5;

e. 9/3/15 – bilateral S1 joint injection.

13. Respondent's records document Patient 1's pain levels during follow-up visits consistently in the 6 out of 10 to 8 out of 10 range.

[10] A trigger point injection (TPI) is a procedure which involves insertion of a small needle containing a local anesthetic or saline, and may include a corticosteroid into the patient's trigger point. A trigger point is a hyperirritable spot in the fascia surrounding skeletal muscle. With the injection, the trigger point is made inactive and the pain is alleviated.

14. Respondent often performed epidural steroid injections (ESIs) and facet joint injections (FJIs) on the same day on Patient 1 without documented pain and function assessments before and after the procedures to justify the continuation of this combination.

15. On March 15, 2016, shortly after Respondent received notice from the Board of Patient 1's complaint, Respondent retroactively electronically signed all records of office visits for Patient 1 from January 2014 to October 2015.

16. Respondent engaged in unprofessional conduct, gross overutilization, and failed to meet standards for quality medical care regarding his care and treatment of Patient 1 in that Respondent:

a. Exceeded the number of generally accepted and recommended ESIs and FJIs per year, without any significant pain improvement;

b. Consistently combined ESIs with FJIs which can lead to improper diagnosis, unnecessary treatment, and excessive dosing; and

c. Failed to periodically review the course of treatment and continued to employ an ineffective treatment despite lack of significant improvement in Patient 1's symptoms and function.

17. Respondent failed to keep adequate medical records regarding his care of Patient 1 in that Respondent:

a. Failed to document informed consent and procedure notes for trigger point injections performed on November 14, 2014, November 21, 2014, and February 20, 2015;

b. Failed to document periodic progress and treatment efficacy; and

c. Failed to timely sign Patient 1's treatment records.

Patient 2

18. On April 8, 2014, Patient 2, a male in his mid-40s, began seeing

Respondent for lower back and leg pain. Respondent saw Patient 2 once a month or more for medications and injections.

19. Respondent diagnosed Patient 2 with chronic lower back pain ("LBP") and radicular pain, myofascial pain, trochanteric bursitis and degenerative joint disease ("DJD") of the right wrist and forearm.

20. In 2014, Respondent performed six lumbar ESIs, eight FJIs, three transforaminal steroid injections, six TPIs, and four trochanteric injections for a total of 27 injections.[11] For example, on October 30, 2014, Respondent performed right and left lumbar facet injections and a lumbar epidural injection; and on November 6, 2014, Respondent performed right and left facet injections (and a trochanteric injection[12]) without waiting to see if Patient 2 was experiencing post-procedural pain which would remit.

21. From January through May 2016,[13] Respondent performed four lumbar ESIs with bilateral lumbar facet injections at L3-4, L4-5, L5-S1, one left trochanteric bursa injection and one right trochanteric bursa injection.

22. The frequency and dose of these steroid injections exceeded 6 mg/kg of body weight.

23. Respondent billed follow-up visits as CPT code 99214 (level IV established patient visit involving a detailed history, detailed examination and medical decision making of moderate complexity) even though the physical examinations were usually

[11] A complete listing of the dates, location, and amount of steroid injections that Respondent administered to Patient 2 is provided in the Peer Review Report of Reviewer A, which has previously been provided to Respondent.

[12] A trochanteric injection is in the trochanter which is the outside point area of the hip.

[13] The Board issued a subpoena to Respondent for patient records on May 23, 2016; therefore, there is no record of care beyond June 2, 2016. In June 2, 2016, Patient 2 was scheduled for follow-up in four weeks for lumbar epidural injections.

inadequate and the clinical decision making was straightforward (i.e., "proceed with injection.")

