IN THE MATTER OF	*	**BEFORE THE**
LAWRENCE VIDAVER, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D25559	*	**Case Number: 2014-0981B**

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CONSENT ORDER

PROCEDURAL BACKGROUND

On November 17, 2015, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged **LAWRENCE VIDAVER, M.D.** (the "Respondent"), License Number D25559, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") §§ 14-101 *et seq.* (2014 Repl Vol.).

Specifically, Panel B charged the Respondent with violating the following provisions of the Act under Health Occ. II § 14-404:

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

On February 24, 2016, the Respondent appeared before Panel B of the Board's Disciplinary Committee for Case Resolution ("DCCR"). Based on negotiations occurring as a result of the DCCR, the Respondent agreed to enter into the following Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

FINDINGS OF FACT

Panel B makes the following Findings of Fact:

I. Background

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on or about August 4, 1980, under License Number D25559. The Respondent's license is currently active and scheduled for renewal on September 30, 2017.

2. The Respondent is not board-certified in any medical specialty.

3. At all times relevant hereto, the Respondent maintained a medical office at 1414 North Crain Highway, Suite 6A, Glen Burnie, Maryland 21061.

II. The Complaint

4. The Board initiated an investigation of the Respondent after receiving a report from a physician (the "Complainant")[1] who practices at a health care facility in the vicinity of the Respondent's practice. The Complainant expressed concern that the

[1] For confidentiality purposes, the name of the Complainant, patients or other individuals referenced herein have not been identified in this Consent Order. The Respondent is aware of the identities of all complainants, patients and other individuals referenced herein.

Respondent was prescribing "excessive amounts of narcotics to patients without any clear indication of what's causing their pain."

III. Disciplinary Panel Findings

5. As part of its investigation, the Board obtained a series of pharmacy surveys from area pharmacies of the Respondent's prescribing practices and a series of patient charts from the Respondent for review. The Board referred the patient charts and related materials to its peer review entity for a practice review.

6. In a significant majority of the cases reviewed ("Patients A through J"), the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40).

7. The Respondent typically prescribed various combinations of short and/or long-acting opioid medications (both Schedule II and III controlled dangerous substances, or "CDS") to the patients for lengthy periods of time, ranging up to several years, purportedly to address their pain complaints. Throughout the treatment period, the Respondent referred the patients for various specialty consultations, including pain medicine specialists. The Respondent, however, typically did not follow the recommendations of the specialists, who recommended against long-term opioid prescribing, recommended alternative opioid therapies or treatments, or recommended weaning patients off of these medications.

8. The Respondent failed to meet quality medical standards and failed to keep adequate medical records for reasons including but not limited to the following:

(a) the Respondent inappropriately prescribed multiple short-acting opioid medications to patients for lengthy periods of time, without transitioning, or documenting or implementing a plan to transition, the patients to long-acting opioid medications;

(b) the Respondent inappropriately prescribed two short-acting opioid medications in conjunction with two benzodiazepines;

(c) the Respondent inappropriately prescribed multiple opioid medications in escalating quantities and/or dosages without documented support and appropriate ongoing evaluation of effectiveness;

(d) the Respondent inappropriately prescribed high dosages of opioid medications without sufficient pathology to support the level and type of opioid medications prescribed;

(e) the Respondent prescribed opioid medications to patients who exhibited a high risk for abuse, without proper safeguards;

(g) the Respondent continued to prescribed high dosages of opioid medications to patients after referral to pain medicine specialists who recommended against long-term oral opioid prescribing;

(h) the Respondent prescribed opioid medications to patients without assessing the risk of addictive disorders;

(i) the Respondent prescribed opioid medications to patients without documenting or performing appropriate treatment compliance screening, to include such modalities such as but not limited to urine drug screening ("UDS") at appropriate intervals and pill counts;

(j) the Respondent prescribed opioid medications to patients without documenting or performing pre- and post-intervention assessment of pain level and function;

(k) the Respondent continued to prescribe high dosages of opioid medications to patients without appropriately addressing aberrant behaviors, inconsistent UDS results, claims of lost/stolen medications, acquisition of opioid medications from other physicians or other "red flag" behaviors; and

(l) the Respondent prescribed opioid medications to patients without maintaining adequate medical records. The Respondent recorded insufficient documentation in his progress notes such as but not limited to results of physical examination findings, a treatment plan, treatment goals.

his thought processes regarding treatment interventions, pain levels, effects on function and the patients' response to treatment.

9. Examples of these deficiencies are set forth in the following patient summaries:

Patient A

10. The Respondent provided medical care to Patient A, a woman currently in her 30s, beginning in or around 2010. The Respondent's chart contains magnetic resonance imaging (MRI) reports from 2005 and 2009, and a neurological consultant's report from 2006. The consultant provided Patient A with a single prescription for Vicodin ES (hydrocodone, an opioid) and recommended that she see a pain medicine specialist and undergo physical therapy.

11. In or around January 2010, the Respondent began prescribing monthly dosages of 20 mg of oxycodone to Patient A (Percocet 10/325 mg # 60)[2].

12. In or around July 2010, the Respondent began prescribing two short-acting opioids for Patient A (oxycodone 15 mg # 90 and Percocet 10/325 mg # 180).

13. The Respondent continued prescribing escalating dosages of one or two oxycodone-containing medications until late 2014. During this treatment period, the Respondent escalated his prescribing of opioid medications from about 20 mg per day to over 300 mg per day.

14. The Respondent's chart contains a consultation note from a physician who saw Patient A for complaints of constipation. The consultant's report states that Patient

[2] "#" indicates number of pills prescribed.

A was taking 7.5/500 mg of Percocet, when in fact she was being prescribed about 310 mg of oxycodone per day during this time period.

15. In a summary of care, the Respondent stated that Patient A's "back pain syndrome is progressive, multi-level arthritis, and the medications have been stable since year 2009 without further progression."

16. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient A, for reasons including the following:

(a) the Respondent inappropriately prescribed escalating dosages of opioid medications without pathology or objective findings to support the level of opioids prescribed;

(b) the Respondent inappropriately prescribed escalating dosages of opioid medications without documenting or performing an appropriate evaluation of Patient A's chronic pain complaints;

(c) the Respondent inappropriately prescribed escalating dosages of two short-acting opioid medications without appropriate justification, and without documenting or implementing a plan to transition Patient A off of these medications;

(d) the Respondent failed to appropriately document or assess Patient A for risk of addiction or abuse;

(e) the Respondent failed to appropriately document or have Patient A enter into a controlled substance use agreement or obtain appropriate informed consent for his prescribing regimen;

(f) the Respondent failed to appropriately document or evaluate Patient A's response to treatment or assess her response to treatment;

(g) the Respondent failed to appropriately document or address Patient A's significant side-effects that led her to seek a gastroenterology consultation;

(h) the Respondent failed to appropriately document or evaluate Patient A's pain levels, effect of pain, or escalating dosages of opioid pain medication on function;

(i) the Respondent inappropriately prescribed escalating dosages of short-acting opioid medications at a level requiring intervention by a pain medicine specialist; and

(j) the Respondent failed to record adequate documentation in his chart. The Respondent recorded very few progress notes during the almost five-year treatment period. The Respondent failed to adequately document the results of physical examination findings, a treatment plan, treatment goals, his thought processes regarding treatment interventions and Patient A's response to treatment.

