IN THE MATTER OF	*	**BEFORE THE MARYLAND**
SHELDON L. MARGULIES, M.D.	*	**STATE BOARD**
Respondent	*	**OF PHYSICIANS**
License Number: D28087	*	**Case Number: 2013-0915**

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CONSENT ORDER

On January 22, 2015, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Sheldon L. Margulies, M.D. (the "Respondent"), License Number D28087, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occupations ("H.O.") §§ 14-401 *et seq.* (2014 Repl.Vol.).

The pertinent provisions of the Act under H.O. § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
> ...
>
> (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 maintain adequate medical records as determined by appropriate peer review[.]

On March 25, 2015, a conference with regard to this matter was held before Panel B of the Board's Disciplinary Committee for Case Resolution Conference ("DCCR"). As a result of the DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

GENERAL FINDINGS OF FACT

1. At all times relevant hereto, the Respondent, who is board-certified in neurology, was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed on July 13, 1982. His license is scheduled to expire on September 30, 2015.

2. The Respondent has been retired from the practice of medicine since October 2013.

3. On May 22, 2013, the Board received a complaint from a relative of a former patient ("Patient A" below) of the Respondent alleging that the Respondent was prescribing an excessive amount of Controlled Dangerous Drugs ("CDS") to Patient A. The complainant further alleged that Patient A had severe addiction issues and may be diverting for financial gain the CDS prescribed by the Respondent.

4. The Board initiated an investigation of the complaint, including interviewing the Respondent and referring ten of the Respondent's patient records for peer review.

5. On December 19, 2013, Board staff interviewed the Respondent under oath. During the interview, the Respondent stated that he had "retired" in September 2013, but some patients may have "lingered on" until October 2013. The Respondent told Board staff that he had no training in pain management, but that "this pain business started in probably late 2011." The Respondent stated that he "[wasn't] sure how it started...they [pain management patients] just came in the door...I started to see more of them." The Respondent observed that his

pain management patients were generally young. He recalled that one patient had stolen his prescription pad and another had stolen some blank checks and forged them. It was at this point that the Respondent "soured on the whole thing" and decided to retire.

6. The Respondent stated that he charged $250 to $300 for an initial office visit and $100 to $200 for follow-up visits.

7. The Respondent told Board staff that he did not use pain management contracts because he "did not have enough training in pain management to understand them" and that after requiring approximately six patients to undergo urinalysis on one occasion he stopped because "it was just so complicated."

8. The Respondent also stated that he does not require patients to bring in prior medical records because he "[hadn't] found it that helpful," and would only obtain records or studies "if I needed to decide, well, should I do this or should I do that?"

SUMMARY OF PRACTICE DEFICIENCIES

9. The peer reviewers noted the following recurring deficiencies when reviewing the Respondent's records:

    a. The Respondent consistently failed to document adequate physical examinations and pain histories;

    b. The Respondent consistently prescribed two short-acting opioids, typically oxycodone and hydrocodone, for patients who complained of chronic pain. When treating chronic pain, prescribing a long-acting

opioid or one short-acting and one long-acting opioid constitutes the standard of quality care;

c. The Respondent started and discontinued opioids and increased dosages in the absence of medical justification and documentation of his treatment rationale;

d. The Respondent consistently prescribed excessive dosages of opioids in the absence of medical justification;

e. The Respondent failed to monitor patient compliance with urinalysis;

f. The Respondent failed to require patients to enter into pain management contracts;

g. The Respondent failed to recognize "red flags" of abuse or diversion and consistently refilled "lost" or "stolen" prescriptions;

h. The majority of the patients whose care was reviewed do not reside in Maryland. They traveled long distances to see the Respondent every several months;

i. The Respondent regularly wrote prescriptions for refills of opioids earlier than indicated;

j. The Respondent regularly wrote multiple post-dated prescriptions;

k. The Respondent continued to write prescriptions for opioids after informing patients that he would no longer do so;

l. The Respondent's notes are scant; some entries indicate only that he refilled opioid prescriptions, often for multiple months, for patients on the specified date.

