IN THE MATTER OF	*	BEFORE THE
VABIAN L. PADEN, M.D.	*	MARYLAND STATE BOARD
Respondent	*	OF PHYSICIANS
License Number: D60744	*	Case Number: 2017-0270B

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FINAL DECISION AND ORDER

On May 21, 2018, Vabian L. Paden, M.D. ("Dr. Paden" or the "Respondent") was charged under the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, with failure to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care in this State,[1] *see* Health Occ. § 14-404(a)(22); and with failure to keep adequate medical records as determined by appropriate peer review,[2] *see* Health Occ. § 14-404(a)(40).

On February 6 and 7, 2019, an evidentiary hearing was held before an Administrative Law Judge ("ALJ") of the Office of Administrative Hearings. On May 1, 2019, the ALJ issued a proposed decision, concluding that Dr. Paden violated the standard of care, in violation of Health Occ. § 14-404(a)(22); and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40).[3] As a sanction, the ALJ recommended that Dr. Paden be reprimanded and placed on probation for two years. During the first year of probation the ALJ recommended that Dr. Paden be prohibited from prescribing controlled dangerous substances ("CDS"), except in

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[1] This ground is commonly referred to as violating the "standard of care," which is how it is referred to in this decision.

[2] This decision refers to this ground as the failure to keep adequate records.

[3] The ALJ's proposed conclusions of law contains an error, which is that the ALJ cited Health Occ. § 14-404(a)(19) (gross overutilization of health care services) as a ground that Dr. Paden violated. Because Dr. Paden was not charged with violating this ground, and the ground was not litigated during the administrative proceedings, the Panel considers this simply a typographical error and disregards it.

emergency situations. The ALJ further proposed that Dr. Paden be required to complete courses on opioid prescribing and medical documentation and that, after the first year of probation, he be supervised by a panel-approved peer reviewer. Finally, the ALJ recommended that the Panel issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program. Dr. Paden filed exceptions to the ALJ's proposed decision. On August 14, 2019, Disciplinary Panel A ("Panel A" or the "Panel") of the Maryland State Board of Physicians (the "Board") held a hearing on Dr. Paden's exceptions.

FINDINGS OF FACT AND DISCUSSION

Except as otherwise stated in this decision, Panel A adopts the Stipulated Facts, Proposed Findings of Fact, and Discussion set forth in the ALJ's Proposed Decision (ALJ's Proposed Decision, pages 5-38), which are incorporated by reference into the body of this document as if set forth in full. The ALJ's proposed decision is attached as Exhibit 1. Panel A finds that the factual findings were proven by the preponderance of evidence.

EXCEPTIONS

1. Original Complaint Not Sent to Dr. Paden during the Investigation for a Response

Dr. Paden seems to argue that, during the investigative stage, the Board erred by not sending the original complaint to him for his response. Dr. Paden does not provide any law indicating that a complaint must be provided during the investigation to the licensee under investigation. In fact, Dr. Paden does not support this exception with any legal authority, and the Panel is unaware of any law that would resolve this exception in his favor. Moreover, Dr. Paden's assertion that, had he been given an opportunity to respond to the original complaint, "more likely than not the Board investigator would have elected to take no further action in the case," appears to be based solely upon speculation. In any case, a Board disciplinary panel, not a

Board investigator, makes the decision on whether an investigation proceeds or is closed. The exception is denied.

2. 10-Day Extension to Produce Subpoenaed Records

Dr. Paden takes exception to the Board's decision to extend by only 10 days his time for producing the records the Board subpoenaed. The subpoena was served upon Dr. Paden on April 18, 2017. The subpoena's deadline for Dr. Paden to produce the records was initially May 2, 2017. Due to the voluminous records, Dr. Paden requested an extension to respond to the subpoena. The Board granted the request and extended the deadline by 10 days, to May 12, 2017. Dr. Paden states that he provided the records by that time.

Dr. Paden argues that a 10-day extension was arbitrary and denied him due process. Dr. Paden, again, provides no law to support his exception. Instead, Dr. Paden simply compares his 10-day extension to the time it took the peer reviewers to produce their peer review reports, which, Dr. Paden states, "represents a de facto extension of approximately 120 days." The Panel does not know how Dr. Paden calculated the 120-day figure, but, even if there were a de facto extension of 120 days for the peer review reports, there is no showing that the Board acted arbitrarily or denied him due process. The nature of producing a peer review report is simply far too different from the nature of subpoenas for there to be any meaningful comparison. The Panel finds that the 10-day extension was neither arbitrary nor a denial of due process. The exception is denied.

3. Alleged Bias of a Peer Reviewer

Dr. Paden argues that the ALJ erred in denying his motion to dismiss, which alleged that one of the two peer reviewers for the Board ("Peer Reviewer 1"), was biased against him because "[Peer Reviewer 1] had been a member of the Board of Physicians at the time [ ] that

[Dr. Paden] entered into a Consent Order in May 2014." (Dr. Paden's Exceptions at 4.) According to Dr. Paden, "[Peer Reviewer 1] clearly had knowledge of [Dr. Paden]'s prior disciplinary history at the time that [Peer Reviewer 1] agreed to serve as a peer reviewer for the Board." *Id.*

Section 14-401.1(e)(5) of the Health Occupations Article provides, however, that "[t]he hearing of charges may not be . . . challenged because of the selection of peer reviewers under this subsection before the filing of charges." The Panel interprets this to mean that the selection of peer reviewers that took place before the filing of charges cannot be challenged. However, if the selection of a peer reviewer before the filing of charges actually compromised a licensee's opportunity for a full and fair hearing, then the Panel would allow for that challenge. *See Bd. of Physician Quality Assur. v. Levitsky,* 353 Md. 188, 206 (1999).

In this case, there has been no showing that Dr. Paden's opportunity for a full and fair hearing was compromised. Peer Reviewer 1 did not testify in the evidentiary hearing, and Peer Reviewer 1's report was not entered into evidence.[4] The second peer reviewer, not Peer Reviewer 1, testified during evidentiary hearing. Dr. Paden's challenge regarding [Peer Reviewer 1] is therefore precluded.

Furthermore, even if Dr. Paden's challenge were not precluded, the record does not show that Peer Reviewer 1 was biased or even that Peer Reviewer 1 had knowledge of the Consent Order. As the ALJ explained, other than the fact that Peer Reviewer 1 was on the Board at the

[4] Stipulated Fact 5 states that, during the investigation, "the peer reviewers found deficiencies in [Dr. Paden]'s prescribing practices and record keeping." Peer Reviewer 1's findings, however, were not considered by the ALJ or Panel A in determining whether Dr. Paden violated the standard of care or kept adequate medical records. Stipulated Fact 5 only sets forth the facts of the investigation that led to the charges. This stipulated fact was not used substantively by either the ALJ or Panel to determine whether Dr. Paden was guilty of the grounds alleged in the charges.

time Dr. Paden entered into the Consent Order, "[Dr. Paden] offered no additional facts to support his assertion that [Peer Reviewer 1] had bias that influenced her peer review decision." (ALJ's Proposed Decision at 4.) Moreover, Dr. Paden entered into the Consent Order, in 2014, with Board Disciplinary Panel B ("Panel B"), and there is no material in the record of this case establishing that Peer Reviewer I was a member of Panel B. If Peer Reviewer 1 had not been a member of Panel B, then one can only speculate as to whether Peer Reviewer 1 was even aware of the Consent Order. And, even if Peer Reviewer 1 had been on Panel B at the time Dr. Paden entered into the Consent Order, there is no showing that Peer Reviewer I remembered that case when she performed the peer review or harbored any bias against Dr. Paden.

Dr. Paden claims that bias is proven by the number of violations found by Peer Reviewer 1 in comparison to the number of violations found by the second peer reviewer. According to Dr. Paden, Peer Reviewer 1 found that Dr. Paden violated the standard of care with respect to his treatment of nine of the ten patients at issue and failed to keep adequate medical records with respect to eight of the ten patients. Dr. Paden states that the second peer reviewer found that Dr. Paden violated the standard of care with regards to his treatment of six of the ten patients at issue and kept inadequate medical records with regards to two of the ten patients. The Panel does not find this convincing. If one were to accept Dr. Paden's argument, then anytime peer reviewers do not find the same number of violations there would be a demonstration of bias. A difference of professional opinion does not equate to bias. The exception is denied.

4. 18-Month Investigation Provision

Dr. Paden argues that the ALJ erred by denying his motion to dismiss, which argued that the disposition of the complaint surpassed the 18-month period set forth in § 14-401.1(k) of the

Health Occupations Article. Dr. Paden contends that the 18-month period set forth in § 14-401.1(k) is mandatory. Section 14-401.1(k) reads:

> It is the intent of this section that the disposition of every complaint against a licensee that sets forth allegations of grounds for disciplinary action filed with the Board shall be completed as expeditiously as possible and, in any event, within 18 months after the complaint was received by the Board.

The Board received the complaint on October 25, 2016, and the charges were filed approximately 19 months later, on May 21, 2018.

Dr. Paden claims, "the 'disposition' of the complaint, in terms of commonly accepted usage, was not until May 1, 2019." The ALJ issued her proposed decision on May 1, 2019. Dr. Paden thus argues that "[t]his constitutes a delay of some 32 months, almost twice the time period specified in the statute." The Panel does not accept that the commonly accepted usage of "disposition" is the date of the ALJ's proposed decision. While the disposition of the complaint could possibly mean any number of occurrences, the Panel finds that the issuance of the ALJ's proposed decision is not one of them.

More importantly, Dr. Paden is incorrect that the 18-month period in § 14-401.1 is mandatory. In *Solomon v. Board of Physician Quality Assurance,* 130 Md. App. 447, 456 (2000), the Court of Special Appeals held that this 18-month period is not mandatory.

The ALJ noted that Dr. Paden "had not alleged any prejudice or violation of his due process rights as a result of the slight delay." In his exceptions, Dr. Paden asserts that any delay in disposing of a disciplinary matter "inherently" creates prejudice. Dr. Paden's assertion of inherent prejudice does not establish actual prejudice, and the Panel finds that the assertion of inherent prejudice does not suffice for the Panel to grant the exception. Dr. Paden's exception is denied.

5. Dr. Paden's Professional Background

Dr. Paden faults the ALJ for only noting Dr. Paden's medical experience beginning in 2005, which was when Dr. Paden became board-certified in physical medicine and rehabilitation.[5] Dr. Paden states, the "ALJ completely disregarded [Dr. Paden]'s medical knowledge, training and experience for the previous twenty years from 1985 to 2005, apparently finding it unworthy of consideration." Dr. Paden was not accepted as an expert in this case because he did not submit a written expert report as required by COMAR 13.02.04.03B. And Dr. Paden's exception does not explain how his experience between 1985 to 2005 is relevant to the issues in this case. And the Panel declines to guess why Dr. Paden believes his professional experience between 1985 and 2005 is relevant. Without, at least, an explanation as to how Dr. Paden's experience between 1985 and 2005 is relevant to the issues in this matter, the Panel cannot find that the ALJ erred. The exception is denied.

6. Dr. Paden's Response to Advisory Letter

Dr. Paden takes exception to the ALJ's finding that he "completely ignored" the advice the Board gave him in a June 30, 2014, advisory letter, which recommended that he improve his monitoring of patients by using unannounced toxicology screens and pill counts. Dr. Paden testified that, in response to the advisory letter, he contracted with Millennium Labs in 2014 to perform urine drug screens. He further testified that he used Millennium until 2016. The records substantiate that Dr. Paden did hire Millennium in response to the Board's 2014 advisory letter. This exception is accepted. The Panel, therefore, does not find that Dr. Paden "completely ignored" the Board's 2014 advisory letter.