Patient B

17. The Respondent provided medical care to Patient B, a woman currently in her 30s, beginning in or around November 2007. The Respondent treated Patient B for various pain complaints including abdominal/pelvic pain, myalgia and lumbago. During

the treatment period, which extended into late 2014, the Respondent treated Patient B with various opioid medications, including oxycodone and OxyContin; and non-opioid medications, including Xanax and Valium (both benzodiazepines). The Respondent typically prescribed these medications on a monthly or more frequent basis. Throughout the treatment period, the Respondent prescribed escalating dosages of opioid medications. During the initial phase of treatment, the Respondent prescribed about 35 mg of oxycodone per day. At the conclusion of the treatment period, the Respondent had escalated his dosages of oxycodone-containing medications to 500 mg per day.

18. Beginning in 2008, the Respondent, on a monthly or more frequent basis, began prescribing two benzodiazepines at the same time (*e.g.*, Xanax and Valium), in addition to prescribing multiple opioids (*e.g.*, OxyContin 20 mg, Percocet 7.5/325 mg and Percocet 10/325 mg).

19. In early 2008, Patient B began reporting that her medication was stolen, which caused the Respondent to reissue her prescriptions for opioids and benzodiazepines.

20. In or around February 2008, the Respondent noted that a pharmacist questioned why Patient B was receiving prescriptions for two different strengths of oxycodone. Beginning in March 2008, the Respondent increased Patient B's OxyContin prescription from 20 mg to 40 mg, without a clear rationale in his chart.

21. In or around July 2008, the Respondent increased Patient B's OxyContin by prescribing two prescriptions in 10 mg and 40 mg strengths, in addition to his prescribing of oxycodone 10 mg, Valium and Xanax.

22. In or around August 2008, the Respondent had Patient B enter into a controlled substance use agreement and planned to refer her to a pain medicine specialist. The Respondent continued prescribing opioid, benzodiazepine and muscle relaxant medications for Patient B, however.

23. Beginning in or around March 2009, the Respondent increased Patient B's OxyContin to 80 mg three times per day ("TID").

24. In or around April 2009, the Respondent noted in his records that Patient B underwent UDS testing that was positive for a benzodiazepine he had not prescribed. The Respondent noted that he intended to refer Patient B to a pain medicine specialist.

25. In or around June 2009, Patient B underwent another UDS, with inconsistent results. Patient B tested negative for oxycodone, which the Respondent was prescribing, and positive for a specific benzodiazepine, which he did not prescribe. Patient B underwent a second UDS in June 2009, with inconsistent results. Patient B tested positive for hydrocodone, which the Respondent did not prescribe; positive for a specific benzodiazepine, which he did not prescribe; very low levels of oxymorphone; and negative for oxycodone, which he was regularly prescribing. Notwithstanding these inconsistencies, the Respondent continued to prescribe opioid medications for Patient B. On a UDS test result from July 2009, the Respondent stated that he instructed Patient B to stop borrowing medications.

26. In or around August 2009, Patient B underwent UDS, with inconsistent results. Patient B tested positive for Valium, which he was not prescribing at that time. Despite these inconsistencies, the Respondent continued prescribing opioid and benzodiazepines without alteration.

27. The Respondent continued to prescribe opioid medications for Patient B into 2010. The Respondent's chart contains a letter from a nurse case manager that indicates that Patient B underwent in-patient treatment for abuse of narcotic medications in October 2009 and that her risk stratification was at a high level.

28. In or around June 2010, the Respondent began prescribing OxyContin 80 mg (#90), oxycodone 30 mg (#90), Percocet 10/325 mg (#120), Xanax 1 mg (#120) and Soma 350 mg (#120).

29. In or around November 2010, Patient B underwent UDS, with inconsistent results. Patient B tested positive for a non-prescribed benzodiazepine. This same month, the Respondent noted that Patient B contacted his office and reported that her OxyContin was stolen and she took a friend's Suboxone to prevent withdrawal.

30. The next month, the Respondent continued to prescribe opioid medications (OxyContin 80 mg, oxycodone 30 mg), without referencing Patient B's notification from the prior month. Also in December 2010, Patient B contacted the Respondent's office and reported that her medications had been stolen from her home.

31. The Respondent's chart for Patient B contains other instances in which she claimed her medications had been stolen. Patient B reported that in or around September 2011, a family member stole her prescriptions for oxycodone and a benzodiazepine.

32. The Respondent's chart also contains a letter from a prescription benefits company that notified the Respondent that Patient B was using three or more pharmacies to fill her prescriptions and that she was using large daily dosages of controlled substances. The Respondent noted that he intended to refer Patient B to a pain medicine specialist for a consultation.

33. The Respondent continued to prescribe large quantities of opioids during this period (*e.g.*, August 13, 2012, OxyContin 80 mg (#90), OxyContin 80 mg (#30), oxycodone 30 mg (#240)). On this visit, the Respondent also prescribed Soma 350 mg (#120), Xanax 1 mg (#120) and Trazadone 100 mg (#60).

34. In or around November 2012, the Respondent referred Patient B to a pain medicine specialist. During this time period, the Respondent continued to prescribe opioid and benzodiazepine medications.

35. In or around May 2013, the Respondent noted that Patient B was scheduled to see a pain medicine specialist. In his progress note for this date, the Respondent did not document a pain history.

36. In or around September 2013, the Respondent noted his intention to lower Patient B's monthly use of oxycodone. The Respondent continued to prescribe monthly dosages of oxycodone at a greater-than-monthly frequency, however.

37. The Respondent continued to prescribe large quantities of opioids and benzodiazepines until the conclusion of his progress notes, in October 2014, when he was prescribing OxyContin 80 mg (#90), OxyContin 80 mg (#30), and oxycodone 30 mg (#180).

38. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient B, for reasons including the following:

(a) the Respondent prescribed escalating dosages of opioid medications without appropriately documenting or evaluating Patient A's pain complaints or

response to treatment, particularly in view of the significant escalations in Patient B's opioid medication dosages;

(b) the Respondent inappropriately prescribed escalating dosages of two short-acting opioid medications without appropriate justification,

(c) the Respondent failed to address Patient B's multiple inconsistent UDS or take appropriate action to address these inconsistencies;

(d) the Respondent failed to appropriately document or address Patient B's "red flag" behaviors, including multiple claims of lost/stolen opioid and benzodiazepine medications;

(e) the Respondent failed to have Patient B enter into a timely controlled substance use agreement, and did not enforce the agreement when Patient B violated it;

(f) the Respondent inappropriately provided concurrent prescriptions of multiple opioid and benzodiazepine prescriptions, sometimes along with muscle relaxants;

(g) the Respondent failed to appropriately document or evaluate Patient B's pain levels;

(h) the Respondent failed to record adequate documentation in his chart. The Respondent recorded few progress notes during the seven-year treatment period. The Respondent failed to adequately document the results of physical examination findings, a treatment plan, treatment goals, his thought processes regarding treatment interventions and Patient B's response to treatment.

Patient C

39. The Respondent provided medical care to Patient C, a man currently in his 40s, from in or around May 2008 until November 2014. The Respondent initially evaluated Patient C for back and clavicular pain and prescribed Percocet 7.5/325 mg TID (#40). At the conclusion of the treatment period in 2014, the Respondent escalated Patient C's oxycodone dosage to over 270 mg per day. During the course of treatment, the Respondent prescribed two short-acting opioid medications (*e.g.*, Percocet 10/325 mg, oxycodone 30 mg), a benzodiazepine, and a muscle relaxant (Soma).

40. Throughout the treatment period, the Respondent noted that he referred Patient C to pain medicine specialists and to see other specialists (*e.g.*, chiropractic).

41. As of 2012, the Respondent had increased Patient C's opioid prescriptions upward on a monthly basis to Percocet 10/325 mg (#90), oxycodone 30 mg (#240), in addition to Diazepam 5 mg (#90) and Soma (#90).

42. The Respondent continued to prescribe opioid and other non-opioid medications at these levels into 2014. In 2013, the Respondent noted his intention to decrease Patient C's oxycodone prescription to 210 pills per month.

43. In or around November 2014, the Respondent was prescribing oxycodone 30 mg (#180), Percocet 10/325 mg (#90), Diazepam 5 mg (#90), and Soma (#90).

44. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient C, for reasons including the following:

(a) upon initiation of treatment, the Respondent failed to verify Patient C's prior medical treatment or use of opioid medications;

(b) upon initiation of treatment, the Respondent, other than ordering plain radiographs, failed to fully evaluate Patient C's complaints of back pain;

(c) the Respondent inappropriately prescribed escalating dosages of multiple short-acting opioid medications, without appropriate indication;

(d) the Respondent failed to appropriately document or evaluate Patient C's pain levels or response to treatment;

(e) the Respondent failed to obtain a controlled substance use agreement or undertake appropriate treatment compliance, including UDS. Throughout the several year treatment period during which the Respondent prescribed escalating dosages of opioid medications, he only ordered one UDS;

(f) the Respondent prescribed escalating dosages of multiple short-acting opioid medications in an inappropriate manner. The Respondent typically provided monthly prescriptions for opioid medications but frequently wrote prescriptions sooner than one-month intervals; and

(g) the Respondent failed to record adequate documentation in his chart. The Respondent recorded insufficient documentation in his progress notes during the multi-year treatment period. The Respondent failed to adequately document the results of physical examination findings, a treatment plan, treatment goals, his thought processes regarding treatment interventions and Patient C's response to treatment.

Patient D

45. The Respondent provided medical care to Patient D, a woman currently in her 40s, from in or around 2007 to June 2014. The Respondent treated Patient D for conditions including neck and cervical pain, low back pain and sacroiliac joint dysfunction, and psychological issues. Patient D's medical history included multiple surgeries for orthopedic conditions. During the treatment period, the Respondent referred Patient D to numerous specialists for her medical conditions.

46. The Respondent began prescribing opioid medications to Patient D in or around 2007. Throughout the treatment period, the Respondent referred Patient D to several pain medicine specialists. Patient D also underwent several UDS, with inconsistent findings.

47. For example, Patient D underwent UDS in 2008 and 2013 that were positive for marijuana. She underwent UDS in 2009 and 2011 that were negative for oxycodone, for which she was receiving prescriptions.

48. As of December 2012, the Respondent was prescribing OxyContin 40 mg (#60), oxycodone 30 mg (#120), and Valium 5 mg (#120). At around that time, the Respondent referred Patient D to a pain medicine specialist who stated in a consultation note that her office would not take over her prescribing of pain medications "until there are no illicit substances in her urine toxicology screen." The pain medicine specialist discharged Patient D after she tested positive for cocaine and marijuana. In her note, the pain medicine specialist stated that Patient D reported that the Respondent advised her to smoke marijuana.

49. Notwithstanding this report, the Respondent resumed treating Patient D and continued prescribing OxyContin and oxycodone at similar dosages/amounts.

50. Shortly thereafter, the Respondent referred Patient D to a second pain medicine specialist who, in a consultation note dated February 13, 2013, stated that he initiated her on oxycodone 10 mg (#60), with a plan to slowly wean her medication as clinically appropriate.

51. The Respondent, however, continued to prescribe OxyContin 40 mg (#60), oxycodone 30 mg (#120) and Valium 5 mg (#90).

52. The Respondent's chart for Patient D contains a second note from the second pain medicine specialist who stated, "There are several discrepancies in [Patient D's] reports of what medications have been RX'd to her." In April 2013, the specialist reported that Patient D tested positive for cocaine, which caused him not to prescribe opioids to her on that visit.

53. Patient D continued with this pain medicine specialist but terminated treatment in June 2013, purportedly due to the cost of care.

54. In a summary of care, the Respondent claimed that the second pain medicine specialist "managed her pain syndromes which included increasing her opiate doses," which was not true.

55. The Respondent then resumed prescribing opioid medications, including OxyContin 40 mg and oxycodone 30 mg, as well as Valium. The Respondent continued prescribing these medications on a monthly basis until June 2014, when he discharged her from his practice.

56. The Respondent's chart states that in April 2014, Patient D was hospitalized for lower extremity numbness. Patient D's history of present illness noted hypotension,

and that she fell asleep in the middle of her interview. In his summary of care, the Respondent stated that Patient D was arrested in May 2014.

57. The Respondent's chart also contains a referral note from another pain medicine specialist in July 2014, who noted a plan to wean Patient D off OxyContin and oxycodone.

58. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient D, for reasons including the following:

(a) the Respondent inappropriately prescribed high dosages of short and long-acting opioid medications without proper risk assessment and monitoring;

(b) the Respondent inappropriately prescribed high dosages of short and long-acting opioid medications without appropriately addressing aberrant behaviors, which included positive UDS findings for illicit substances;

(c) the Respondent inappropriately resumed prescribing high dosages of short and long-acting opioid medications after referring Patient D to pain medicine specialist(s);

(d) the Respondent inappropriately resumed prescribing short and long-acting opioid medications to Patient D after she left treatment with a pain medicine specialist, and in fact increased the dosages of the medications the pain medicine specialist had been prescribing;

(e) the Respondent inappropriately prescribed high dosages of short and long-acting opioid medications without appropriate monitoring, such as increasing the frequency of UDS and employing pill counts;

(e) the Respondent continued to prescribe high dosages of short and long-acting opioid medications but failed to address other aberrant behaviors, including Patient D's falling asleep during a hospitalization interview; and

(f) the Respondent failed to record adequate documentation in his chart. The Respondent recorded insufficient documentation in his progress notes during the multi-year treatment period. The Respondent failed to adequately document the results of physical examination findings, a treatment plan, treatment goals, his thought processes regarding treatment interventions and Patient D's response to treatment.

Patient E

59. The Respondent provided medical care to Patient E, a woman currently in her 30s, from in or around August 2008 until in or around April 2014, for low back pain, chest wall pain, injuries sustained in motor vehicle collisions and psychological issues. During the treatment period, the Respondent prescribed two short-acting opioid medications (oxycodone 30 mg and oxycodone 15 mg). The Respondent referred Patient E for numerous specialty consultations including pain medicine specialists.

60. The Respondent initially began prescribing hydrocodone to Patient E in or around August 2008. At the time, Patient E was complaining of low back pain. In visits shortly thereafter, the Respondent escalated his prescribing to oxycodone 10 mg (#120), every two-to-three weeks.

61. Patient E was in a motor vehicle accident in or around January 2009, and complained of left sternum pain. The Respondent referred Patient E to a surgeon, who ordered diagnostic tests that found that Patient E had mild degenerative disc disease at L3-L4. The consultant stated,

> Back pain superimposed on mild degenerative disk disease, subjective complaints disproportionate to objective findings . . . I am unable to explain the degree of her subjective complaints and the necessity of such high doses of narcotic analgesics for the past several months. I would place her on an anti-inflammatory medication. A short course of physical therapy might be indicated. The discrepancy between her subjective complaints and objective findings raises the issue of a non-organic component to her symptomatology but I will defer to you in that regard.

62. The Respondent continued to prescribe Patient E oxycodone 10 mg (#120), Valium and Soma on a monthly or more frequent basis.

63. In or around October 2009, Patient E went to the emergency room for a sternum injury, where she obtained prescriptions for oxycodone and ibuprofen.

64. The Respondent's chart contains a charging document in which it was alleged that Patient E attempted to forge a prescription for oxycodone 80 mg in the name of a local pain medicine specialist.

65. The Respondent then decided to give ten-day supplies of hydrocodone to Patient E "until we hear from court."

66. In or around February 2010, the Respondent then began prescribing oxycodone in either 15 or 30 mg dosages.

67. In or around June 2010, Patient E was scheduled for a consultation with a thoracic surgeon, who ordered a computed tomography ("CT") scan. Patient E canceled the scan.

68. In or around July 2010, Patient E underwent UDS, which was positive for cocaine metabolites and Methadone.

69. The Respondent referred Patient E to an area hospital for a pain medicine consultation, which took place in or around August 2010. The Respondent's chart for Patient E contains the pain consultant's report, which states, "We advised the patient that no narcotics will be prescribed for her."

70. The Respondent then began prescribing oxycodone 30 mg (#120), Valium and other medications.

71. In or around October 2010, the Respondent ordered UDS for Patient E, which was positive for oxycodone but negative for Valium, which he was also prescribing for her. The Respondent did not document how if at all he addressed this inconsistency in Patient E's UDS.

72. Patient E sought emergency room care In November 2010, for complaints of chest wall pain. A thoracic surgeon evaluated Patient E and noted, "mild pectus excavatum which is congenital and traumatic deformity." The physician was unable to explain Patient E's symptoms based on CT scan findings.

73. On or about November 9, 2010, the Respondent prescribed oxycodone 15 mg (#100). On November 15, 2010, he prescribed oxycodone 30 mg (#150). On November 23, 2010, he prescribed oxycodone 30 mg (#150), which he marked "replacement." On December 14, 2010, he provided Patient E with two prescriptions for oxycodone 30 mg (#150)(one of which was marked, "please don't fill until 1-10-11"). On December 28, 2010, the Respondent prescribed oxycodone 30 mg (#150), which he marked, "travel supply."

74. Thereafter, the Respondent continued to prescribe oxycodone 30 mg (#150) and oxycodone 15 mg (#100 to #120), on a monthly or more frequent basis near the end of 2011. The Respondent's chart contains a note from November 2011, indicating that Patient E was getting prescriptions from another physician.

75. The Respondent's chart states that he resumed writing prescriptions for Patient E in or around May 2011, typically for oxycodone 30 mg, oxycodone 15 mg, Valium, and other drugs.

76. The Respondent referred Patient E to another pain medicine specialist. A telephone note states that in or around February 2013, Patient E had canceled prior appointments and had a "last chance" appointment with the pain medicine specialist in or around April 2013. Patient E failed to appear for the appointment, however.

77. The Respondent continued to prescribe oxycodone 30 mg, oxycodone 15 mg (at times 10 mg strength) and Valium, typically on a monthly or more frequent basis, until November 2014. The Respondent's chart contains a handwritten note from July 2014, in which he ordered UDS. A post-it note states, "Don't think she had this done!"

78. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient E, for reasons including the following:

(a) the Respondent inappropriately prescribed escalating dosages of opioid medications without pathology or objective findings to support the level of opioids prescribed;

(b) the Respondent inappropriately prescribed escalating dosages of two short-acting opioid medications without appropriate justification, and without documenting or implementing a plan to transition Patient E off of these medications;

(c) the Respondent failed to appropriately document or assess Patient E for risk of addiction or abuse;

(d) the Respondent failed to appropriately address inconsistent UDS findings and other aberrant behaviors, such as use of illicit drugs and criminal charges relating to prescription forgery;

(e) the Respondent inappropriately resumed prescribing short-acting opioid medications after a pain medicine specialist declined to prescribe opioid medications, and the Respondent in fact escalated the dosages of those medications; and

(f) the Respondent failed to record adequate documentation in his chart. The Respondent recorded insufficient documentation in his progress notes during the multi-year treatment period. The Respondent failed to adequately document the results of physical examination findings, a treatment plan, treatment goals, his thought processes regarding treatment interventions and Patient E's response to treatment.