Patient-Specific Findings of Fact

In addition to the above general deficiencies, the peer reviewers noted patient-specific deficiencies including, but not limited, to the following:

Patient A

10. Patient A, a female in her twenties, initially presented to the Respondent in July 2011. Her prior medical history included low back pain for which she had undergone lumbar fusion in 2001. Patient A had been under the care of a pain management physician before seeing the Respondent.

11. When Patient A presented to the Respondent, she reported that her medication regimen included oxycodone[1] and Duragesic patches.[2] The Respondent did not obtain records of Patient A's care by previous physicians.

12. On Patient A's first visit, the Respondent discontinued the Duragesic patches, noting that they made Patient A nauseated.

13. During the course of Patient A's treatment, through May 2013, the Respondent increased Patient A's dosage of oxycodone from 15 mg three times a day to 30 mg four times a day. The Respondent also added a second short-acting opioid, hydrocodone 10/325, four times a day.

14. By letter dated August 13, 2012 to Patient A's internal medicine physician, the Respondent noted that Patient A had twice telephoned him asking for extra hydrocodone. The Respondent further noted, "[b]ecause of all the telephone calls, I switched [Patient A] today from hydrocodone to [m]ethadone[3] (which she used to take) 10 mg QID [four times a day] or 20 mg BID [twice a day]."

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[1] A short-acting Schedule II opioid.
[2] A long-acting Schedule II opioid.
[3] A long-acting Schedule II opioid.

15. During the course of Patient A's treatment, the Respondent refilled Patient A's prescriptions for CDS on two occasions based on her reports that her medications had been stolen.

16. On October 12, 2012, the Respondent post-dated three months of oxycodone and methadone for Patient A, noting that he will be retiring soon.

17. In March 2013, the Respondent documented that he and Patient A "had a long discussion" about his retirement and he wrote yet another prescription for one month of oxycodone #240 and methadone #120.

18. In May 2013, the Respondent documented that Patient A was "crying and begging for something." The Respondent told her that he was retiring, but wrote a prescription for oxycodone #60 and methadone #60.

19. In his summary of care, the Respondent noted that he stopped prescribing to Patient A in late May 2013 after learning from a relative of Patient A that Patient A was a "drug addict."

20. The Respondent did not require Patient A to undergo urinalysis at any time during the course of her treatment. The Respondent prescribed excessive quantities of opioids in the absence of documented medical necessity. The Respondent failed to recognize "red flags" of drug abuse or diversion.

21. The Respondent's documentation was scant; he failed to document his treatment rationale.

Patient B

22. Patient B, a male in his mid-twenties who does not reside in Maryland, initially presented to the Respondent in April 2012 with complaints of chronic back pain. Patient B's chart contains notes from an out-of-state physician ("Physician A") whose last note was dated August 16, 2011.

23. Physician A's medication regimen for Patient B included oxycodone 30 mg (every four to six hours) and muscle relaxants.

24. During Patient B's course of treatment, the Respondent prescribed to Patient B oxycodone 30 mg every four hours.

25. The Respondent wrote multiple post-dated prescriptions for opioids on several occasions for Patient B reportedly so that Patient B could work out-of-state.

26. The Respondent did not require Patient B to undergo urinalysis despite the high dosages of opioids he prescribed.

27. The Respondent's documentation was sparse with no evidence of the underlying pathology justifying the doses and quantities of opioids he prescribed.

28. The Respondent prescribed short-acting opioids to Patient B for his chronic back pain despite the lack of indication for such a regimen.

Patient C

29. Patient C, a male in his sixties and a relative of Patient B, initially presented to the Respondent in July 2012 with complaints of chronic lower back pain. Like Patient B, Patient C does not reside in Maryland.

30. Patient C provided the Respondent with prior records from Physician A. Upon review of Physician A's records, the Respondent documented that he agreed

with Physician A's diagnosis of multilevel degenerative disc disease and adopted Physician A's medication regimen of oxycodone 30 mg four times a day.

31. Patient C returned to the Respondent in November 2012, March 2013 and June 2013. On each occasion, the Respondent wrote four months of post-dated prescriptions for oxycodone 30 mg, reportedly because Patient C was going out of town to work.

32. The Respondent did not require Patient C to undergo urinalysis despite the high dosages of opioids he prescribed.

33. The Respondent's documentation is sparse with no evidence of the underlying pathology justifying the doses and quantities of opioids he prescribed.