24. Respondent engaged in unprofessional conduct, gross overutilization, and failed to meet standards for quality medical care regarding his care and treatment of Patient 2 in that Respondent:

a. Exceeded the generally accepted and recommended number of ESIs and FJIs in one year despite the lack of any significant relief or improvement in Patient 2's pain;

b. Combined ESIs and FJIs on the same day without justification, thereby exposing Patient 2 to doses of steroids that are higher than if used in isolation, potentially increasing the risk of side effects; and

c. Failed to demonstrate in the documentation that there was a sustained benefit to Patient 2's pain level and functional capacity to justify persisting with these interventions.

25. Respondent failed to keep adequate medical records regarding his care of Patient 2 in that Respondent:

a. Failed to adequately document physical examinations in the progress notes to evaluate Patient 2's chronic pain;

b. Failed to have sufficient documentation to support the level of billing; and

c. Failed to timely sign Patient 2's treatment records.

Patient 3

26. On November 1, 2007, Respondent first saw Patient 3, a male in his early-50s, for neck, lower back, knee, and shoulder pain. Respondent last saw Patient 3 on or about May 12, 2016.[14]

[14] Patient 3 was scheduled for follow-up in two weeks for lumbar facet and epidural injections. There are no records of care after May 12, 2016 since the Board's subpoena for patient records was sent to Respondent on May 23, 2016.

27. In a "Summary of Care" which Respondent prepared at the request of the Board, Respondent diagnosed Patient 3 with chronic LBP and neck pain from degenerative spondylosis, myofascial pain syndrome, degenerative arthritic pain and pain in the shoulder, knees, and hands.

28. From November 1, 2007 to May 12, 2016, Respondent administered 72 injections, including ESIs and FJIs, to Patient 3.[15] The frequency of injections given to Patient 3 exceeded the accepted and recommended number. These injections also exceeded the dosage of 6 mg/kg of body weight.

29. On several occasions, the interval between injections was only one week.

30. On multiple occasions, Respondent administered ESIs and FJIs to Patient 3, on the same day, without justification of their benefit. This combined treatment exposed Patient 3 to doses of steroids that are higher than if there were isolated doses, potentially increasing the risk of side effects.

31. Respondent billed follow-up visits (i.e. on April 23, 2008), as CPT code 99214 (level IV established patient visit involving a detailed history, detailed examination and medical decision making of moderate complexity) even though the physical examinations were usually inadequate and the clinical decision making was straightforward, (i.e., "proceed with injection").

32. On May 25, 2016, shortly after receipt of the Board's subpoena for Patient 3's records, Respondent retroactively electronically signed most of the records of Patient 3's office visits.

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[15] A complete listing of the dates, location, and amount of steroid injections that Respondent administered to Patient 3 is provided in the Peer Review Report of Reviewer A, which has previously been provided to Respondent.

33. Respondent engaged in unprofessional conduct, gross overutilization, and failed to meet standards for quality medical care regarding his care and treatment of Patient 3 in that Respondent:

a. Exceeded the number of generally accepted and recommended ESIs and FJIs per year, without sustained benefit to Patient 3's pain level and functional status;

b. Performed ESIs and FJIs on the same day without justification when such combined treatment exposed Patient 3 to doses of steroids that are higher than usually used if isolated ESI and FJIs, potentially increasing the risk of side effects; and

c. Failed to timely signed Patient 3's treatment records.

Patient 4

34. On August 5, 2014, Respondent first saw Patient 4, a female in her early-50s, for chronic neck, thoracic, lower back, and knee pain. Patient 4's last visit was on May 13, 2016.[16]

35. In a "Summary of Care" which Respondent prepared at the request of the Board, Respondent diagnosed Patient 4 with chronic LBP, thoracic pain, chronic neck pain, myofascial pain syndrome, and knee pain from mild DJD.

36. Respondent's treatment records lack the appropriate level of "completeness" that should accompany the CPT codes utilized by Respondent. For example, the initial evaluation of August 5, 2014, was billed with CPT code 99204. This code requires three of the three following actions: Comprehensive History, Comprehensive Physical Examination and Moderate Complexity Medical Decision Making. Neither the History nor Physical Examination achieve the level of detail required.

[16] Patient 4 was scheduled for follow-up in four weeks for repeat parathoracic trigger point injections.