Patient F

79. The Respondent provided medical care to Patient F, a man currently in his 40s, from April 2006 through October 2014. Throughout the treatment period, the

Respondent treated Patient F for medical conditions such as back and foot pain, and also provided care for other medical conditions. The Respondent referred Patient F to a series of specialists including pain medicine specialists.

80. The Respondent's initial records for Patient F from April 2006 involve prescriptions for opioid medications (OxyContin 40 mg and Percocet 10/325 mg) and a benzodiazepine (Valium). The Respondent also referred Patient F to a pain medicine specialist who, in a report from April 2006, stated that he did not feel that Patient F's current use of narcotic medications was "warranted or beneficial on a long term" basis.

81. The pain medicine specialist provided a follow-up note in June 2006, in which he stated, "I would be reticent about utilizing narcotic medication in this patient." He recommended a surgical consultation and advised converting Patient F's medications to a different long-acting opioid, and that if Patient F expressed reluctance, it "would represent a significant red flag and possible addictive tendency."

82. The Respondent, however, continued to prescribe OxyContin 40 mg (#60), Percocet 7.5/325 mg (#120) and Valium for Patient F on a monthly or more frequent basis.

83. The Respondent also referred Patient F to another pain medicine specialist and for a neurosurgical consultation.

84. In a note from January 2007, the Respondent reported that Patient F's neurosurgeon recommended lumbar surgery.

85. The Respondent had Patient F enter into a controlled substance use agreement in or around June 2007.

86. The Respondent's chart for Patient F contains another consultation report from the pain medicine specialist from June 2007, which states that Patient F has a "moderate to significant of pain magnification" and recommended surgery.

87. Patient F underwent UDS in June 2007, which was negative for all opioids, which the Respondent had been prescribing on a monthly or more frequent basis. The Respondent, however, continued prescribing these medications on a monthly or more frequent basis, despite this inconsistent test finding.

88. The Respondent had Patient F enter into a controlled substance use agreement in or around August 2008.

89. Patient F underwent UDS in or around February 2009, which was positive for oxycodone, but also positive for alprazolam (Xanax), which the Respondent had not prescribed. The Respondent wrote, "borrowed from friend."

90. Patient F underwent UDS in June 2009, which was negative for oxycodone, which the Respondent had been consistently prescribing. The Respondent noted, "no OxyContin."

91. Despite this inconsistency and the Respondent's intention not to prescribe further OxyContin, he resumed prescribing OxyContin 40 mg (#60), Percocet 7.5/325 mg (#120) and Valium on a monthly or more frequent basis.

92. Patient F underwent UDS in or around August 2009, which was positive for oxycodone, but also positive for oxazepam and nordiazepam, two benzodiazepines the Respondent was not prescribing for Patient F. Notwithstanding these inconsistencies, the Respondent continued to prescribe OxyContin 40 mg and Percocet 7.5/325 mg on a monthly or more frequent basis.

93. Patient F underwent UDS in or around July 2010, which, while positive for oxycodone, was also positive for hydrocodone, which the Respondent was not prescribing for Patient F. Despite this inconsistency, the Respondent continued to prescribe OxyContin 40 mg (#60), Percocet 7.5/325 mg (#120) and Valium on a monthly or more frequent basis.

94. Patient F underwent UDS in or around December 2010, which was positive for oxycodone, but was negative for benzodiazepines, which the Respondent was prescribing.

95. The Respondent continued to prescribe OxyContin 40 mg (#60), Percocet 7.5/325 mg (#120), and Valium 10 mg (#90), on a periodic basis (roughly, monthly) until October 2014.

96. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient F, for reasons including the following:

(a) the Respondent inappropriately prescribed high dosages of opioid medications without pathology or objective findings to support the level of opioids prescribed;

(b) the Respondent inappropriately prescribed high dosages of opioid medications without documenting or performing an appropriate evaluation of Patient F's chronic pain complaints;

(c) the Respondent inappropriately prescribed high dosages of opioid medications without documenting or verifying Patient F's prior use of opioid medications;

(c) the Respondent inappropriately prescribed high dosages of opioid medications without appropriate justification, and without documenting or implementing a plan to transition Patient F off of these medications;

(d) the Respondent failed to appropriately document or assess Patient F for risk of addiction or abuse;

(e) the Respondent failed to account for leftover opioid medications when he refilled monthly prescriptions on a more frequent than monthly basis;

(e) the Respondent inappropriately prescribed high dosages of opioid medications without addressing aberrant behaviors, including multiple inconsistent UDS findings. Even when the Respondent noted that he intended to discontinue prescribing certain opioid medications (*e.g.*, OxyContin) following inconsistent UDS findings, he continued to prescribe the same medications without alteration;

(f) the Respondent failed to follow recommendations provided by a pain medicine specialist, who recommended not providing long-term opioid therapy or switching to alternative opioid medications;

(g) the Respondent failed to have Patient F enter into a timely controlled substance use agreement;

(h) the Respondent failed to appropriately evaluate Patient F's pain levels or response to treatment; and

(h) the Respondent failed to record adequate documentation in his chart. The Respondent recorded insufficient documentation in his progress notes during the multi-year treatment period. The Respondent failed to adequately document the results of physical examination findings, a treatment plan, treatment goals, his thought processes regarding treatment interventions, Patient F's response to treatment, or consultative recommendations from pain medicine specialists.

Patient G

97. The Respondent treated Patient G, a man currently in his 50s, from December 2006 through October 2014. Patient G's medical history included several back surgeries including fusions, cervicalgia, lumbago, myalgia and radiculitis. The Respondent treated Patient G for chronic pain complaints and other somatic conditions. Throughout the treatment period, the Respondent referred Patient G to various pain medicine specialists.

98. The Respondent's chart for Patient G indicates that he saw him in or around December 2006. The Respondent's initial prescriptions for Patient G included Lortab 10/325 mg (hydrocodone) (#150), Flexeril and Ambien. The Respondent then began prescribing these medications on a monthly or more frequent basis.

99. In or around July 2007, the Respondent had Patient G enter into a controlled substance use agreement and made a referral for Patient G to be evaluated for his pain complaints.

100. Patient G underwent UDS in July 2007 that was positive for opioids, which the Respondent was prescribing.

101. In or around August 2007, the Respondent added Valium to his prescribing of Lortab, Ambien and Flexeril. The Respondent continued to prescribe this regimen into 2008. In or around August 2008, the Respondent replaced prescribing hydrocodone with oxycodone 10 mg, initially 150 pills per month. He then increased Patient G's oxycodone to 180 pills per month.

102. Patient G underwent UDS in May 2009, which was positive for opioids, which the Respondent was prescribing, but negative for benzodiazepines, which the Respondent was also prescribing.

103. Patient G underwent UDS in August 2010, which was consistent. Patient G underwent UDS in December 2010, which was consistent for oxycodone, but at a level requiring review, and negative for nordiazepam, which the Respondent had been prescribing for Patient G.