34. The Respondent prescribed short-acting opioids to Patient C for his chronic back pain despite the lack of indication for such a regimen.

Patient D

35. Patient D, a male in thirties, initially presented to the Respondent on or about May 4, 2010 with complaints of headaches and neck pain which Patient D attributed to a December 2009 accident. Patient D does not reside in Maryland.

36. The Respondent diagnosed Patient D with post-concussive syndrome and possible C7 fracture based on the diagnosis of Patient D's previous physician.

37. Throughout Patient D's course of treatment (through June 2013), the Respondent prescribed varying dosages of hydrocodone, Roxicodone and Soma in the absence of a physical examination. The Respondent's notes for several months document only that he wrote a prescription for opioids for Patient D, often with multiple refills.

38. On more than one occasion, the Respondent refilled Patient D's prescriptions of opioids based on Patient D's reports that he had lost the prescriptions or tablets. Throughout Patient D's record, the Respondent documented that he provided to Patient D on multiple occasions post-dated prescriptions for opioids based on Patient D's report that he was relocating.

Patient E

39. Patient E, a female in her seventies, initially presented to the Respondent in 2002 with complaints of hip and back pain. Patient E does not reside in Maryland. On Patient E's first visit, the Respondent documented focal tenderness over the right and sacroiliac joints. The Respondent prescribed Lorcet #90 with two refills and Soma #60.

40. Patient E returned to the Respondent three years later, in 2006. At that visit, the Respondent documented that Patient E was "doing reasonably well on hydrocodone 10.650 QID (four times a day) , Soma] TID (three times a day) and Adderall TID." The Respondent refilled these medications and noted that she would be seen in six months.

41. From 2006 through August 2013, Patient E saw the Respondent twice a year. The Respondent noted on several occasions that she had travelled from out-of-state to see him. The Respondent prescribed short-acting opioids to treat Patient E's complaints of pain in the absence of objective evidence to support chronic opioid use. The Respondent typically provided to Patient E several months of post-dated prescriptions at each visit.

Patient F

42. Patient F, a male in his thirties, initially presented to the Respondent in October 2012 with complaints of "chronic lumbosacral, right scapular and right shoulder pain..." Patient F did not reside in Maryland at the time.

43. The Respondent noted that a three-year old MRI revealed degenerative disc disease in the lower lumbar region with no herniation.

44. Patient F reported that his medication regimen included Roxicodone 30 mg, 8 tablets a day and Dilaudid 8 mg five tablets a day.

45. The Respondent documented that he told Patient F that he would be retiring and would not be able to see Patient F after his first visit. The Respondent noted that Patient F asked for 3 months of pain medication which would permit him (Patient F) to find a pain clinic. The Respondent provided the prescriptions as requested.

46. Patient F returned to the Respondent in February 2013. The Respondent provided him with prescriptions for three months of Roxicodone and Dilaudid, after conducting a minimal examination.

47. Patient F returned again in July 2013. The Respondent provided him with prescriptions for two months of Roxicodone and Dilaudid after conducting a minimal examination and in the absence of objective evidence to support chronic opioid use by Patient F.

Patient G

48. Patient G, a female in her thirties, initially presented to the Respondent in April 2002 after sustaining injuries in an automobile accident. The Respondent diagnosed Patient G with post-traumatic migraine headaches.

49. The Respondent prescribed non-opioid migraine medications to Patient G until June 2004, when the noted that Patient G was taking one Percocet a day because other medications did not relieve her headaches. The Respondent had not documented that he had initially prescribed Percocet to Patient G.

50. In February 2005, the Respondent advised Patient G in writing that he was "not allowed to prescribe narcotics" to her because he had not seen her in six months.

51. In March 2005, Patient G presented to the Respondent with complaints of shoulder pain. The Respondent documented that Patient G was taking 2 Vicoprophen[4] at a time because Percocet made her sick. The Respondent had not previously prescribed Vicoprophen to Patient G. The Respondent documented that Patient G was going to discontinue taking Percocet and amitriptyline and "rely on Vicoprophen 7.5 mg #100 per month."

52. In September 2006, however, Patient G once again presented and the Respondent documented that she was taking eight Vicoprophen tablets a day, an average of one Percocet a day "plus about 20 per month for her arm pain and occasional Flexeril mg." At this visit, the Respondent noted that he "refilled Percocet for six months through February 2007", as well as Flexeril, amitriptyline and Vicoprophen.