37. Further, an office visit conducted on or about January 19, 2016 was billed with CPT code 99214. This code requires two of the three following actions: "Detailed History, Detailed Physical Examination, and Moderate Complexity Medical Decision Making." None of these requirements were satisfied by the information provided in Respondent's records.

38. Respondent's treatment records do not contain procedural notes and informed consent forms for injections which, according to the progress notes, Respondent performed on March 2, 16, and 25, April 13 and 29, and May 13, 2016.

39. On May 27, 2016, shortly after receipt of the Board's subpoena for Patient 4's medical records, Respondent retroactively electronically signed the majority of Patient 4's records of office visits.

40. Respondent failed to maintain adequate medical records of his care of Patient 4 in that Respondent:

a. Failed to provide sufficient documentation to support use of corresponding CPT codes;

b. Failed to provide procedural notes and informed consent for five procedures; and

c. Failed to timely sign Patient 4's treatment records.

Patient 5[17]

Patient 6

41. On August 28, 2007, Respondent first saw Patient 6, a female in her early-70s, for neck, thoracic, lower back, and shoulder pain.

42. In a "Summary of Care" which Respondent prepared at the request of the

[17] There are no allegations regarding Patient 5.

Board, Respondent diagnosed Patient 6 with hip pain, knee pain, shoulder pain, trochanteric bursitis, and myofascial pain.

43. Respondent's treatment records lack the appropriate level of "completeness" that should accompany the CPT codes utilized by Respondent. For example, the initial evaluation conducted on August 28, 2007, was billed under CPT code 99245. This code requires three of the three following actions: "Comprehensive History, Comprehensive Physical Examination, and Moderate Complexity Medical Decision Making." Neither the history nor the PE achieve the level of detail required by the CPT code.

44. Respondent's treatment records do not contain procedural notes for injections performed on Patient 6 on June 2, 2010, November 14, 2014, March 11, 2015, April 1, 2015, and June 9, 2015.

45. Respondent last saw Patient 6 on May 24, 2016.[18]

46. On June 3, 2016, shortly after receipt of the Board's subpoena for Patient 6's medical records, Respondent electronically signed the majority of Patient 6's records of office visits.

47. Respondent failed to maintain adequate medical records of his care of Patient 6 in that Respondent:

a. Failed to provide sufficient document to support use of corresponding CPT codes;

b. Failed to document procedural notes for several procedures; and

c. Failed to timely sign Patient 6's treatment records.

[18] Patient 6 was scheduled for follow-up in 4 weeks for a complete series of cervical facet and epidural injections.

Patient 7

48. On or about March 14, 2013, Respondent first saw Patient 7, a female in her early-60s, for bilateral lower extremity, right upper extremity, hip, and lower back pain.

49. In a "Summary of Care" which Respondent prepared at the request of the Board, Respondent diagnosed Patient 7 with chronic LBP and radicular pain.

50. Respondent's treatment records do not contain any procedure notes for right trochanteric bursa injections which according to the progress notes he gave to Patient 7 on February 24, 2016 and March 23, 2016.

51. On June 3, 2016, shortly after receipt of the Board's subpoena for Patient 7's medical records, Respondent retroactively electronically signed Patient 7's records of office visits.

52. Respondent failed to maintain adequate medical records regarding his care of Patient 7 in that Respondent:

a. Failed to document procedural notes for several procedures; and

b. Failed to timely sign Patient 7's treatment records.

Patient 8

53. On or about December 7, 2010, Respondent first saw Patient 8, a male in her late-60s, for chronic bilateral thumb pain. On or about July 30, 2013, Patient 8 presented himself to Respondent due to LBP. Respondent diagnosed Patient 8 with severe chronic LBP associated with radicular pain.