[5] Dr. Paden's board-certification in physical medicine and rehabilitation expired in December 2015.

7. Patient 4's Toxicology Screen on September 18, 2014

The ALJ found that, on September 18, 2014, Patient 4 "tested positive for Oxycodone, Oxymorphone, and Methadone. [Dr. Paden] had not prescribed these drugs to the Patient." (ALJ's Proposed Finding of Fact 54.) Dr. Paden argues that the records establish that the patient was being prescribed "oxycodone and methadone" at the time of the drug test. Dr. Paden cites to VB4811, which only shows the results of the urinalysis. The results state that an analyte for Oxycodone, Oxymorphone, and Methadone were detected "but no corresponding medication reported."

The Panel's review of Dr. Paden's records, however, shows that the patient was prescribed Methadone and Roxicodone[6] on August 20, 2014. (VB5272.) The exception is accepted. The Panel, therefore, replaces the part of the ALJ's proposed finding of fact 54 stating that "[Dr. Paden] had not prescribed these drugs to the Patient." The Panel finds instead that Dr. Paden prescribed Methadone and Roxicodone to Patient 4 on August 20, 2014.

8. Patient 9's June 8, 2011, Positive Drug Test for Methadone

The ALJ found that, on June 8, 2011, Patient 9's "lab screen was positive for methadone even though she was not prescribed methadone." (ALJ's Proposed Finding of Fact 69.) Dr. Paden's exception states, "the records reflect that the patient was receiving 100 mg per day of methadone. The patient suffered an overdose on June 22, 2012. (¶22)." Dr. Paden provides no citation to support his representation that the patient was receiving 100 mg per day of methadone. In any event, Patient 9's most recent visit to Dr. Paden before June 8, 2011, was on May 17, 2011, which appears to be the patient's initial visit with Dr. Paden. The Panel was able to find in the records for May 17, 2011, a Pain Questionnaire in which Patient 9 listed

[6] Roxicodone is the brand name of medication that contains oxycodone.

Methadone as a pain medication she was currently taking. (VB13725.) Dr. Paden's exception is accepted. The Panel, therefore, does not adopt the ALJ's Findings of Fact 69.

9. No Referrals for Psychiatric Care or Rehabilitation Program for Patient 9 after Apparent Overdose in 2012

The ALJ found that Dr. Paden "did not follow up with [Patient 9] on the June 2012 apparent overdose by either referring her for psychiatric care or a rehabilitation program." (ALJ's Proposed Finding of Fact 75.) Dr. Paden took exception to this finding, arguing that it "erroneously implies that [Dr. Paden] took no action in response to the overdose." Dr. Paden asserts that he followed-up with the patient one day after the patient's discharge from the hospital and that, at that follow-up, the patient agreed that she would not be in control of dispensing her daily medication and that her sons would control her medication. Dr. Paden also asserts that he decreased the dosages of the patient's opioid medications "at the same visit." The Panel denies this exception.

Dr. Paden's representation that he took some measures with respect to Patient 9 in response to the patient's 2012 overdose does not indicate that the ALJ's finding was "clearly erroneous." The ALJ accurately specified two measures that Dr. Paden did not take in following-up on the patient's 2012 overdose. Moreover, the Panel does not find that the ALJ's proposed finding implies that Dr. Paden took no action. The ALJ's finding simply sets forth the fact that, in following-up on the patient's apparent overdose in 2012, Dr. Paden did not refer the patient for psychiatric care or a rehabilitation program.

Dr. Paden's exception also states that the follow-up visit with the patient was on "*July 3, 20[1]2.*" (Italics added.) But Dr. Paden also states in the exception that "[t]he patient's opioid medications were also decreased *at the same visit* from 580 to 320 MME *on March 26, 2013.*" (Italics added.) The July 3, 2012 visit, however, is not the same as the March 26, 2013 visit.

The March 26, 2013, visit was after the patient's second overdose episode, which occurred in March 2013.

10. Urine Drug Screens for Patient 10 after 2012

Dr. Paden's exception 10 asserts:

> [t]he ALJ states that in regard to Patient 10, the records do not reflect that [Dr. Paden] monitored the patient with UDS [urine drug screens] subsequent to August 1, 2012. On the contrary, the medical records reveal that Patient 10 was monitored on September 24, 2014 . . . and February 18, 2015.

There is a discrepancy in the ALJ's findings. The ALJ's proposed finding of fact 84 states, "[Patient 10] had the following three urine drug screens while under [Dr. Paden]'s care: June 29, 2012, September 24, 2014 and February 18, 2015." Additionally, on page 37 of the ALJ's proposed decision, the ALJ, referring to Patient 10, wrote, "The Patient had the following three urine drug screens while under [Dr. Paden]'s care: June 29, 2012, September 24, 2014 and February 18, 2015." However, the ALJ's finding of fact 88 states, "[t]he records do not reflect that [Dr. Paden] monitored the Patient with urine drug screens subsequent to the Patient's August 1, 2012 office visit." The Panel, therefore, modifies the ALJ's finding of fact 88 to state: The records do not reflect that Dr. Paden monitored the Patient with urine drug screens subsequent to the Patient's August 1, 2012 office visit *until September 24, 2014.*

CONCLUSIONS OF LAW

Based upon the findings of fact and discussion, Panel A concludes that Dr. Paden failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care performed in this State, in violation of § 14-404(a)(22) of the Health Occupations Article; and failed to keep adequate medical records as determined by appropriate peer review, in violation of § 14-404(a)(40) of the Health Occupations Article.

Sanctions

The ALJ recommended that the Panel reprimand Dr. Paden and place him on probation for two years. During the first year of probation the ALJ recommended that Dr. Paden be prohibited from prescribing CDS, except in emergency situations. The ALJ also proposed that Dr. Paden be required to complete courses on opioid prescribing and medical documentation and that, after the first year of probation, he be supervised by a panel approved peer reviewer. Finally, the ALJ recommended that the Panel issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program.

The ALJ noted that Dr. Paden demonstrated a genuine concern for the well-being of his patients and that his prescribing was not indicative of "pill mill." The ALJ, however, found that Dr. Paden "fail[ed] to monitor his patients for compliance" with his care and treatment, and that he failed to "follow-up with patients when non-compliance was apparent." The ALJ determined that Dr. Paden's drug testing of patients, in which he ordered drug testing only once per year per patient, was far too infrequent for these high-risk patients.

Dr. Paden argues that a less severe sanction is appropriate. He emphasizes the portion of the State's expert's testimony in which the expert stated that Dr. Paden did not operate a "pill mill," had a genuine interest in his patients, and spent a substantial amount of time with patients. Concerning the specific sanctioning conditions recommended by the ALJ, he disagrees with the one-year prohibition on prescribing CDS, which he believes is excessive.

The Panel finds that there are crucial aspects of Dr. Paden's CDS treatment that are in need of significant improvement. Dr. Paden's monitoring of his patients' compliance with his CDS treatment was unacceptable. The drug testing he ordered for these high-risk patients was far

from adequate. There also was inadequate follow-up with respect to significant red flags, noncompliance, and alternative treatments.

Although the Panel has, based upon Dr. Paden's exceptions, rejected or modified several of the ALJ's findings, those changes are relatively minor, especially in comparison to the ALJ's findings that were adopted by the Panel, and those changes do not affect the crux of the findings. The Panel finds that terms and conditions recommended by the ALJ for sanctioning are necessary to ensure the safe use of CDS. The Panel, therefore, adopts, in general, those terms and conditions. The prohibition on prescribing CDS will go into effect 30 days after the execution of this Final Decision and Order to allow for an orderly transition of treatment of patients needing non-emergency CDS prescriptions.

ORDER

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

ORDERED that Dr. Paden is **REPRIMANDED**; and it is further

ORDERED that Dr. Paden is placed in **PROBATION** for a minimum period of **TWO YEARS.** During probation, Dr. Paden shall comply with the following terms and conditions of probation:

1. (a) For a minimum period of **one year**, except as provided in probationary condition 1(b), the Respondent is prohibited from prescribing and dispensing all Controlled Dangerous Substances ("CDS"). The CDS are set forth in §§ 5-401 *et seq.* of the Criminal Law Article, Annotated Code of Maryland. This condition goes into effect **30 days** after this Final Decision and Order goes into effect;

   (b) In emergency cases, the Respondent may issue no more than one prescription for a CDS listed above for each patient per year, but the prescription may not exceed the lowest effective dose and quantity needed for a duration of five days. The prescription may not be refilled, nor may it be renewed. The Respondent shall notify the Board within 24 hours of any prescription written under the authority of this paragraph;

(c) The Respondent is prohibited from certifying patients for the medical use of cannabis;

(d) The Respondent's delegation agreements, if any, shall be modified to prohibit the Respondent from supervising physician assistants in their prescribing of CDS as limited by this Order;

(e) The prohibition on prescribing and dispensing CDS goes into effect 30 calendar days after this Final Decision and Order goes into effect;

(f) After one year from the date the prohibition on CDS prescribing and dispensing goes into effect, the Respondent may petition the Panel to lift the prohibition;

2. Within **SIX (6) MONTHS**, the Respondent is required to take and successfully complete courses in opioid prescribing and in medical documentation. The following terms apply:

(a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the courses are begun;

(b) the disciplinary panel will not accept a course taken over the internet;

(c) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

(d) the courses may not be used to fulfill the continuing medical education credits required for license renewal;

(e) the Respondent is responsible for the cost of the courses.

3. After the prohibition on the Respondent prescribing CDS is terminated, the Respondent shall be subject to supervision for a minimum period of **one year**[7] by a disciplinary panel-approved supervisor who is board-certified in physical medicine and rehabilitation as follows:

(a) At least **30 days** before the condition prohibiting the Respondent from prescribing CDS can be terminated, *see* Probationary Condition 1(a), the Respondent shall provide the disciplinary panel with the name, pertinent professional background information of the supervisor whom the Respondent is

[7] If the Respondent is not practicing medicine, the supervision shall begin when the Respondent resumes the practice of medicine and the disciplinary panel has approved the proposed supervisor. The Respondent shall submit the name of a proposed supervisor at least 30 days before the Respondent returns to the practice of medicine and shall be subject to supervision by a disciplinary panel approved supervisor upon the return to the practice of medicine.

offering for approval, and written notice to the disciplinary panel from the supervisor confirming his or her acceptance of the supervisory role of the Respondent and that there is no personal or professional relationship with the supervisor;

(b) the Respondent's proposed supervisor, to the best of the Respondent's knowledge, should not be an individual who is currently under investigation, and has not been disciplined by the Board within the past five years;

(c) the disciplinary panel, in its discretion, may accept the proposed supervisor or request that the Respondent submit a name and professional background, and written notice of confirmation from a different supervisor;

(d) the supervision begins after the disciplinary panel approves the proposed supervisor;

(e) the disciplinary panel will provide the supervisor with a copy of this Final Decision and Order and any other documents the disciplinary panel deems relevant;

(f) the Respondent shall grant the supervisor access to patient records selected by the supervisor, which shall, to the extent practicable, focus on the type of treatment at issue in the Respondent's charges;

(g) if the supervisor for any reason ceases to provide supervision, the Respondent shall immediately notify the Board and shall not practice medicine beyond the 30th day after the supervisor has ceased to provide supervision and until the Respondent has submitted the name and professional background, and written notice of confirmation, from a proposed replacement supervisor to the disciplinary panel;

(h) it shall be the Respondent's responsibility to ensure that the supervisor:

(i) reviews the records of 10 patients each month, such patient records to be chosen by the supervisor and not the Respondent;
(ii) meets in-person with the Respondent at least once each month and discusses in-person with the Respondent the care the Respondent has provided for these specific patients;
(iii) be available to the Respondent for consultations on any patient;
(iv) maintains the confidentiality of all medical records and patient information;
(v) provides the Board with quarterly reports which detail the quality of the Respondent's practice, any deficiencies, concerns, or needed improvements, as well as any measures that have been taken to improve patient care; and
(vi) immediately reports to the Board any indication that the Respondent may pose a substantial risk to patients.