53. Throughout the remainder of Patient G's course of treatment (through October 2013), the Respondent continued to prescribe various short-acting opioids to Patient G based primarily on her subjective complaints.

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[4] Hydrocodone and ibuprophen. A short-acting Schedule II opioid.

54. In January 2013, the Respondent documented that Patient G "complain[ed] of ADD[5] which was at once helped with Adderall 20 mg TID." Based on Patient G's statement, the Respondent added Adderall to her medication regimen.

Patient H

55. Patient H, a female in her forties, initially presented to the Respondent in May 2012 with complaints of chronic low back pain radiating into her buttocks. The Respondent noted that her medication regimen included oxycodone 30 mg twelve per day and Xanax.

56. At Patient H's first visit, the Respondent diagnosed her with spinal stenosis with right sciatica and right carpal tunnel syndrome. He documented that he reduced her dosage of oxycodone from 180 tablets a month to 150 tablets and her methadone (which he had not listed as having been part of her previous regimen) from 90 tablets to 60 tablets a month.

57. Two weeks later, Patient H returned and reported "adequately controlled back pain." The Respondent started Dilaudid and began a trial of Exalgo (extended release hydromorphone).

58. In June 2012, one month later, the Respondent increased Patient H's dosage of oxycodone to 180 tablets per month, and continued to prescribe methadone and Dilaudid.

59. In July 2012, the Respondent documented that "[Patient H] is still on excessive opiates." He further documented that Patient H had agreed to a "slow taper" and he reduced her monthly prescription of methadone from 60 tablets to 40 tablets.

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[5] The abbreviation for Attention Deficit Disorder.

60. In August 2012, Patient H returned with complaints of back pain. The Respondent documented that he was aware that Patient H had a drug-related conviction. The Respondent further documented that Patient H was "calm and rational" as they checked the Maryland Judiciary Case Search and she "recalled details of her multiple cases." When the Respondent told Patient H that she would thereafter have to obtain opioids from a pain clinic, Patient H asked for two months to locate a clinic. The Respondent wrote prescriptions for two months of oxycodone #180, methadone BID (quantity unspecified) and Dilaudid TID (quantity unspecified).

61. In late September 2012, Patient H returned once again to the Respondent who documented that she "promised to never return." The Respondent prescribed to her oxycodone #120, Dilaudid #90 and Xanax BID (quantity unspecified).

62. Patient H's last documented visit occurred in December 2012. The Respondent documented that Patient H "brought paperwork documenting that she has no criminal record." Patient H reported having undergone an EMG (location unspecified) that revealed an abnormality. The Respondent documented that examination revealed in part, "focal tenderness in the lumbosacral spine with moderate limitation of flexion at the waist." The Respondent told Patient H that he was retiring and prescribed to her one month of oxycodone #180 and Dilaudid.

Patient I

63. Patient I, a female in her thirties, initially presented to the Respondent in August 2011 for neurological evaluation. The Respondent documented that Patient I

reported cervical and lumbar pain after having suffered viral encephalitis and being in a coma for a month when she was a twenty years old.

64. The Respondent noted that Patient I had documented narcolepsy and chronic pain. At Patient I's first visit, he continued her oxycodone TID and provided her prescriptions for three months.

65. Less than one month later, Patient I returned complaining of low back pain. The Respondent noted that he "renewed 120 oxycodone 30 mg today."

66. In October 11, 2011, Patient I complained of worsening pain in her lower back. The Respondent documented focal tenderness in the right sciatic notch and midline posterior hamstrings. He continued Patient I's oxycodone and added Opana[6] #30.

67. In November and December 2011, the Respondent wrote letters to two of Patient I's physicians in which he advised that he would no longer be prescribing oxycodone for Patient I or any of his other patients.

68. Notwithstanding his earlier letters, in January 2012, the Respondent wrote to one of the physicians that Patient I had returned with persistent severe low back pain for which he prescribed Percocet 10/325 QID #120. Percocet is a combination of acetaminophen and oxycodone.