104. The Respondent continued to prescribe this same regimen (oxycodone 10 mg (#180), Valium 10 mg (#30) and Flexeril on a roughly monthly basis into 2012.

105. In or around February 2012, the Respondent increased Patient G's oxycodone strength to 15 mg (#120) and Valium 10 mg (#60). In or around March 2012, the Respondent then increased Patient G's oxycodone 15 mg to 150 pills per month. The Respondent prescribed various combinations of opioid medications during this period, including Percocet and Norco (hydrocodone).

106. The Respondent referred Patient G to a pain medicine specialist who, in a report from July 2012, stated that Patient G was a candidate for long-term opiate management but "due to circumstances at home," should be prescribed a transdermal

long-acting opioid. The specialist offered to take over Patient G's pain medication management but Patient G declined and wished to stay under the Respondent's care.

107. The Respondent did not follow the advice of the consultant and continued to prescribe oral opioid medications for Patient G. In or around October 2012, the Respondent also added Opana -ER 40 mg (#60) to his prescribing of oxycodone 15 mg Valium 10 mg (#60) and Ambien.

108. The Respondent referred Patient G to another pain medicine specialist in or around April 2013. In a report from April 2013, the specialist recommended increasing his dosage of Opana from two to three times per day and decreasing his dosage of oxycodone from five times per day to twice per day. The specialist also recommended physical therapy and spinal cord stimulation.

109. The Respondent, however, continued to prescribe Opana twice per day and oxycodone five times per day.

110. The pain medicine specialist reported that he took over Patient G's pain medicine management and initiated him on MS Contin 15 mg TID and lowered his oxycodone dosage to every four-to-six hours. A handwritten note indicates that Patient G returned the prescriptions because he was unhappy with the pain medicine specialist's plan.

111. The pain medicine specialist continued to see Patient G into July 2013, and indicated his intention to continue Patient G on MS Contin 15 mg three times per day and wean down Patient G's use of oxycodone.

112. In or around August 2013, the Respondent prescribed MS Contin 15 mg (#90), oxycodone 15 mg (#150) and diazepam 10 mg (#90).

113. Thereafter, Patient G reportedly lost his health insurance benefits and returned to the Respondent's practice. The Respondent made another referral to a pain medicine specialist but continued to prescribe MS Contin 15 mg and oxycodone as of October 2014.

114. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient G, for reasons including the following:

(a) the Respondent inappropriately prescribed high dosages of short-acting opioid medications for a period of several years, without a plan to transition Patient G off of these medications;

(b) the Respondent failed to decrease his prescribing of short-acting opioid medications after adding long-acting opioid medications to his prescribing regimen;

(c) the Respondent prescribed high dosages of opioid medications without documenting or evaluating Patient G's pain levels or response to treatment;

(d) the Respondent failed to follow consultants' recommendations, which included use of transdermal patches or a decrease in short-acting opioid medications;

(e) the Respondent inappropriately prescribed high dosages of opioid medications without performing risk assessment, addiction risk or risk versus benefit assessment;

(f) the Respondent failed to document or perform appropriate neurological or musculoskeletal examinations; and

(g) the Respondent failed to record adequate documentation in his chart. The Respondent recorded insufficient documentation in his progress notes during the multi-year treatment period. The Respondent failed to adequately document the results of physical examination findings, a treatment plan, treatment goals, his thought processes regarding treatment interventions, Patient G's response to treatment, or consultative recommendations from pain medicine specialists.

Patient H

115. The Respondent treated Patient H, a woman currently in her 40s, from 2003 through October 2014. Patient H's medical history included motor vehicle accidents, injuries due to falls, headaches, lumbago, thoracic radiculitis, scoliosis and myalgia. During the treatment period, the Respondent treated Patient H for chronic pain complaints and other medical conditions, primarily with multiple high-dosage opioid medications. The Respondent also referred Patient H to several pain medicine specialists. No consultants' reports detailing their evaluations are in Patient H's chart, however. Despite referring Patient H to these pain medicine specialists, the Respondent continued to prescribe multiple high-dosage opioid medications on a monthly or more frequent basis to Patient H.

116. The Respondent initially provided treatment for Patient H in 2003 for injuries sustained in a fall. The Respondent initiated Patient H on short-acting opioid medications (*e.g.*, oxycodone). By the end of 2003, the Respondent at times added prescriptions for hydrocodone in addition to oxycodone for Patient H's pain complaints.

117. The Respondent continued to prescribe oxycodone and at times, hydrocodone, in conjunction with Soma and a sleeping aid such as Ambien or Lunesta, for Patient H on a monthly or more frequent basis. In or around February 2008, the Respondent began prescribing Methadone 10 mg (#60), on a monthly basis in addition to prescribing oxycodone and hydrocodone.

118. In or around March 2008, the Respondent began prescribing OxyContin 80 mg (#60), oxycodone 10 mg, hydrocodone, Soma and Valium to Patient H on a monthly or more frequent basis. The Respondent continued to prescribe this combination of medications until the conclusion of the treatment period, typically on a monthly or more frequent basis. At the conclusion of the treatment period, the Respondent was providing Patient H with monthly or more frequent prescriptions for OxyContin 80 mg (#90), oxycodone 10 mg (#120), Methadone 10 mg (#30), Valium 10 mg (#90), Soma 350 mg (#90) and Ritalin 10 mg (#60).

119. Patient H's chart contains instances of unusual occurrences. For example, an office note from February 12, 2009, states that the Respondent's office received a report from a pharmacy that someone was using Patient H's name and was looking for Methadone and had tried five different pharmacies. Another office note from March 2011 stated that Patient H attempted to fill two prescriptions dated one day apart. The Respondent's chart also contains a UDS from in or around June 2009, which was inconsistent due to negative tests results for Methadone and oxycodone, and positive for oxymorphone, which the Respondent did not prescribe.

120. The Respondent's chart for Patient H does not contain treatment records from 2009 into 2010, during which time the Respondent provided opioid medications to Patient H.

121. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient H, for reasons including the following:

(a) the Respondent inappropriately prescribed escalating dosages of opioid medications without documenting or performing an appropriate evaluation of Patient H's chronic pain complaints;

(b) the Respondent inappropriately prescribed escalating dosages of two short-acting opioid medications without appropriate justification;

(c) the Respondent inappropriately prescribed high dosages of multiple opioid medications without documenting or performing an assessment of risk, addiction risk or risk versus benefit assessment;

(d) the Respondent failed to appropriately document or have Patient H enter into a controlled substance use agreement or obtain appropriate informed consent for his prescribing regimen;

(e) the Respondent failed to account for left over medications after prescribing monthly dosages of opioid medications at sooner than monthly intervals;

(f) the Respondent prescribed high dosages of opioid medications without documenting or evaluating Patient H's pain levels or response to treatment;

(g) the Respondent failed to document or perform appropriate neurological or musculoskeletal examinations;

(h) the Respondent failed to appropriately document or evaluate Patient H's pain levels, effect of pain, or escalating dosages of opioid pain medication on function other than notes such as "stable" or "patient doing well on meds";

(i) the Respondent prescribed high dosages of multiple opioid medications without documenting or undertaking appropriate compliance monitoring, including UDS and pill counts;

(j) the Respondent prescribed high dosages of opioid medications without documenting or evaluating Patient G's pain levels or response to treatment;

(k) the Respondent failed to address aberrant or "red flag" behaviors, including inconsistent UDS and reports of medication misuse from pharmacies;

(l) the Respondent's chart is missing progress notes for a significant number of patient visits; and

(m) the Respondent failed to record adequate documentation in his chart. The Respondent recorded very few progress notes during the almost five-year treatment period. The Respondent failed to adequately document the results of physical examination findings, a treatment plan, treatment goals, his thought processes regarding treatment interventions and Patient H's response to treatment.

Patient I

122. The Respondent treated Patient I, a woman currently in her 30s, from June 2007 to September 2014, when he dismissed her from his practice. The Respondent

treated Patient I for various conditions including backache, lumbago, chronic foot pain (painful bunions) and psychological issues. Throughout the treatment period, the Respondent treated Patient I's pain complaints with short and long-acting opioid medications and other non-opioid medications, and referred her to various specialists, including specialists in pain medicine.

123. The Respondent initiated providing primary care to Patient I in or around June 2007. The Respondent began prescribing opioid medications for Patient I's chronic foot pain from a remote injury requiring surgery. The Respondent prescribed OxyContin 40 mg (#60), Percocet 10/325 mg (#120) and Ativan. The Respondent did not obtain Patient I's prior medical records to confirm that she had been prescribed these medications. The Respondent referred Patient I to a specialist for evaluation of her foot.

124. On or about June 29, 2007, the Respondent refilled Patient I's medications and had her enter into a controlled substances use agreement.

125. The Respondent's chart contains an undated note that states that a pharmacy informed the office that Patient I had received Percocet 5/325 mg (#30) from a dentist.

126. The Respondent ordered UDS for Patient I, which took place on July 20, 2007. Patient I tested negative for oxycodone.

127. The Respondent continued to prescribe the same opioid regimen to Patient I. In a handwritten progress note dated August 16, 2007, the Respondent noted that a hospital-associated pain clinic refused to accept Patient I due to an inconsistent UDS. The Respondent referred Patient I to another pain medicine specialist who, in a report dated August 30, 2007, recommended that Patient I see a foot surgeon. He also stated

that because Patient I's UDS detected no opioids, which the Respondent had been prescribing, it should raise concerns about diversion. The pain medicine specialist concluded, "I do not believe that long-term narcotic medication is in the patient's best interest."

128. The Respondent continued prescribing the same opioid regimen to Patient I until September 5, 2007.

129. A gap of care then occurred, after which the Respondent saw Patient I on August 7, 2008. The Respondent reinitiated prescribing OxyContin 40 mg, Percocet 10/325 mg and Ativan. The Respondent had Patient I enter into a new controlled substance use agreement on this visit. In his progress note for this date, the Respondent reported that Patient I had been prescribed these medications by a physician in a different state. The Respondent did not note if or whether he verified this information independently.

130. Patient I underwent UDS on August 6, 2008, which was negative for oxycodone, which Respondent had been prescribing, and also positive for lorazepam, which she had not been prescribed.

131. The Respondent ordered radiographs and electromyography in or around August 2008. The radiographic report stated normal findings other than evidence of prior osteotomy and a single orthopedic screw. The EMG findings were normal. The neurologist who performed the EMG reported that Patient I's complain was probably related to anxiety.

132. The Respondent continued to prescribe OxyContin 40 mg (#60), oxycodone 10 mg (#120), Ativan and an anti-depressant to Patient I on a monthly basis.

133. The Respondent's chart contains a progress note from September 2008 stating that Patient I reported that OxyContin was less effective than Percocet. The Respondent lowered Patient I's OxyContin to 20 mg and continued Patient I on Percocet.

134. In a progress note from November 2008, the Respondent reported increasing Patient I's OxyContin from 20 mg to 40 mg, without an explanation for the change.

135. The Respondent continued to prescribe his opioid medication regimen into 2011.

136. In a progress note, dated February 6, 2009, the Respondent stated that Patient I saw a pain medicine specialist who stated that Patient I's "meds are okay." Patient I's chart, however, does not contain a consultation note from this specialist during this time frame.

137. Patient I underwent UDS on or about February 11, 2009, which was positive for oxycodone, THCA (marijuana metabolite) and lorazepam, which the Respondent had not prescribed for Patient I.

138. The Respondent's next progress note does not reference this inconsistent UDS.

139. The Respondent wrote a progress note, dated June 30, 2009, in which he stated that Patient I was taken in handcuffs to a hospital for psychiatric care. The Respondent did not discuss obtaining Patient I's records and continued prescribing his opioid regimen on a monthly basis.

140. Patient I's chart contains a handwritten note from her dated January 14, 2010, in which she reported that her medications had been stolen. The Respondent provided replacement opioid prescriptions for Patient I.

141. Patient I's chart contains a letter from her pharmacy benefits manager from November 2010 that states that she was receiving hydrocodone 7.5 mg from a provider other than the Respondent. The Respondent noted that Patient I was in an automobile accident.

142. The Respondent continued to prescribe his opioid regimen until June 2011, when he noted that Patient I reported that her OxyContin wore off in less than 12 hours. As a result, the Respondent reduced her OxyContin strength to 20 mg, added Opana ER 20 mg (#60), and continued her on oxycodone 10 mg (#120).

143. On June 30, 2011, the Respondent prescribed the same opioid regimen.

144. Patient I's chart contains a handwritten note, dated July 11, 2011, which notes that Patient I reported losing her medications while on vacation and had requested refills of her medications.

145. The Respondent wrote a progress note dated July 15, 2011, in which he noted the above report. The Respondent prescribed oxycodone 30 mg (#60) and oxycodone 15 mg (#90).

146. A gap of care then occurred. On December 16, 2011, the Respondent prescribed Opana ER 20 mg (#60) and oxycodone 30 mg (#90). The Respondent provided no explanation for the change in Patient I's oxycodone prescription.

147. Patient I's chart contains a letter from her pharmacy benefits manager from January 2012, which stated that she received several recent opioid prescriptions that "highlights a pattern of medication use that may be excessive."