(i) if the disciplinary panel, upon consideration of the supervisory reports and the Respondent's response, if any, has a reasonable basis to believe that the Respondent is not meeting the standard of quality care or failing to keep adequate medical records in his or her practice, the disciplinary panel may find a violation of probation after a hearing.

4. A disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's CDS prescriptions. The administrative subpoenas will request the Respondent's CDS prescriptions from the beginning of each quarter; and it is further

ORDERED that a violation of probation constitutes a violation of this Order; and it is further

ORDERED that, after the Respondent has complied with all terms and conditions of probation and the minimum period of probation imposed by the Order has passed, the Respondent may submit to the Board a written petition for termination of probation. After consideration of the petition, the probation may be terminated through an order of the disciplinary panel. The Respondent may be required to appear before the disciplinary panel to discuss his or her petition for termination. The disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel, if the Respondent has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

ORDERED that the Final Decision and Order goes into effect upon the signature of the Executive Director of the Board. The Executive Director signs the Final Decision and Order on behalf of Board Disciplinary Panel A; and it is further

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

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by this Order, the Respondent shall be given notice and an opportunity for a hearing. If a disciplinary panel determines there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if a disciplinary panel determines there is no genuine 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 the Respondent has failed to comply with any term or condition imposed by this Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

ORDERED that this Final Decision and Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

12/12/2019
Date

Signature on File
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. Paden 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 Final Decision and Order was sent on the date of the cover letter accompanying the Final Decision and Order. 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. Paden petitions for judicial review, the Board is a party and should be served with the court's process. In addition, Dr. Paden 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.

Exhibit 1

MARYLAND STATE BOARD OF	*	BEFORE GERALDINE A. KLAUBER,
PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
VABIAN L. PADEN, M.D.,	*	OF ADMINISTRATIVE HEARINGS
RESPONDENT	*	
LICENSE No.: D60744	*	OAH No.: MDH-MBP-71-18-33087

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

PROPOSED DECISION

STATEMENT OF THE CASE

On May 21, 2018, a disciplinary panel of the Maryland State Board of Physicians (Board) issued charges against Vabian L. Paden, M.D., (Respondent) alleging violations of the State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 through 14-508, and 14-601 through 14-607 (2014 & Supp. 2018). Specifically, the Respondent is charged with violating section 14-404 of the Act. Health Occ. 14-404(a)(22) and (40) (Supp. 2017); Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d). The disciplinary panel to which the complaint was assigned forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) for issuance of Proposed Findings of Fact, Proposed Conclusions of Law and Proposed Disposition. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

I held a hearing on February 6 and 7, 2019 at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland. Health Occ. § 14-405(a) (Supp. 2018); COMAR 10.32.02.04. Thomas C. Morrow, Esquire, represented the Respondent, who was present. Victoria H. Pepper, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State).

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board of Physicians, and the Rules of Procedure of the Office of Administrative Hearings. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2018); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent violate section 14-404(a)(22) of the Medical Practice Act by failing to meet appropriate standards for the delivery of quality medical care in connection with his prescribing of opioids for the treatment of chronic pain?
2. Did the Respondent violate section 14-404(a)(40) of the Medical Practice Act by failing to keep adequate medical records as determined by appropriate peer review?
3. What sanctions, if any, are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits into evidence on behalf of the State:[1]

State Ex. 1 - Complaint, October 25, 2016

State Ex. 2 - Memorandum of Board staff site visit, April 18, 2017

State Ex. 3 - Subpoena Duces Tecum, April 18, 2017

[1] Due to the voluminous patient records, the parties stipulated that State's exhibits 1-16 were an abstract of the records of the patients at issue for "illustrative" purposes. The parties submitted a disc containing the entire patient records for admission.

State Ex. 4 - Subpoena Ad Testificandum and transcript of May 12, 2017 Board staff interview of Respondent

State Ex. 5 - Certification of Medical Records, May 3, 2017, and extract of medical records for Patient #2

State Ex 6 - Certification of Medical Records, May 3, 2017, and extract of medical records for Patient #4

State Ex. 7 - Certification of Medical Records, May 3, 2017, and extract of medical records for Patient #6

State Ex. 8 - Certification of Medical Records, May 3, 2017, and extract of medical records for Patient #9

State Ex. 9 - Certification of Medical Records, May 3, 2017, and extract of medical records for Patient #10

State Ex. 10 - Curriculum Vitae of [redacted]

State Ex. 11 - Peer review report by [redacted]

State Ex. 12 - Consent Order, May 10, 2014; Order, December 10, 2014

State Ex. 13 - Advisory Letter, June 20, 2014

State Ex. 14 - Advisory Letter, July 29, 2016

State Ex. 15 - Charges under the Maryland Medical Practice Act, May 21, 2018

State Ex. 16 - Disc containing material sent to peer reviewers including complete patient records for Patients 1-10

The Respondent offered no exhibits into evidence.

Testimony

The following witnesses testified on behalf of the State:

[redacted] who was accepted as an expert in pain management, including the diagnosis and treatment of chronic pain and the application of the appropriate standard of quality of care for treatment of chronic pain patients;[2]

Molly Dicken, Compliance Analyst, Board Investigation Unit.

The Respondent testified in his own behalf.[3]

MOTION TO DISMISS

The Respondent moved to dismiss the charges on two grounds. First, the Respondent argued that one of the peer reviewers [redacted], was a member of the Board when a Consent Order of May 10, 2014 was entered into with the Respondent in a separate matter. The Consent Order pertained to the Respondent's failure to cooperate and respond to the Board's investigation of the Respondent. The Respondent contended that [redacted] prior knowledge of the Respondent made it unfair to the Respondent for [redacted] to participate in the peer review, and her participation tainted the peer review process.

I find this argument without merit. The fact that [redacted] was on the Board at the time of the Respondent's prior Consent Order that dealt with a matter unrelated to the Respondent's standard of care does not establish any bias on the part of [redacted]. The Respondent offered no additional facts to support his assertion that [redacted] had bias that influenced her peer review. Additionally, [redacted] was the second peer reviewer, besides [redacted] who found the Respondent had violated the Maryland Medical Practice Act with regard to standard of care and medical record keeping. The Board is entitled to rely solely upon

[2] [redacted] expertise includes interventional treatment modalities, the application of appropriate prescribing and dosing of opioids, recognition and management of aberrant patient behavior, recognition and management of diversion of opioids. His expertise also includes adequate record keeping of the care and treatment of patients.

[3] The Respondent requested that he be accepted as an expert in rehabilitation and physical medicine. I denied the Respondent's request based on the State's argument that the Respondent had not filed a written report as required by COMAR 13.02.04.03B and because the Respondent has not been Board certified since 2015.

one peer reviewer's testimony to support its case. [redacted] was not offered to provide her expert opinion in the matter.

The Respondents also argued that the charges must be dismissed because the disposition of the complaint was not made within eighteen months from the Board's receipt of the complaint. The Board received the complaint on October 25, 2016 and the charges were not made until May 21, 2018. Thus, the disposition was not made until approximately nineteen months from the Board's receipt of the complaint. In support of his argument, the Respondent cites the provision in the Medical Practice Act that states, "that the disposition of every complaint... shall be completed as expeditiously as possible and, in any event, within 18 months after the complaint was received by the Board." Md. Code Ann., Health Occ. § 14-401.1(k).

The Respondent's argument is without merit. The Court of Special Appeals has specifically held that the eighteen-month period for completing the disposition of complaints is directory and not mandatory. *Solomon, M.D., v. Board of Physician Quality Assurance*, 130 Md. App. 447, 456 (2000). The Respondent had not alleged any prejudice or violation of his due process rights as a result of the slight delay in completing the disposition of the matter. Thus, the Respondent's motion to dismiss the charges is denied.

STIPULATED FACTS

The parties stipulated to the following facts:

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on August 4, 2003. His license is scheduled to expire on September 30, 2019.

2. The Respondent was board-certified in physical medicine and rehabilitation; however, his certification expired in December 2015.

3. The Respondent maintains an office for the practice of medicine in Waldorf, Maryland.

4. The Board initiated an investigation of the Respondent after receiving a complaint dated October 25, 2016, from a law enforcement official who reported concerns about the quantity of opioids the Respondent was prescribing.

5. In furtherance of its investigation, the Board obtained ten patient records from the Respondent for review. The Board referred the patient charts and related materials to a peer review entity for review. The peer reviewers found deficiencies in the Respondent's prescribing practices and record keeping.

6. In furtherance of the Board's investigation, the Board staff interviewed the Respondent under oath.

7. The medical records transmitted to the Board by the Respondent in response to the Board's subpoena are authentic.

8. The Board has disciplined the Respondent previously. In 2014, the Board charged the Respondent with failure to cooperate with a legitimate investigation conducted by the Board after the Respondent failed to fully comply with a Board subpoena for patient records for almost nine months. To resolve the charges, the Respondent entered into a Consent Order under the terms of which the Board concluded as a matter of law that the Respondent had failed to cooperate with a lawful investigation of the Board in violation of Health Occ. §14-404 (a)(33), and order that the Respondent pay a monetary fine of $2,000.00 within six months. In July 2016, in response to a complaint with a pharmacist, the Board issued to the Respondent an Advisory Letter that advised him to be accessible to patients and pharmacists.

PROPOSED FINDINGS OF FACT

I find the following additional facts by a preponderance of the evidence:

BACKGROUND FACTS

1. In 2005, the Respondent became Board certified in physical medicine and rehabilitation, also known as physiatry. The goal of a physiatrist is to optimize a patient's functioning.

2. In 2005, the Respondent began working at Potomac Pain and Rehabilitation located in La Plata, Maryland. The Respondent worked with that business until 2008. (TR[4] 218)

3. In 2008, the Respondent started his own practice, which was located at 20 St. Patrick Drive, Suite 404, Waldorf, Maryland. In his practice he addressed patients' musculoskeletal complaints and helped manage their chronic pain. In 2016, the Respondent moved his business location to 3225 Old Washington Road, Suite 105, Waldorf, Maryland. (TR 219).

4. In 2008, the Respondent's practice consisted of approximately ninety to one hundred patients and he was working five days per week. (TR 221).

5. The Respondent's wife, a psychiatrist, and his sister, a certified nurse technician, would help the Respondent with billing. In 2011, the Respondent and his wife separated. As a result, the Respondent's financial situation changed and he was not able to hire staff to perform the administrative duties that his wife had been performing on his behalf. (TR 221-222).

6. Between 2011 and 2016, the Respondent discharged many patients and began practicing on a part-time basis. At that time he had approximately eighty patients under his care. (TR 223).

[4] TR refers to the transcript of the hearing and the corresponding page number follows.

7. On October 25, 2016, the Board's Investigation Unit received a complaint from the Calvert County Sheriff's officer regarding concerns surrounding the Respondent and fraudulent prescriptions.[5] (TR 173-174).