54. From August 6, 2013 to January 14, 2016, Respondent administered approximately 23 steroid injections to Patient 8 over 29 months, almost one injection a

month.[19] This frequency exceeded the generally accepted and recommended frequency of injections per year. Respondent administered the following epidural steroid injections:

a. 2013 – Between August and December 2013 (five months), Respondent administered six lumbar ESIs (either by intralaminar or transforaminal approach) combined with lumbar FJIs;

b. 2014 – Between March and April 2014, and September to October 2014 Respondent administered six injections of the same type; and

c. 2015 – Between February 2015 through January 2016 – Respondent administered nine LESIs along with FJIs and one shoulder joint injection.

55. Respondent administered ESIs and FJIs on the same day. This combined treatment can increase the risk of side effects and expose the patient to doses of steroids higher than typically used in the setting of isolated ESIs and FJIs.

56. On June 3, 2016, shortly after receipt of the Board's subpoena for Patient 8's records, Respondent retroactively electronically signed Patient 8's.

57. Respondent engaged in unprofessional conduct, gross overutilization, and failed to meet standards for quality medical care regarding his care and treatment of Patient 8 in that Respondent:

a. Exceeded the number of generally accepted and recommended ESIs and FJIs per year, of 6 mg/kg, without any significant pain improvement;

b. Administered ESIs and FJIs on the same day without documented justification, exposing Patient 8 to doses of steroids that are higher than typically used in isolated ESIs and FJIs, potentially increasing the risk of side effects; and

c. Failed to timely sign Patient 8's treatment records.

[19] A complete listing of the dates, location, and amount of steroid injections that Respondent administered to Patient 8 is provided in the Peer Review Report of Reviewer A, which has previously been provided to Respondent.

Patient 9

58. On January 14, 2009, Respondent first saw Patient 9, a male in his early-60s, for neck, lower back, and shoulder pain.

59. In a "Summary of Care" which Respondent prepared at the request of the Board, Respondent diagnosed Patient 9 with chronic neck pain, DJD of the shoulders, sacroiliac joint pain, myofascial pain of the back and neck, and LBP.

60. In 2009 through 2013, Respondent administered seven steroid injections to Patient 9.[20]

61. In 2014, Respondent administered steroid injections with an interval as short as seven days (the first injection on December 23, 2014, and the second on December 30, 2014, exposing the Patient 9 to unnecessary risk.)

62. From January 20, 2015 to January 12, 2016, over one year, Respondent administered the following injections to Patient 9:

a. January, February, April 2015 - three bilateral lumbar facet joint injections at L3-4, L4-5, L5-S1 combined with three bilateral sacroiliac joint injections,

b. September and October 2015 - three lumbar epidural steroid injections combined with three bilateral lumbar facet injections, and

c. December 2015 and January 2016 - three cervical epidural steroid injections combined with three bilateral cervical facet joint injections.

63. Respondent electronically signed Patient 9's on June 3, 2016, shortly after receipt of the Board's subpoena for Patient 9's records.

64. Respondent engaged in unprofessional conduct, gross overutilization, and failed to meet standards for quality medical care regarding his care and treatment of

[20] A complete listing of the dates, location, and amount of steroid injections that Respondent administered to Patient 9 is provided in the Peer Review Report of Reviewer A, which has previously been provided to Respondent.

Patient 9 in that Respondent:

a. Exceeded the number of generally accepted and recommended injections per year, without any significant pain improvement or justification for continuing such a frequency of injections; and

b. Failed to timely sign Patient 9's treatment records.

Patient 10[21]

IV. Summary of Findings

65. Respondent's repeated use of steroid injections, including consistently exceeding the generally accepted and recommended frequency of injections and combining types of injections in a single treatment, without documented medical indication or documented response to such treatment, is evidence of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(3)(ii), gross over-utilization of health care services, in violation of Health Occ. § 14-404(19), and failure to meet standards for quality medical care, in violation of Health Occ. § 14-404(a)(22).

66. Respondent's overutilization of steroid injections, combination of steroid treatments contrary to generally accepted standards, and failure to maintain appropriate documentation of efficacy of treatments, is evidence of failure to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22).