148. The Respondent wrote a progress note, dated July 6, 2012, in which he stated that Opana ER was too expensive, which caused him to switch Patient I to OxyContin 30 mg every 12 hours and continue oxycodone 30 mg three times per day.

149. The Respondent wrote a progress note, dated August 3, 2012, in which he discontinued OxyContin and switched Patient I to oxycodone 30 mg (#120) due to "patient's preference."

150. In or around late 2012, the Respondent was prescribing oxycodone 30 mg (#120).

151. The Respondent wrote a progress note, dated January 25, 2013, in which he noted prescribing Percocet 10/325 mg twice per day for breakthrough pain, with no explanation for adding a second short-acting opioid medication.

152. During this time frame, the Respondent also attempted to refer Patient I to pain medicine specialists.

153. By March 2013, the Respondent was prescribing oxycodone 30 mg (#120) and oxycodone 10 mg (#60) on a roughly monthly basis.

154. Patient I's chart contains an office note from an individual who called the office on March 11, 2014, to report that two of the Respondent's patients were selling their prescription medications. The chart contains a follow-up note from March 12, 2014, which quotes Patient I as stating that the other individual was acting maliciously when making this report.

155. The Respondent continued to prescribe this opioid regimen to Patient I on a monthly basis until in or around October 2014, when he discharged her as a patient. The Respondent wrote a note stating that Patient I was about to see a pain medicine specialist.

156. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. II § 14-404(a)(40), with respect to Patient I, for reasons including the following:

(a) upon initiation of treatment, the Respondent prescribed significant quantities of short and long-acting opioid medications without verifying independently Patient I's prior opioid usage;

(b) the Respondent prescribed high dosages of short and long-acting opioid medications without pathology or objective findings to support the level of opioids prescribed;

(b) the Respondent inappropriately prescribed high dosages of opioid medications without documenting or performing an appropriate evaluation of Patient I's chronic pain complaints;

(c) the Respondent inappropriately prescribed high dosages of short and long-acting opioid medications without documenting or implementing a plan to transition Patient I off of these medications;

(d) the Respondent inappropriately prescribed high dosages of opioid medications despite inconsistent UDS findings and a recommendation from a pain medicine specialist against long-term prescribing of opioid medications;

(e) the Respondent failed to appropriately document or assess Patient I for risk of addiction or abuse;

(f) the Respondent failed to appropriately document or evaluate Patient I's response to treatment;

(g) the Respondent failed to appropriately document or evaluate Patient I's pain levels, effect of pain, or effect of prescribing on function;

(h) the Respondent failed to appropriately address aberrant or "red flag" behaviors, including: inconsistent UDS findings; UDS findings that were positive for use of illicit substances; claims of lost/stolen medications; requests for specific combinations of medications (short-acting opioids); and/or reports of misuse or acquisition of opioid medications from other physicians;

(i) at times during the treatment period, the Respondent inappropriately prescribed two short-acting opioid medications concomitantly;

(j) the Respondent failed to refer Patient I for a psychiatric evaluation despite numerous instances of dysfunctional behaviors; and

(k) the Respondent failed to record adequate documentation in his chart. The Respondent recorded very few progress notes during the eight-year treatment period. The Respondent failed to adequately document the results of physical examination findings, a treatment plan, treatment goals, his thought processes regarding treatment interventions and Patient I's response to treatment.

IV. Grounds for Discipline

157. The Respondent's actions, as described above, constitute a violation of the following provisions of the Act: Health Occ. II § 14-404(a)(22), Fails to meet appropriate

standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; and/or Health Occ. II § 14-404(a)(40), Fails to keep adequate medical records as determined by appropriate peer review.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel B concludes as a matter of law that the Respondent violated Health Occ. II § 14-404(a)(22), Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, and Health Occ. II § 14-404(a)(40), Fails to keep adequate medical records as determined by appropriate peer review.

ORDER

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

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

ORDERED that after sixty (60) days, the Respondent is permanently prohibited from practicing pain management and shall not prescribe any opioid medications to chronic pain patients. The Respondent may prescribe CDS and opioids in emergency situations for acute pain, not to exceed a period of seven (7) days.

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **EIGHTEEN (18) MONTHS**. During the probationary period, the Respondent shall fully and satisfactorily comply with all of the following probationary terms and conditions:

1. Within six (6) months, the Respondent shall successfully complete a Panel B-approved course in appropriate medical recordkeeping. This course shall not be

internet-based but shall involve personal didactic instruction. The Respondent shall enroll in the required course within ninety (90) days. The Respondent shall submit written documentation to Panel B regarding the particular course he proposes to fulfill the condition. Panel B reserves the right to require the Respondent to provide further information regarding the course he proposes, and further reserves the right to reject his proposed course and require submission of an alternative proposal. Panel B will approve a course only if it deems the curriculum and the duration of the course adequate to satisfy its concerns. The Respondent shall be responsible for submitting written documentation to Panel B of his successful completion of the course. The Respondent understands and agrees that he may not use the course to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing Panel B with adequate written verification that he has completed the course according to the terms set forth herein;

2. The Respondent shall register with the Chesapeake Regional Information System for our Patients (CRISP) in order to obtain access to the DHMH Prescription Drug Monitoring Program (PDMP), and on a quarterly basis shall query prescription information for patients for whom he is prescribing controlled substances and shall submit timely written reports to Panel B;

3. The Respondent shall place a copy of the information obtained from the PDMP in the medical records of all patients for whom he is prescribing controlled substances;

4. During the probationary period, the Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agent; and

5. The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. II §§ 14-101 *et seq.*, and all laws, statutes and regulations governing the practice of medicine.

AND IT IS FURTHER ORDERED that after the conclusion of the entire eighteen (18) month period of probation, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Board panel. The Board or Board panel will grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that if the Respondent fails to comply with any term or condition of probation or this Consent Order, the Board or Board disciplinary panel, after notice and an opportunity for a hearing before an Administrative Law Judge of the Office of Administrative Hearings if there is a genuine dispute as to a material fact or a show cause hearing before the Board or Board disciplinary panel if there is no genuine dispute as to a material fact, may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's medical license; and it is further

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

ORDERED that, unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes

into effect upon the signature of the Board's Executive Director, who signs on behalf of the Board disciplinary panel; and it is further

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

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

03/16/2016
Date

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

CONSENT

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

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of Panel B to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of Disciplinary Panel A that might have followed any such hearing.

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

terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

3-10-16
Date

Lawrence Vidaver, M.D.
Respondent

Read and approved:

Andrew E. Vernick, Esquire
Counsel for Dr. Vidaver

NOTARY

STATE OF Maryland

CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 10th day of March, 2016, before me, a Notary Public of the foregoing State and City/County personally appear Lawrence Vidaver, M.D. and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Notary Public

My commission expires:
01/15/2019