8. On April 18, 2017, Board Compliance Analyst Molly Dickens made an unannounced visit to the Respondent's medical office. The purpose of the visit was to serve the Respondent with a subpoena for the immediate delivery of ten patient records. Ms. Dickens also requested that the Respondent provide a summary of care for the patients. (TR 179, 183).

9. Due to the voluminous nature of the records, the Respondent was originally provided until May 2, 2017 to produce the documents. The Board subsequently granted the Respondent an extension for the production of the records to May 12, 2017. The Respondent produced the requested records to the Board on that date. The Respondent never provided a summary of care of the patients requested by the Board. (TR 184).

10. The ten patient records provided to the Board by the Respondent were referred for peer review. Permedion is a formal peer review organization with which the Board has a contract to obtain peer reviews. [redacted] was contacted by Permedion to conduct a peer review of the Respondent. (TR 32).

11. As part of his peer review and in preparation for his testimony in this case, [redacted] reviewed the patient records obtained by the Board, the Board's charges, and the Respondent's testimony to the Board on May 12, 2017.[6] (TR 35).

12. All of the patients included in the peer review had been referred to the Respondent for pain management. (State Ex. 11[7]).

[5] The facts alleged in the Charles County Sherriff's office complaint were not part of the Board's charges and the allegations contained in that complaint are not relevant to this matter.
[6] All of these documents are contained in the State's exhibits.
[7] Where applicable I have referenced the Peer Review Report as State's exhibit 11.

13. [redacted] completed and submitted a peer review report, which included his findings. He found that the Respondent failed to meet the standards for the delivery of quality medical care with respect to his treatment of Patients 2, 4, 6, 9 and 10, and that his medical records were inadequate with respect to Patients 4 and 9. (State Ex. 11).

14. Pain management entails managing pain with various modalities and usually refers to either medical management of pain or interventional management of pain. Pain management involves a number of different treatments (modalities) for the alleviation of pain, ranging from relatively benign treatments such as physical therapy, acupuncture and the use of non-prescription analgesics, to the prescription of highly addictive drugs, for which prescriptions are required. Among these latter drugs are opioids. Interventional management of pain is often used in combination with medical management and includes procedures such as epidurals, steroid injections, facet blocks, and implanting devices. (TR 20).

15. Chesapeake Regional Information System (CRISP)[8] is a health information exchange service contracted by the State of Maryland, which provides patient history, including prescriptions. The information contained in CRISP includes the physician who prescribed the medication(s) and the pharmacy that filled the prescription. CRISP is used by physicians to check if patients are receiving other prescribed medications from other physicians. CRISP came into existence on or around 2014. It did not become a mandate that physicians use CRISP as a resource until 2018. (TR 109).

16. The Respondent did not routinely check his patients' prescription histories through CRISP. (State Ex. 11; TR 62, 82 and 88).

[8]CRISP is also referred to as PDMP or prescription drug monitoring program. CRISP is the PDMP used in Maryland.

17. Opioids are Schedule 2 controlled dangerous substances regulated by the government. Schedule 2 drugs have the highest risk for diversion or abuse. Morphine Oxycodone, OxyContin[9], Methadone, Hydromorphone, Oxymorphone and Dilaudid are schedule 2 drugs. Oxycodone is a short acting opiate often used to treat episodic pain, also referred to as breakthrough pain. (TR 48).

18. Benzodiazepines, such as Ativan and Xanax, are anti-anxiety drugs or sedatives. The concomitant use of opioids and benzodiazepines has been correlated with potential respiratory related overdosing and increase the risk for an accidental overdose.

19. The standard of care for chronic opioid therapy include the following requirements:

- Close follow-up to check compliance;
- Offer alternative treatments to opioids;
- Counsel patients as to the risks of opioid medications;
- Require the patient submit to random urine screens to monitor for compliance;
- Require the patient to enter into an Opioid Agreement;
- See a functional benefit of the prescribed medication;
- A willingness to discharge a patient who is noncompliant. (State Ex. 11; TR 42-46).

20. The main purpose of medical documentation is to relay information to the next person who reads the patient's record as an understanding of the patient's treatment status. Medical records must be legible, organized, and sufficiently detailed to provide a clear understanding of the matters they address. An opioid agreement, or contract, is a fundamental element of the standard of care in treatment by a pain rehabilitation physician as to the terms

[9] Oxycodone and OxyContin are the commercial names for the long- and short-acting versions of the same drug. Opioids are derivatives of poppy. Some other opioids are codeine, morphine, and hydrocodone.

upon which the physician will prescribe CDS, the patient's responsibilities as to the consumption of those substances, and the circumstances pursuant to which the physician will no longer prescribe those substances and/or will terminate treatment. (TR 48-56).

21. The Respondent required that upon initiation of treatment his patients enter into an opioid contract. All of the patients included in the peer review entered into an opioid contract when they initiated treatment with the Respondent. (State Ex. 11).

22. In 2106, the CDS published guidelines regarding morphine equivalence (mme) for opioids. The guidelines included conversion tables setting out how to convert particular drugs to morphine equivalents. A mme is determined by using an equivalency factor to calculate a dose of morphine that is equivalent to the ordered opioid. (TR 46-47).

23 The risk of mortality increases significantly for a mme exceeding 100 mg. According to the CDS guidelines, prescribing opioids over a 90 milligram mme is considered a very high dose and requires a health care provider to document justification for prescribing a higher dose. (TR 111).

PATIENT 2

24 The Patient is sixty-seven years old and the Respondent began treating the Patient in 2004. The Patient has a history of multiple orthopedic traumas and poorly controlled diabetes with diabetic peripheral neuropathy. The Patient is on disability. (VB[10] 3109-3110).

25 The Respondent completed a thorough initial intake note for the Patient. The Respondent had face-to-face monthly visits with the Patient over the course of his treatment.

26 The Patient received treatment from a chiropractor and massage therapist while under the Respondent's care. (VB 3208). The Respondent referred the Patient several times to

[10] VB references the page of the patient record. The State's exhibits also included a Bates stamp. Because I reviewed all of the medical records for the Patients, including the records on the disc provided, for the sake of consistency, I have referenced the VB number only.

physical therapy and aqua therapy, but the mainstay of treatment was high doses of opioids and Gabapentin.[11] (VB, 3165, VB 3175). The Respondent added prescriptions of Ativan, Phenergan and Restoril to the regimen, which along with the high doses of prescribed opioids increased the risk of an accidental overdose.

27 While under the Respondent's care, the Patient's dosage of opioids continued to increase. In 2004, the Patient's medication regimen consisted of 650 mg of Percocet every six hours, and 60 mg of codeine, twice per day. By August 2016, the Respondent prescribed the Patient 25 mg of Promethazine,[12] morphine, 60 mg, every eight hours; Oxycodone, 15mg, every 4 to 6 hours (60 tablets) and Oxycodone, 30 mg IR[13], every four to six hours (150 tablets). The oxycodone and morphine prescribed to the Patient was well above 90 mme. (VB2342).

28 The Patient's assessment of his high level of pain did not significantly change over the course of time while under the Respondent's care. The Respondent did not investigate into the underlying causes of the Patient's constant high level of pain through confirmatory studies, such as an (EMG) or Nerve Conduction Studies (NCS). (TR 64).

29 While under the Respondent's care, the Patient had several falls, chronic nausea, and slurred speech. The Patient's records reflect falls on June 2009, (fell off of a ladder) (VB 3097), February 2012 (fell down stairs) (VB 2732), November 8, 2016 (fell in tub) (VB 1907), and August 16, 2016 (Patient reported falling five times in last three days and feeling drunk) (VB 1934), but the records do not reflect that the Respondent considered these symptoms to be a possible manifestation of poly pharmacy. The Respondent did not order urine drug screens or modify the Patient's drug regimen after these reported incidents.

[11] Gabapentin is also known as Gralise or Neurontin and is an anticonvulsant also used to treat nerve pain.
[12] Promethazine is an antihistamine used to control nausea associated with opiates but has an ancillary effect of accentuating the effect of opiates.
[13] IR stands for immediate release.

30 There are three random urine drug screens on record for the Patient. The urine drug screen on June 2, 2010 tested positive for morphine, but not Oxycodone. At the time of the urine drug screen, the Patient had been on a medication regimen that included Oxycodone. The Patient reported explanation for the absence of Oxycodone was that he lost twenty pills. (VB 1702).

31 Oxycodone is a frequently diverted drug. The negative urine screens for Oxycodone is a significant red flag for diversion. (TR 68).

32 The Patient's urine drug screen on September 16, 2014 tested positive for morphine and hydromorphone, drugs that had not been prescribed to the Patient. (VB 1708).

33 The Respondent did not follow up on the Patient's problematic drug screens with additional drug screens.

34 Over the courses of treatment, the Respondent's quality of note taking declined. The Respondent relied on templates for his note taking and the notes often appeared incomplete. A majority of the Respondent's notes are not legible. (TR 56-57).

PATIENT 4

35 The Patient was referred to the Respondent in September 2009 for reported pain in the Patient's lower back and leg. (TR 71).

36 The Respondent's record of October 21, 2009 reflects that in 2002 an MRI showed degenerative disc disease. (VBR 6124). The record further reflects that the Patient had back surgery in 1992. (VB 6126). The Patient also had a tear of the patellar ligament while under the Respondent's care. (Tr. 130).

37 The Patient had monthly face-to-face office visits with the Respondent. (State Ex. 11).

38 Over the course of treatment with the Respondent, the Patient had a forearm fracture requiring surgery, shoulder pain, and left knee pain. (State Ex. 11).

39 Upon referral to the Respondent, the Patient was taking high doses of opioids, specifically 60 mg of Methadone and 120mg Oxycodone daily.

40 In 2009, the Patient's medication regimen as prescribed by the Respondent consisted of Lyrica, 100 mg once a day; Tizanidine, (a muscle relaxant), twice a day; Methadone, 60 mg a day; and Percocet, 60 mg every four hours. By April 2017, the Patient's medication regimen consisted of the following: Methadone, 60 mg a day; Risperdal (for sleep); and Oxycodone, 30 mg four times a day. The Patient's prescribed mme was 420 mg. This was a significant increase in opioid dosage over the course of treatment by the Respondent. (Tr. 73).

41 The Respondent referred the Patient to acupuncture and physical therapy. The Respondent's records do not reflect verification of attendance from an acupuncturist or physical therapist. The Patient did not have surgical or interventional pain consults while under the Respondent's care. (TR 71).

42 The Patient had the following seven urine drug screens while under the Respondent's care: June 1, 2010, July 26, 2010, August 23, 2010, September 21, 2010, October 20, 2010, September 18, 2014 and March 4, 2015. (VB 4808-4825).[14]

43 The June 1, 2010 urine drug screen tested positive for Fentanyl, which is a drug that was not prescribed to the Patient. The Patient denied taking Fentanyl. (VB 4825).

44 The Patient's July 26, 2010 and August 23, 2010 urine drug screen tested positive for marijuana, fentanyl and Hydromorphone, none of which had been prescribed to the Patient. (VB4822; 4819-4821).

[14] [redacted] testified that the Patient had six urine drugs screens. However, VB 4808 through VB4825 (State Ex. 6, Bates 141-158) includes seven urine drug screen results, including July 26, 2010, which was not referred to on direct examination.

45 The Patient's justification for the positive test result for fentanyl and Hydromorphone was that the he was prescribed several different drugs in the past and had some left over patches which he took when his pain was severe.

46 On August 23, 2010, the Respondent performed a pill count of two of the Patient's prescriptions. The record only identifies the pills by color and not by name. The Respondent noted that there was an excess of the dark green pills and a shortage of light cream. (VB6005).