69. In March 2012, the Respondent noted that Patient I was taking four to five tablets of Percocet 10/325 a day after sustaining an "extensive contusion over the entire lumbosacral area." The Respondent added Percocet 7.5/325 #120 to Patient I's regimen.

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[6] Trade name for oxymorphone, a Schedule II CDS.

70. Three weeks later, the Respondent prescribed another 120 tablets of Percocet 10/325 to Patient I in the absence of documentation of his treatment rationale.

71. In April 2012, the Respondent instructed Patient I to mix Vicodin tablets with the large number of Percocet 7.5/325 she had in order to "convert to Vicodin entirely." The Respondent documented that he "agreed to supplement her lower narcotic dose with Xanax."

72. In May 2012, Patient I returned with complaints of muscle pain in her neck and back and right sciatic nerve pain. The Respondent prescribed: "Percocet 10/325 #150 for two months; MS Contin 60 mg BID for two months and Xanax 2 mg #75 with three refills."

73. The Respondent's last entry in Patient I's chart is a note that a family member of Patient I had telephoned and advised the Respondent that Patient I's marital conflict may be "related to her pain and narcotic use."

Patient J

74. Patient J, a female in her forties, initially presented to the Respondent in October 2011. Her past medical history included fibromyalgia and arthritis in her hands. She presented to the Respondent with complaints of neck and back pain. The Respondent noted that Patient J's current medication regimen included oxycodone 40 mg TID, oxycodone 30 mg seven or eight tablets a day and Adderall 25 tablets per month. The Respondent noted that he reduced her oxycodone to 120 per month.

75. By letter dated January 27, 2012, the Respondent notified one of Patient J's physicians that the Respondent was "no longer prescribing any oxycodone or oxycontin for any patients."

76. Notwithstanding his January 2012 letter, in February 2012 the Respondent "renewed" Patient J's Opana (failing to note the source of the initial prescription), oxycodone 30 mg #120 a month, Adderall and a muscle relaxant.

77. In April 2012, the Respondent documented that Patient J "doing rather well" on oxycontin 80 mg #90, oxycodone 30 mg #120, oxycodone 15 mg #90, Xanax 1 mg TID and Adderall 30 mg TID. The Respondent documented that he reduced Patient J's dosage of Oxycontin from 90 mg to 60 mg but increased the quantity of oxycodone 15 mg he prescribed. The Respondent failed to document when or why he had started Oxycontin at one of the highest dosage levels.

78. In May 2012, the Respondent added Soma to Patient J's medication regimen in the absence of documentation of his treatment rationale.

79. In early June 2012, the Respondent noted that Patient J "fell off a bus and lost her wallet and medications." He further noted "[r]efilled 60 tablets 30 mg." Presumably, he was referring to oxycodone.

80. The Respondent continued to prescribe high dosages of potentially addictive drugs to Patient J in the absence of documentation of underlying pathology.

81. The Respondent's last note in Patient J's, dated September 5, 2012, states merely "[a]rrested for forging stolen prescriptions."

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, Disciplinary Panel B concludes as a matter of law that the Respondent failed to meet standards of care for the delivery of quality medical or surgical care, in violation of H.O. § 14-404(a)(22) and failed to maintain adequate medical records, in violation of H.O. § 14-404(a)(40).

ORDER

Based on the foregoing Findings of Fact and Conclusion of Law, it is, by Disciplinary Panel B, hereby

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

ORDERED that the Respondent's license is inactive; and it is further

ORDERED that the Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., General Provisions, §§4-101 – 4-601 (2014).

5/4/2015
Date

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

CONSENT

I, Sheldon L. Margulies, M.D., acknowledge that I have had the opportunity to be represented by counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by Disciplinary Panel B, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered 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 provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of Disciplinary Panel B to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of a disciplinary panel of the Board that I might have filed after any such hearing.

I sign this Consent Order voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

4/23/2015
Date

Sheldon L. Margulies, M.D.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Montgomery

I HEREBY CERTIFY that on this 23rd day of April 2015, before me, a Notary Public of the foregoing State and City/County, personally appeared Sheldon L. Margulies, 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 notarial seal.

Notary Public

My commission expires: 6/21/15

Matthew D. Alman
Notary Public
Montgomery County, Maryland
My Commission Expires June 21, ~~2011~~ 2015