67. Respondent's failure to maintain appropriate documentation of efficacy of treatments, failure to provide procedure notes for every treatment, failure to adequately document for corresponding CPT codes, and electronically signing the majority of patients' medical records all on the same day, shortly after receipt of the Board's

[21] There are no allegations regarding Patient 10.

subpoena for the medical records, is evidence of a failure to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40).

ORDER

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

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

ORDERED that Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS**[22]: During the probationary period, Respondent shall comply with all the following probationary terms and conditions:

1. Respondent's medical practice shall be supervised by a panel-approved peer supervisor for the duration of probation. Within 30 days of the effective date of the Consent Order, Respondent shall provide the panel with the name and professional background information of the supervisor whom he is offering for approval. The panel-approved supervisor must familiarize himself or herself with the relevant Board and Panel orders and peer review reports concerning Respondent. Respondent consents to the release of these documents to the supervisor. Each month the supervisor shall review the patient records, chosen by the supervisor, of at least ten (10) of Respondent's patients. The supervisor shall meet in-person with Respondent at least one (1) time each month. Discussion at the in-person meetings shall include the care Respondent has provided for specific patients and detailed feedback from the supervisor on Respondent's practices. The supervisor shall be available to Respondent for consultations on any patient and have access to Respondent's patients' records and shall maintain the confidentiality of all medical records and patient information. Additionally, Respondent shall ensure that the supervisor provides the Board with quarterly reports concerning whether there are any concerns with Respondent's medical practice. If there are indications that Respondent poses a substantive risk to patients, the supervisor shall immediately report his or her concerns to the Board. An unsatisfactory supervisory report may constitute a violation of the terms and conditions of this Consent Order;

2. Within six (6) months, Respondent shall successfully complete a Board disciplinary panel-approved course in medical documentation and record

[22] If the Respondent's license expires during this two-year period, the two-year period and any conditions will be tolled.

keeping. The Board disciplinary panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. Respondent must provide documentation to the Board that Respondent has successfully completed the course;

3. Within six (6) months, Respondent shall successfully complete a Board disciplinary panel-approved course in medical ethics related to the issues in this case. The Board disciplinary panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. Respondent must provide documentation to the Board that Respondent has successfully completed the course;

4. Within six (6) months, Respondent shall successfully complete a Board disciplinary panel-approved course in medical coding. The Board disciplinary panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. Respondent must provide documentation to the Board that Respondent has successfully completed the course;

5. Within six (6) months, Respondent shall pay a fine in the amount of $5,000.00 by money order or bank certified check made payable to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297-3217 for deposit into the General Fund of Maryland;

6. Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, and all laws and regulations governing the practice of medicine in Maryland; and it is further

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

ORDERED that after a minimum of two (2) years, Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Panel A. The Board or Panel A will administratively terminate the probation if Respondent has complied with all the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that if Respondent allegedly fails to comply with any term of probation or any other term imposed by this Consent Order, Respondent shall be given notice and an opportunity for a hearing. If there is a dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if there is no dispute as to a material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that after the appropriate hearing, if the disciplinary panel determines that Respondent has failed to comply with any term of probation or any other term imposed by this Consent Order, the Panel may reprimand Respondent, place Respondent on probation with appropriate terms and conditions, or suspend or revoke Respondent's license to practice medicine in Maryland. The Panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on Respondent; and it is further

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

ORDERED that unless stated otherwise in the order, any time prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of Panel A; and it is further

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.*

04/05/2018
Date

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

CONSENT

I, Benjamin Lee, M.D., License No. D57974, by affixing my signature hereto, acknowledge that:

I am represented by counsel and have consulted with counsel before entering this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I am waiving those procedural and substantive protections. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

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

3/30/18
Date

Signature on File

Benjamin Lee, M.D., Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 30th day of March, 2018 before me, a Notary Public of the State and County aforesaid, personally appeared Benjamin Lee, M.D., License number D57974, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Tracy E. Klima
Notary Public

My commission expires 12/16/19