47 The Patient's September 21, 2010, urine drug screen tested positive for marijuana, which was at the time an illegal drug, even for medicinal purposes. (VB 4823).

48 Based on the results of the Patient's urine drug screens, on October 5, 2010, the Respondent referred the Patient to Walden/Sierra, Inc., (Walden), which is a drug and alcohol treatment /rehabilitation program. (VB 5978).

49 On November 11, 2010, Walden completed an assessment of the Patient using the Treatment Assessment Protocol (TAP) and DSM-IV criteria associated with psychoactive substance abuse disorders. As a result of the assessment and the Patient's addiction problem, Walden recommended the Patient participate in 90-day Level I group as well as submit to random urinalysis and weekly breath tests. (VB 4797).

50 The Respondent's notes of November 30, 2010 (VB 5915), March 28, 2011 (VB5849), and April 26, 2011 do not state that he received any reports from Walden. (VBR5836).

51 On May 23, 2011, the Patient reported to Respondent that he had completed treatment at Walden. (VB 5817).

52 On December 5, 2011, Walden faxed a document to the Respondent which verified that the Patient failed to enter treatment as recommended and had been discharged on November 17, 2010. (VB 4801).

53 The Respondent continued to prescribe the Patient Roxycodone and Methadone in 2011 through 2012. (VB 5873; VB 5453).[15]

54 The Patient's September 18, 2014, urine drug screen tested positive for Oxycodone, Oxymorphone and Methadone. The Respondent had not prescribed these drugs to the Patient. (VB 4811-4813).

55 The March 4, 2015 urine drug screen testified positive for Oxycodone, Oxymorphone and Methadone, all of which are drugs the Respondent had not prescribed to the Patient. (VB 4808-4810).

56 The Patient's medical records do not contain any urine dug screens after March 4, 2015. The Respondent continued to treat the Patient through March 2017. (VB 4871-4872).

57 The Patient had no surgical or interventional pain consults for his back while under the Respondent's care. The Respondent did not attempt to treat the Patient's lumbar pain with means other than opioids outside of early visits to physical therapy. (TR 71).

PATIENT 6

58 The Patient is a forty-two year old male who came under the Respondent's care in or about June 2012 from a referral by an orthopedist. The Patient has a history of bilateral hip replacement, and degenerative joint disease with reported pain in back, knee, hip and shoulder. (VB 8562, 8597-8599).

59 When the Patient came under the Respondent's care, he was on a medication regimen of 330 mg of Oxycodone a day. (VB8587; TR 83).

[15] These document numbers reference just two prescription dates. The Patient's records contain many prescriptions written from January 2011 through 2012.

60 In March 2017, the Patient was on a medication regimen that correlates to 230 mg of Oxycodone per day. (VB 7754; TR. 84). The prescribed medication dosage is well above the 90 mme proposed by the CDC. (TR 85).

61 The Patient had monthly face-to-face office visits with the Respondent.

62 The Patient had two urine drug screens while under the Respondent's care; September 21, 2014 and February 20, 2015. (VB 7706-7707).

63 The Patient's February 20, 2015 urine drug screen was positive for cocaine and morphine. (VB 7706).

64 The Respondent did not follow up with the Patient regarding the positive drug screen for cocaine at the Patient's next visit, and the Respondent did not discharge the Patient from his care as a result of the positive screen. (State Ex. 11).

PATIENT 9

65 On April 28, 2011, the Patient's treating physician referred the Patient to the Respondent for evaluation and pain management. The Patient is a fifty-six year-old morbidly obese smoker with chronic back pain, scoliosis, degenerative joint disease of the knees, carpal tunnel syndrome and depression. At all times relevant, the Patient has been on disability. (VB12212; VB 12390).

66 The Patient has a history of over thirty years of narcotic use. (VB,12389; VB12395).

67 The Patient had monthly face-to-face office visits with the Respondent.

68 While under the Respondent's care, the Patient had frequent falls, syncopal episodes and vomiting episodes. She had a CT scan in April 2012 for a purported episode of syncope. (VB12432).

69 On June 8, 2011, the Patient's lab screen was positive for methadone even though she was not prescribed methadone. (VB 124240).

70 In 2014, the Patient was diagnosed with metastatic breast cancer and had a mastectomy of the left breast. (VB 12302).

71 For the period of 2014-2015, the Respondent placed the Patient on a drug regimen that included high doses of opioids mixed with Xanax, a benzodiazepine. (TR. 92; VB 12510).

72 On June 22, 2012, the Patient was admitted to a hospital emergency department after being found non-responsive. Medical personnel assessed the Patient to have altered mental status, likely secondary to opiate and benzodiazepine overdose with a possible brain injury due to lack of oxygen. (VB12376).

73 On June 24, 2012, the Patient had a psychiatric evaluation at the hospital. The psychiatrist who performed the evaluation recommended inpatient psychiatric care and a rehabilitation program. (VB 12389-12390).

74 The Respondent's record of the Patient's visit following the hospitalization reflects that he was aware of the event. (VB13409-13410). The Respondent prescribed the Patient a two week supply of Gralise, a neuropathic pain medicine. By August 2012 the Patient was back on her monthly prescribed medications. (VB13390).

75 The Respondent did not follow up with the Patient on the June 2012 apparent overdose by either referring her for psychiatric care or a rehabilitation program.

76 The Patient had random urine drug screens on September 23, 2014 and March 4, 2015. (VB12263-12266).

77 On March 26, 2013, the Respondent noted that the Patient overdosed on Baclofen.[16] The Respondent noted that the Patient's reason for the overdose was that she had

[16] Baclofen is a muscle relaxant.

forgotten how many she had taken. (VB 13250). There is nothing in the Patient's records that indicate that the Respondent considered that overdose was a due to multiple medications, including her opioids. After the overdose, the Respondent stopped prescribing the Patient Baclofen. The Respondent's only documented follow-up on this overdose was his instruction that the Patient see a psychologist.

78 On September 22, 2016, the Patient reported early to the Respondent's office stating that she had "messed up" and taken all of her of MSIR[17] and her OxyContin in two weeks' time. (VB 12549).

79 The Patient had early refills on several occasions. (VB12794).

80 A patient running out of medication early is a red flag for risk of overdose. The Respondent did not follow up with the Patient in regard to her running out of medication early. (TR 94).

81 The Respondent did not consider the Patient for any interventional treatments such as physical therapy. The only medical consult the Respondent ordered for the Patient was with an orthopedist, who diagnosed her with severe symptomatic carpal tunnel syndrome. (TR 96).

PATIENT 10

82 The Patient transferred to the Respondent in 2012, after his treating orthopedic surgeon, who was recognized as an over-prescriber of opioids, died.

83 At the time of the peer review the Patient was a fifty-five year old male. The Patient has an extensive history of spinal procedures and since 1995 has undergone fifteen back surgeries. The Patient has been diagnosed with insulin dependent diabetes, hypertension, anxiety and depression. (VB14924).

[17] MSRI is immediate release form of morphine

84 The Patient had the following three urine drug screens while under the Respondent's care: June 29, 2012, September 24, 2014 and February 18, 2015.

85 The June 29, 2012 urine drug screen tested negative for opiates, which indicated non-compliance with his prescribed medications. (TR 102; VB 13847).

86 The Patient's urine drug screen of July 4, 2012 tested negative for opiates, despite being prescribed opiates. (VB 13847).

87 The Respondent discussed the negative screen with the Patient on August 1, 2012 and documented that he would "monitor for compliance with medication over next month. Decide from tests whether to stop meds and/or discharge." (VB 143851 ; VB 14870, VB 14876).

88 The records do not reflect that the Respondent monitored the Patient with urine drugs screens subsequent to the Patient's August 1, 2012 office visit.

DISCUSSION

Legal Background

The Board maintains that the Respondent is subject to discipline for violating the following provisions of the Maryland Medical Practice Act:

> (a) *In general.* – Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
> ...
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State[.]
> ...
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review;

Health Occ. § 14-404(a)(22) and (40) (2014 &Supp. 2018).

Before the Board takes any action under section 14-404(a), the individual against whom the action is contemplated is entitled to the opportunity for a hearing before an Administrative Law Judge (ALJ) at the OAH. Factual findings made by the ALJ shall be supported by a preponderance of the evidence. Md. Code Ann., Health Occ. § 14-405(b)(2) (2014).

The State, as the moving party acting on the Board's behalf, bears the burden to prove by a preponderance of the evidence that the Respondent violated the statutory provisions at issue. Md. Code Ann., State Gov't § 10-217 (2014); Md. Code Ann., Health Occ. § 14-405(b)(2) (2014); *Comm'r of Labor & Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34 (1996) (citing *Bernstein v. Real Estate Comm'n*, 221 Md. 221, 231 (1959)). As discussed below, I find that the State has met its burden with respect to the charges.

In support of its case, the State presented testimony from [redacted] was accepted as an expert in pain management and medical recordkeeping practices. [redacted] is a pain management physician in private practice at the Pain Management Institute in Bethesda, Maryland. He has practiced pain management for twenty-one years and is Board certified in anesthesiology and pain management. His experience in pain management includes a residency and fellowship at Walter Reed National Military Medical Center, where he also ran the pain management clinic for several years before leaving for private practice.

[redacted] explained that the practice of prescribing opioids has changed significantly over the twenty-one years that he has practiced. Throughout the course of his career he has continued extensive reading on what constitutes good prescribing practices, reading guidelines and consulting with colleagues on issues in the area of prescribing opioids. With regard to record keeping, [redacted] has reviewed many different patient charts and bases his knowledge of adequate medical charts on his many years of experience

[redacted] testified that when he agreed to conduct a peer review of the Respondent, he did not know the Respondent and he felt no pressure to come to conclusions either for or against the Respondent. He testified that his review included review of the Board's May 12, 2017 interview with the Respondent and the complete medical records of Patients 2, 4, 6, 9 and 10. He also reviewed the May 10, 2014 Consent Order and the June 20, 2014 and July 29, 2016 advisory letters to the Respondent in a separate case.

The Respondent did not object to [redacted] qualifications as an expert and I accepted him as an expert in pain management, including the diagnosis and treatment of chronic pain and record keeping for treatment of patients. The Respondent testified and opposed some of [redacted] opinions and conclusions, but he did not provide expert testimony that rebutted [redacted] opinions and findings of his peer review.

I found [redacted] to be a persuasive witness for the State. His explanations were clear and he was consistent in his opinions. He was thoughtful in reaching conclusions and gave the Respondent the benefit of the doubt in certain areas where he thought it was appropriate to do so. I therefore relied heavily on [redacted] testimony and written peer review report with respect to the adequacy of the Respondent's medical records in his practice of pain management treatment, and with respect to the quality of the Respondent's opioid prescribing practices.

Medical record keeping

[redacted] testified as to general criteria that should be met in order for medical record keeping to be considered appropriate. He explained that medical documentation serves several purposes, including some purpose unrelated to treatment, such as billing, but that the most important purpose of maintaining medical records is to relay information to the next person who may refer to it for treatment purposes. Thus, a medical record is adequate when, retrospectively,

a similarly-situated reasonable physician would be able to follow the doctor's reasoning. Also, the prescribing of opioids must be supported by appropriate reasoning and documentation. [redacted] explained that adequate medical record keeping includes documentation regarding why the patient is seeking care for pain, what particular issues the patient is experiencing, where the pain is located, and the location, nature and degree of pain. The physician also needs to document his or her findings on physical exam and after gathering all of the necessary information and arriving at an assessment. The physician must, perhaps most importantly, document a treatment plan.

As noted by [redacted], appropriate medical record keeping also means that a physician's notes must be legible. This requirement is for the obvious reason as otherwise they serve no purpose for anyone who needs to access and understand the patient record. [redacted] noted in his report that in many instances the Respondent's record keeping was not adequate because the Respondent's handwriting was illegible. Upon my review of the medical records that were included as marked exhibits, as well as those contained on the disc, I had difficulty deciphering the Respondent's handwriting on the vast majority of the Respondent's notes for all of the patients in question.

The Respondent met with these patients on a regular basis and had notes that corresponded to the visits. [redacted] pointed out the Respondent relied upon templates for his record keeping. Although [redacted] found that the Respondent kept adequate medical records for Patient 2, he noted that the templates were often incomplete or not filled out at all, upon my review of the records, I found that many of the templates, particularly later in the Respondent's treatment were blank or incomplete. [redacted] found the Respondent's record keeping with respect to Patients 6 and 10 were adequate. He again, however, noted that there were many blank pages of

templates for these Patients and his handwriting was so hard to read that it was difficult to assess the Respondent's decision making.

It was [redacted] opinion that the Respondent's record keeping for Patients 4 and 9 had the same issues with his use of templates along with the additional issue of illegible handwriting that rendered his record keeping substandard. [redacted] noted specifically with regard to Patient 4, the Patient's records totaled over 1,000 pages, yet despite the voluminous amount of notes and records maintained, a summary of care for this patient was notably absent. Additionally, [redacted] explained that it was problematic that Patient 4 was on large doses of opioids, yet there was no documented objective justification in the record for these doses other than the Patient's subjective complaints of pain.

[redacted] opined that the Respondent's record keeping for Patient 9 was inadequate because despite this patient's history and treatment regimen being complicated, the records did not contain a summary or otherwise legible notes from which one could ascertain the Respondent's thought process and decision making

Based on [redacted] testimony and my review of the records, I conclude that the Respondent's record keeping was often incomplete, illegible and did not adequately set forth the Respondent's justification for maintaining the patients on high dosages of opioids. These deficiencies render his record keeping inappropriate and support the State's charges.

Standard of Care in the practice of pain management

[redacted] testified that a general definition of "standard of care" as applied in this particular case is what a reasonable physician would do under the same or similar circumstances in the area or pain management. [redacted] explained that although some parts of the standard of care in pain management are somewhat subjective based upon the knowledge, training and

experience of a particular practitioner, and what is considered reasonable may differ some from reviewer to reviewer, there is a broad consensus as to certain fundamental aspects.

[redacted] explained further that his opinion regarding the standard of care for the treatment of chronic pain management patients was also based on his education, medical training, expertise, experience, his involvement in peer reviews, his interaction with other providers, and his reading of a variety of medical literature. Based on all of this input it is his opinion that the standard of care for treating chronic pain management patients included seven components. The first component requires the treating physician to follow up with the patient through face-to-face visits at least once every three months, to examine the patient and assess how the patient is doing. The second component of the standard of care is offering alternative treatments, which take into consideration the patient as a whole. The third component requires an opioid agreement or pain management contract signed by the provider and patient outlining the rules for the prescription of opioids. Along similar lines, a fourth component requires the physician to counsel the patient as to the risks associated with taking opioids, especially overdoses and falls. The fifth element offered by [redacted] requires the treating physician to have random urine screens, also referred to as UDS, for proper compliance with the use of opioid medication. He explained that the purpose of toxicology screening or other monitoring methods was to ensure that a patient was using the medication as prescribed, was not diverting the medication, and was not using non-prescribed or illicit substances. According to [redacted] a sixth component of the standard of care mandates that the treating physician see functional improvement in the patient as a result of the medications. Finally, the standard of care requires that the treating physician be willing to discharge a patient for noncompliance. The discharge often requires a referral to a rehabilitation center.

The Respondent testified on his own behalf, he did not offer any expert testimony or medical literature that disputed [redacted] assessment of the standard of care for chronic pain management patients. The Respondent's testimony was often circular, off point or difficult to follow. In some instances his responses were evasive, which rendered his testimony on several issues simply not credible.

I have accepted [redacted] opinions regarding the standard of care. [redacted] opined that the Respondent failed to comply with the standard of care in several respects with regard to each of these patients. For the reasons set forth below, I agree.

Patient 2

Patient 2 is a sixty-seven year old male with a history of orthopedic traumas that resulted in part from a 2002 motor vehicle accident and a 2004 work related accident. The Patient participated in several sports in earlier years, which contributed to a variety of degenerative orthopedic disorders. In addition, the Patient has poorly controlled diabetes, which causes him diabetic peripheral neuropathy pain.

The Respondent prescribed this Patient a very high dose of opioids (450 mme), including Oxycodone and morphine. According to [redacted] Patient 2's records do not support the high opioid dosage and despite the continued regimen of high dosages of opioids, the Patient had numerous and continual pain complaints. [redacted] also found problematic the Respondent's reliance on the Patient's subjective complaints and failure to require diagnostic tests to confirm the complaints or determine if there were alternatives other than continuation of high level of opioids. For example, Patient complained of pain in his legs and feet presumably from peripheral neuropathy, yet there is no record of an electromyogram or nerve conduction study to confirm or further analyze the condition. The record reflects that the Patient underwent an MRI

of the spine in 2004 and the only other reference to diagnostic testing is a January 13, 2017 note that indicates a need to complete an MRI. Without additional testing to assess the etiology of the Patient's pain complaints, it was not possible for the Respondent to recommend appropriate alternative treatments that would be beneficial to the Patient. Additionally, the record includes reports by the Respondent of continued nausea and four falls. The Respondent's lack of investigation as to sources of unrelenting pain was a violation of the standard of care.

The record reflects that the Respondent referred the Patient to physical therapy and aqua therapy but there were no additional referrals and there was no follow-up to determine if the Patient actually attended the therapy. [redacted] explained that one referral to a patient such as this, who continues to have various problems and pain complaints is not sufficient. Additionally, it was incumbent upon the Respondent to explore others sources of the patient's pain through diagnostic tests, but the Respondent did not order any diagnostic tests. The Respondent disputed [redacted] assertion that he had not met the standard of care because he did not offer the Patient alternative treatments. The Respondent noted that the Patient was already under a chiropractor's care. According to the Respondent, he gave the Patient shoulder injections and sent the Patient to physical therapy and aqua therapy. While there are some notes in the Patient's record documenting the Respondent's suggestion of physical therapy, there is nothing in the records to indicate that the Respondent followed up to see if the Patient was actually attending the therapies, if not why, or if so what benefit was being received. Interventional therapies as a viable option to high dose opioid therapy are only successful if the Patient actually attends. The Respondent's act of increasing prescribed dosages of opioids throughout the years without following up on viable alternative therapies was a violation of the standard of care.

The most concerning dereliction the standard of care regarding the Respondent's treatment of all of the patients, including Patient 2, was his failure to monitor patient compliance through the use of random drug screens. As explained by [redacted], one important purpose of random drug testing is to confirm that the patient is taking the prescribed medication and is not taking non-prescribed medications or illegal drugs. This is important not only for the patient's well-being, but it also is important to the community at large because it monitors for possible diversion of the drugs into the community. Some of the drugs prescribed to his patients have significant street value as recreational drugs and diversion is a common problem. According to [redacted] the generally accepted standard for the frequency of drug urine screens for patients on high doses of opiate therapy is once every three months.

The Respondent prescribed this Patient 450 mme of opioids, including Oxycodone and morphine, which as [redacted] explained, was a very high dose of opioids. The Respondent added prescriptions of Gabapentin, Ativan, Phenergan and Restoril to the regimen. These medications, along with the high doses of prescribed opioids, increased the risk of an accidental overdose. Despite this risk, the Patient had just three urine drug screens during eight years while under the Respondent's care.

Not only should the drug screens have been ordered more frequently for the Patient's wellbeing, but there was a red flag for diversion that the Respondent ignored. Two of the drug screens indicated non-compliance by the Patient. The Patient's urine screen on June 2, 2010, tested positive for morphine, but not Oxycodone. At the time of the UDS, the Patient had been on a medication regimen that included Oxycodone. Oxycodone has a high street value and is a frequently diverted drug. The Patient's reported explanation for the absence of Oxycodone was that he lost twenty pills. [redacted] testified that the Patient's excuse in one often used by patients who are noncompliant and is a red flag for diversion. This red flag required more

scrutiny on the Respondent's part, such as a follow up urine drug screen, but the Respondent did not do any follow-up testing.

There were also signs that the Patient was misusing his prescriptions. The Respondent's records of the Patient reflect that the Patient had falls in 2009, 2012 and 2016 as well as chronic nausea and slurred speech. There is no indication that the Respondent addressed these concerns with additional testing even after the Patient's urine drug screen on September 16, 2014 tested positive for morphine and hydromorphone, drugs that had not been prescribed to the Patient.

The Respondent's rebuttal of [redacted] opinion regarding the needed frequency of urine screens was contradictory and unsatisfactory. Respondent agreed that a component of the standard of care in the practice of pain management is verifying compliance with medication regimens. He stated that based his reading on the subject of the frequency of urine drugs screens, he understood that there was no hard guideline, and it is based on what the physician believes to be appropriate, and the frequency of his Patient's urine screens is "at least once a year." (State Ex. 4, pg. 27). The record for Patient 2 however, reflects that urine drugs screens were not administered even once a year as advocated for by the Respondent.

The Respondent explained that because he met with his patients monthly, he was able to tell if a patient was compliant by looking at the patient, talking to him or her and comparing the behaviors and statements to previous visits. This explanation is inconsistent with Patient 2's medical record. The Respondent denied seeing any aberrational behavior from the Patient, yet the Patient record includes office notes that document the Patient's reported falls, nausea and feelings of being drunk. The Respondent further denied that these reported behaviors are red flags for diversion because Patient 2 was an insulin dependent diabetic who was not taking good care of himself. He was not taking his medication for diabetes or high blood pressure. According to the Respondent, these conditions could have been the cause of his symptoms rather than the

symptoms being related to his opioid dosage. These excuses ring hollow because even when the Respondent had hard evidence of possible diversion through urine screens on June 2, 2010 and September 16, 2016, he did not require any follow-up testing. The Respondent's failure to order more frequent urine screens with this Patient was a clear violation of the standard of care.

PATIENT 4

Patient 4 was a thirty-nine year old male when referred to the Respondent in 2009 for pain management. The Patient suffered from chronic low back and leg pain and had previously been prescribed Soma, Oxycodone, Methadone, Percocet and fentanyl. Shortly after coming under the Respondent's care, the Patient fractured his left forearm and required surgery, which also became a chronic source of pain. While under the Respondent's care, the Patient was on high doses of opioids. In 2009, the Respondent placed the Patient on a medication regimen of Lyrica, 100 mg once a day; Tizanadine,[18] twice a day; Methadone, 60 mg a day; and Percocet, 60 mg a day, every four hours. In 2017, the Patient was still on Methadone, 60 mg a day and Oxycodone, 120 mg a day.

[redacted] testified that the Respondent failed to meet the standard of care with Patient 4 by failing to offer alternative therapies to address his pain. [redacted] noted that while the Respondent referred the Patient to acupuncture and physical therapy, similar to Patient 2, the Respondent did not follow up with the Patient to see if the Patient actually attended the therapies, and there are no records from a physical therapist or acupuncturist that reflect the Patient followed up with the referral. For the same reasons stated in reference to Patient 2, the Respondent's failure to follow up with alternative interventions is a violation of the standard of care.

[18] Tizanidine is a muscle relaxant.

[redacted] also stated that, similar to Patient 2, the Respondent's treatment of the Patient with high dosages of opioids without supporting objective evidence, such as diagnostic studies, violates the standard of care. The Patient's records indicate that the Patient had just one MRI of his back.

Again, the Respondent failed to meet the standard of care with regard to Patient 4 because he failed to require a sufficient number of random urine drug screens to monitor for compliance. Between 2010 and 2015, the Patient had a total of seven urine drug screens. [redacted] testified that the standard of care requires more testing, particularly for a high risk patient, such as Patient 4. The Patient had several positive drug screens that indicated the Patient's noncompliance. On June 1, 2010, the Patient's urine screen tested positive for fentanyl, which was a drug that the Respondent had not prescribed to the Patient. The Patient denied taking the fentanyl yet the Respondent did not order another urine drug screen until July 26, 2010. This screen tested positive for marijuana, fentanyl and Hydromorphone. On September 21, 2010, a third drug screen tested positive for marijuana, which was illegal at the time, even for medicinal purpose.[19] The Patient's records also reflect that a pill count was done on August 23, 2010, which also raised a red flag regarding the Patient's compliance. On that date, the Respondent performed a pill count of two of the Patient's prescriptions. The Respondent's notes only identify the pills by color and not by name. The Respondent noted that there was an excess of the dark green pills and a shortage of light cream. The Respondent's notes are both difficult to read and lacking in content, as the prescriptions at issue are not identified by name, but it is

[19] The medical records include urine drug screens results for samples given on September 18, 2014 and March 4, 2015. The results reflect the presence of opioids not prescribed to the Patient. [redacted] did not address these two tests in his testimony and, therefore, I have not included the results in my assessment of the evidence relating to the standard of care.

evident from the Respondent's notes that the patient's non-compliance was a concern. The Respondent's failure to require more frequent screenings after three positive tests for non-prescribed drugs and a questionable pill count is a clear violation of the standard of care.

According to [redacted] the standard of care, when addressing a patient who has been prescribed opioids and benzodiazepines and has a known substance abuse condition, would require placing the patient on Suboxone,[20] placing them in a substance abuse program, or discharging them from care. Although in October 2010, the Respondent referred the Patient to Walden, a drug rehabilitation program, the Respondent failed to follow up with the Patient's attendance at the program before continuing his treatment of the Patient. The Patient's medical records reflect that Walden performed an assessment of the Patient on November 10, 2010 and diagnosed him with an addiction problem. Walden recommended 90 days of group treatment. The records reflect that on several occasions, the Respondent asked the Patient for documentation from Walden, but he never received the requested verification. The Respondent accepted the Patient's word at face value that he was attending the program and continued prescribing opioids. The Respondent's explanation for not requiring urine screens after November 2010 was that urine screens were part of the Patient's program at Walden. This argument is unpersuasive because the Respondent never followed up with Walden regarding the Patient's treatment. Had he done so, he would have learned that the Patient never entered Walden and was discharged on November 17, 2010. It was not until December 5, 2011 that the Respondent received verification from Walden that the Patient had not entered the treatment program. Nevertheless, the Respondent continued treating the Patient with opioids.

[20] Suboxone is the brand name for a prescription medication used in treating individuals addicted to opioids.

There is no record of additional drug screens until September 18, 2014 and March 4, 2015, both of which tested positive for three non-prescribed opioids. Even after these urine screens, the Respondent did not discharge the Patient and, after March 2015, did not order any additional drug screens. The Respondent testified that he eventually discharged the Patient for noncompliance but the records reflect that he continued to treat the Patient through at least March 2017. The Patient's records include treatment notes for an office visit on January 28, 2017 and prescriptions written in March 2017.

The Respondent's failure to require more frequent drug screens for this Patient, failure to follow up with the Patient's compliance with the drug treatment program and his continued opioid therapy after two additional urine screens indicated opioid abuse were clearly violations of the standard of care.

Patient 6

Patient 6 came under the Respondent's care at the age of thirty-five after having been under the care of an orthopedic surgeon for a significant period of time. The Patient had a history of bilateral hip replacement and degenerative joint disease. The Patient reported pain in his hips, back, knees, ankle and shoulder. [redacted] noted that when the Patient came under the Respondent's care, he was on a high dosage of opioids, 330 mg a day of Oxycodone. As of 2017, the Respondent had decreased the Patient's medications to 230 mg of Oxycodone per day, which was still above the CDC recommended dosage of 90 mme. However, [redacted] explained that he did not find the Respondent's dosing above the recommended 90 mme to be a violation of the standard of care because the CDC standard was not in place at the time the Respondent prescribed the dosages to the Patient.

Although the high dosage of prescribed opioids was not a violation of the standard of care, the Respondent's failure to require a sufficient frequency of urine drug screens was a violation. As noted in the previous patient reviews, urine drug screens are an important tool to monitor a patient's compliance. Even more alarming than the dearth of urine screens, was the Respondent's response to a February 20, 2015 screening that tested positive for morphine and cocaine. As [redacted] stated, the Patient had not been prescribed morphine and the presence of cocaine in a drug screen while the Patient was on a regimen of opiates demonstrates a clear lack of control and opiate abuse by the Patient. Despite this glaring red flag, the Respondent's records do not reflect any follow-up at all by the Respondent. [redacted] suggests that because the Respondent's notes make no mention of the test result, perhaps the Respondent never saw the lab report. [redacted] testified that the standard of care called for the Respondent to discharge the Patient.

The Respondent admitted that such a result should have resulted in the Patient's discharge but according to him, he did not see the document until recently.

I did not find that the Respondent's explanation that he did not see the report because it was not in the records until recently, was not credible. However, even if I believe that he did not see the report, and therefore did not discharge the Patient, that scenario is equally troubling when assessing the Respondent's adherence to a standard of care. Because urine screens are used to monitor compliance, the failure to check a test result, especially for a patient with a history of non-compliance, is an unreasonable practice in the field of opioid prescribed pain management. Under either scenario, the Respondent violated the standard of care.

Patient 9

As in all of the prior patients discussed, Patient 9 was referred to the Respondent for the evaluation and management of her chronic pain. The Respondent began treating the Patient on or about April 28, 2011. The Patient is fifty-six years old, morbidly obese, a smoker with chronic back pain, degenerative joint disease of the knees, carpal tunnel syndrome and depression. The Patient had a long history of opioid use, had substantial tolerance to opioids and was on a morphine equivalent dose of 700 mg when she came under the Respondent's care. (States Ex. 7, pg. 21)

[redacted] notes in his peer review report that the Respondent did not meet the standard of care in regard to offering the Patient alternative treatments because the medical record indicates that he rarely sent the Patient to consults. However, he noted that the she did have lumbar and cervical MRIs that showed mild to moderate findings in the neck and severe degeneration of her lumbar spine with scoliosis. (State Ex. 7, pg. 21) He further noted that the Respondent sent the Patient to an orthopedist for severe symptomatic carpal tunnel syndrome. (State Ex. 7, pg. 22)

[redacted] did not offer any explanation as to when, and to what specialist the Respondent should have referred the Patient to address her specific problems. [redacted] also offered no explanation regarding what interventional therapies the Respondent should have considered for the Patient given her medical conditions. Without further explanation, I cannot find that the Respondent violated the standard of care regarding interventional therapies.

As with all of the other patients previously discussed, [redacted] concluded that the frequency of drug urine screens required of this patient fell short of the required standard of care. In 2014-2015, the Respondent had the Patient on high dose of opioids mixed with Xanax, a benzodiazepine, which [redacted] described as a risky regimen. [redacted] noted that despite prescribing this regimen and having knowledge of the Patient's long history of opioid use, episodes

of syncope, and two apparent overdoses, the Respondent had the Patient submit to just two urine drug screens between September 23, 2014 and on March 4, 2015. The infrequency of urine drug tests for patient on a high dosage of opioids and with a history of two overdoses is clearly a violation of the standard of care.

[redacted] further testified that given the Patient's history of overdoses, the Respondent's lack of appropriate response to these events was not reasonable. The Patient's medical records document that she experienced what appear to be two overdoses. The first event occurred in 2012, when the Patient's son found her unresponsive. The Patient was transported to the hospital where she was diagnosed with an opioid and benzodiazepine overdose. The Patient was referred for a psychiatric evaluation and hospitalization, which the Patient refused. The record reflects that the Respondent was aware of the episode, yet he did not follow up with the Patient or take any proactive measures, such as reducing the medication dosage, removing her from his care, or referring her for psychiatric or drug treatment.

The second overdose episode occurred in March 2013, when the Patient had an overdose on what she claims was Baclofen. As [redacted] explained, Baclofen is a muscle relaxant. He acknowledged that it is possible to overdose on Baclofen, but he further explained that it is unreasonable to attribute the overdose to that particular drug when the patient's drug regime also included high doses of opioid medication. [redacted] pointed out that the overdose was most likely polypharmacy, yet the medical record indicates a lack of concern on the Respondent's part. The Respondent apparently accepted the overdose was attributable to Baclofen as nothing is documented in his notes about the possibility of a polypharmacy overdoes and no follow-up with the Patient was pursued. The Respondent's response that as a result of the overdose he stopped prescribing the Patient Baclofen, does not address the real issue that the overdose was more likely attributable to opioids.

[redacted] report reflects that the Respondent also violated the standard by failing to question several early refills of the Patient's prescription or an incident in September 2016 when the Patient reported to the Respondent that she had "messed up" and taken all of her prescribed short-acting morphine and her OxyContin in a two week period. These incidents are red flags for risk of overdose, yet the Respondent failed to do any follow-up with the Patient, consider discharging the Patient, or refer her to a drug treatment program. The Patient's failure to appropriately address these red flags constitutes a violation of the standard of care.

Patient 10

Patient 10 transferred to the Respondent's care in 2012 after the death of the Patient's orthopedic surgeon, who [redacted] described as a well know over-prescriber of opioids. [redacted] described this fifty-five year- old Patient as an "iatrogenic nightmare." The Patient had an extensive history of spinal procedures and operations prior to coming under the Respondent's care. The Patient was involved in a motor vehicle accident in 1996 and underwent fifteen spinal surgeries as a result. The Patient had multiple complications from the surgeries, including infections and scars. The Patient has been diagnosed with post-laminectomy syndrome, insulin dependent diabetes, anxiety, depression, hypertension and hyperlipidemia.

[redacted] explained that the Respondent's treatment of Patient 10 fell below the standard because the Patient had just three urine drug screens during a five year period, and the Respondent failed to act on two out of the three screens that indicated the Patient was not compliant.[21] The Patient had the following three urine drug screens while under the Respondent's care: June 29, 2012, September 24, 2014 and February 18, 2015. The June 29, 2012 urine drug screen and the

[21] [redacted] peer review report refers to two urine drugs screens, the results of which indicate non-compliance by the Patient. The dates in the report are September 24, 2015 and July 4, 2012. On cross-examination it was clarified that there was a transcription error and the correct date of the second urine drug screen is September 24, 2014. Based on the correction of the screen date, [redacted] agreed that there was no issue of Patient noncompliance with the September 24, 2014 urine drug screen.

Patient's urine drug screen of July 4, 2012 tested negative for opiates, indicating non-compliance and raising a red flag for diversion. The records reflect that on August 1, 2012, the Respondent discussed the negative screen with the Patient on and documented that he would "monitor for compliance with medication over next month," and then"[d]ecide from tests whether to stop meds and/or discharge." The records reflect that the Patient had a follow-up urine drug screen but there is nothing in the record to indicate the results or whether there was any follow-up with the Patient. The Respondent's failure to follow up with this Patient's drug screens is another instance of the Respondent's failure to meet the standard of care in the monitoring of a patient's opioid compliance.

Sanctions

Having found the State proved the Respondent violated the Maryland Medical Practice Act with respect to his treatment of five patients, I now turn to the question of what sanction, if any, is appropriate. The minimum sanction for both a failure to meet appropriate standards for the delivery of quality medical care and a failure to keep adequate medical records is a reprimand. COMAR 10.32.02.10B(19), (22), (40).

The guiding regulations in this matter, found at COMAR 10.32.02.09B, provide in pertinent part as follows:

> B. Aggravating and Mitigating Factors.
>
> (1) Depending on the facts and circumstances of each case, and to the extent that the facts and circumstances apply, the disciplinary panel may consider the aggravating and mitigating factors set out in §B(5) and (6) of this regulation and may in its discretion determine, based on those factors, that an exception should be made and that the sanction in a particular case should fall outside the range of sanctions listed in the sanctioning guidelines.
>
> ...
>
> (5) Mitigating factors may include, but are not limited to, the following:
>
> (a) The absence of a prior disciplinary record;
> (b) The offender self-reported the incident;

(c) The offender voluntarily admitted the misconduct, made full disclosure to the disciplinary panel and was cooperative during the disciplinary panel proceedings;
(d) The offender implemented remedial measures to correct or mitigate the harm arising from the misconduct;
(e) The offender made good faith efforts to make restitution or to rectify the consequences of the misconduct;
(f) The offender has been rehabilitated or exhibits rehabilitative potential;
(g) The misconduct was not premeditated;
(h) There was no potential harm to patients or the public or other adverse impact; or
(i) The incident was isolated and is not likely to recur.

(6) Aggravating factors may include, but are not limited to, the following:

(a) The offender has a previous criminal or administrative disciplinary history;
(b) The offense was committed deliberately or with gross negligence or recklessness;
(c) The offense had the potential for, or actually did cause patient harm;
(d) The offense was part of a pattern of detrimental conduct;
(e) The offender committed a combination of factually discrete offenses adjudicated in a single action;
(f) The offender pursued his or her financial gain over the patient's welfare;
(g) The patient was especially vulnerable;
(h) The offender attempted to hide the error or misconduct from patients or others;
(i) The offender concealed, falsified or destroyed evidence, or presented false testimony or evidence;
(j) The offender did not cooperate with the investigation; or
(k) Previous attempts to rehabilitate the offender were unsuccessful.
...

Regarding the Respondent's issues with record keeping, I have considered as a mitigating factor, that [redacted] found the Respondent's record keeping substandard in just two of the patients records reviewed. The issues with the medical records in those two patients was the Respondent's reliance upon templates that were often left largely incomplete, and the illegibility of his handwriting that made it difficult to understand the patient's status and course of treatment. While the importance of legible and complete medical records should not be dismissed, I believe that the Respondent may be easily rehabilitated in this area through

education and with the use of electronic medical record keeping. The record keeping is also something that may be monitored through a peer review process. The Respondent recognized the issues with his record keeping and expressed the intent to address those issues.

On the issue of the standard of care, in mitigation, I have considered that [redacted] conceded that from all indications it appeared that the Respondent had a genuine concern for his patients' well-being. This was demonstrated by the fact that the Respondent met with his patients on a monthly basis and spent significant time with them on each visit. The Respondent also had each patient enter into a detailed opioid agreement, which he renewed on a periodic basis. Furthermore, [redacted] noted that the Respondent was not operating a "pill mill," as he was not engaging in prescribing practices for financial gain.

As part of its case, the State noted that that there was nothing in the records to indicate that the Respondent checked CRISP for any of his patients. [redacted] acknowledged, however, that the CRISP did not become a mandatory resource for physicians until 2018. Therefore, I have not considered the Respondent's failure to reference CRISP in assessing whether he violated the standard of care.

The State's case regarding the Respondent's failure to meet the standard of care in regard to several patients established that, the Respondent either did not refer the patients to alternative therapies or did not follow up to see if the patients attended the treatments. However, I have taken into consideration the fact that alternative treatments, such as physical therapy, aqua therapy, and massage therapy all require the patient to make a financial investment and have available transportation. The Respondent pointed out, and the medical records reflect, that most of the patients reviewed were on disability, which often means the patients do not have the resources to pay for the treatment. The Respondent's failure to refer the patients to

interventional therapies, or follow up with attendance at these therapies, may have been a legitimate recognition of his patients' limited resources.

On the other side of the coin, I have to consider aggravating factors.[22] The Respondent's greatest failure with his care and treatment of the patients was his failure to monitor his patients for compliance, and to follow up with patients when non-compliance was apparent. The Respondent failed to require random urine drug screening on a sufficiently frequent basis. The Respondent admitted during his interview with the Board that he only required screening approximately once a year. The gist of his reasoning was that because the tests mostly come back clean, the screenings were useless and essentially a waste of time and resources. The Respondent's view is troublesome for several reasons. First, as [redacted] pointed out, random urine screens should be done at least once every three months for high risk patients. All of the Respondent's patients fell under this category because when they came to him for treatment they were already on high doses of opioids, and for some of these patients the Respondent increased these high doses. Additionally, the urine screens of the five patients reviewed belie his assertion that the majority of urine screens come back clean. The Respondent continued to shun the use of urine screens after some of his patients' screens raised red flags for possible overdose or diversion. Perhaps most troubling is that on June 30, 2014, the Board issued the Respondent an advisory letter that strongly advised the Respondent to utilize unannounced urine and toxicology screens and pill counts to assure better monitoring of his patients. The patients' records indicate that the Respondent completely ignored the Board's advice. The Respondent's disregard of the Board's advice suggests that the Respondent may not be a good candidate for rehabilitation without the addition of some significant consequence.

[22] The State included in its exhibits a Consent Order dated May 20, 2014 which addressed charges regarding the Respondent's alleged failure to cooperate with an investigation of the Board (State Ex. 12). I do not find that there was any failure on the part of the Respondent in cooperating with the Board's investigation of this matter and have not considered it an aggravating factor.

The Respondent's continued failure to use random urine drug screens on a sufficiently frequent basis raises a legitimate concern not only for the patients' welfare, but that of members of the public who may have gained access to opioids through his patients' diversion of the drugs. One cannot ignore the opioid crisis in the country and the risks that noncompliant, un-monitored patients pose. The Respondent's failure to discharge a Patient who tested positive for cocaine, and a Patient who had two overdoses, raises a legitimate concern about his willingness to follow his own opioid contract.

Finally, I have considered that the Respondent does have a prior disciplinary history. In 2014, the Board charged the Respondent with failure to cooperate with a legitimate investigation conducted by the Board after the Respondent failed to fully comply with a Board subpoena for patient records for almost nine months. To resolve the charges, the Respondent entered into a Consent Order under the terms of which the Board concluded as a matter of law that the Respondent had failed to cooperate with a lawful investigation of the Board in violation of Health Occ. §14-404 (a)(33), and ordered that the Respondent pay a monetary fine of $2,000.00 within six months. In July 2016, in response to a complaint with a pharmacist, the Board issued to the Respondent an Advisory Letter that advised him to be accessible to patients and pharmacists. Although those charges were not related to medical record keeping or the standard of care, the overall history indicates that the Respondent has a prior instance of non-cooperation with the Board.

Under the applicable law, the Board also may impose a fine instead of, or in addition to, disciplinary sanctions against a licensee who is found to have violated section 14-404. Health Occ. § 14-405.1(a) (2014); COMAR 10.32.02.09C-E. The Board is not seeking a fine but is seeking a reprimand with a minimum of three years on probation, during the first two years of which he is not to prescribe any controlled dangerous substances, except in limited dosages for

patients who come in on an emergency basis. The prescription may not exceed the lowest effective dose needed for the duration of five days. The Respondent may not order a refill or renewal of the prescription and he must notify the Board within twenty-four hours of writing any prescription. The Board is further seeking an order that requires the Respondent, within the first six months of probation, complete intensive Board panel-approved courses in opioid prescribing and medical documentation. The Respondent would be required to provide the Board panel with documentation that he completed the course within six months. The Board further seeks, that after the second year of probation, the Respondent's medical practice be supervised by a Board panel-approved peer reviewer for a minimum period of one year. The peer reviewer shall review at least ten of the Respondent's patient records chosen by the peer reviewer.

Although the State poses the recommended sanction as reprimand with a period of probation, I recognize that the terms of the probation, which prohibit the Respondent's ability to prescribe controlled dangerous substances, is in effect a two-year suspension. The Respondent's practice is centered on treating patients' pain through prescribing and managing dosages of opioids. Without the ability to prescribe, the Respondent has no practice. Based on the Respondent's continued failure to screen and monitor patients on high doses of opioids, I concur with the State's recommendation that the Respondent should be reprimanded. I also agree that he should be placed on probation, but in balancing the aggravating and mitigating circumstances, I find that a two-year probation is sufficient, with the Respondent's preclusion from prescribing controlled dangerous substances, except in emergency situations restricted to the first year. I further recommend that all of the conditions of the probation as proposed by the State be required.

The State has further requested that during probation, the Board be permitted to issue administrative subpoenas to the Maryland Drug Prescription Monitoring Program on a quarterly basis. This request is to ensure that the Respondent is complying with the imposed restriction on prescribing controlled dangerous substances. Given the nature of the charges against the Respondent, I find that the State's request is a reasonable means of ensuring the Respondent's compliance with the restriction.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent did violate the Maryland Medical Practice Act. Md. Code Ann., Health Occ. § 14-404(a)(19), (22), and (40) (Supp. 2018). As a result, I conclude that the Respondent is subject to disciplinary sanctions for the cited violations. *Id.*; COMAR 10.32.02.09A-B.

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on May 21, 2018 be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned by a reprimand; and

I also **PROPOSE** that the Respondent be placed on probation for two years and, during that first year of probation, the Respondent is not to prescribe any controlled dangerous substances, except in limited dosages for patients who come in on an emergency basis. The prescription may not exceed the lowest effective dose needed for duration of five days. The Respondent may not order a refill or renewal of the prescription and he must notify the Board within twenty-four hours of writing any prescription.

I also **PROPOSE** that within the first six months of probation, the Respondent complete an intensive Board panel-approved course in opioid prescribing and medical documentation. The Respondent will be required to provide the Board panel with documentation that he completed the course within six months.

I also **PROPOSE** that after the first year of probation, the Respondent's medical practice shall be supervised by a Board panel-approved peer reviewer for a minimum period of one year. The peer reviewer shall review at least ten of the Respondent's patient records chosen by the peer reviewer.

I also **PROPOSE** that during the first year of probation, the Board may issue administrative subpoenas to the Maryland Drug Prescription Monitoring Program on a quarterly basis to ensure compliance with the restrictive CDS prescribing imposed.

May 1, 2019
Date Decision Issued

Geraldine A. Klauber
Administrative Law Judge

GAK/sw
#178312

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of the Maryland State Board of Physicians that delegated the captioned case to the Office of Administrative Hearings (OAH), and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2014); COMAR 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the Disciplinary Panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the other party will have fifteen (15) days from the filing of exceptions to file a written response addressed as above. *Id.* The disciplinary panel will issue a final order following the exceptions hearing or other formal panel proceedings. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2014); COMAR 10.32.02.05C. The OAH is not a party to any review process.

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