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| **IN THE MATTER OF** | * | **BEFORE THE** |
| **MATTHEW WACHSMAN, M.D.** | * | **MARYLAND STATE** |
| **Respondent** | * | **BOARD OF PHYSICIANS** |
| **License Number: D40922** | * | **Case Numbers: 2014-0535B 2015-0499B** |

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## CONSENT ORDER

On July 14, 2015, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Matthew Wachsman, M.D. (the "Respondent"), License Number D40922, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol.).

The pertinent provisions of the Act under Health Occ. § 14-404 provide the following:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (3) Is guilty of:
>
> (ii) unprofessional conduct in the practice of medicine;
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On October 28, 2015, Disciplinary Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations

occurring as a result of the DCCR, Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

## FINDINGS OF FACT

The Board makes the following findings of fact:

### I. Background

1. At all times relevant hereto, Respondent was and is licensed to practice medicine in the State of Maryland. Respondent was originally licensed to practice medicine in Maryland in 1990. Respondent last renewed his license in or about September 2015, which will expire on September 30, 2017.

2. Respondent maintains an office for the solo practice of medicine in Havre de Grace, Maryland. The office is in a two story frame house, which has been subdivided into two units, on a residential street in an older section of the city.[1] The practice was originated by Respondent's father and for a period of time, in the 1990s, Respondent was in practice with his father. Respondent has continued his medical practice in the same office after his father retired.[2] In addition to his internal medicine practice, Respondent is a certified Suboxone[3] provider.

3. Respondent is board-certified by the American Board of Internal Medicine. Respondent was re-certified on December 15, 2010, which will expire on December 31, 2020.

4. Respondent does not at this time hold any hospital privileges. Previously,

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[1] The other half of the building is a private residence.

[2] Some of the patients who were reviewed by the Board for this case have been in the practice since the late 1960s.

[3] Suboxone is a prescription drug for use in the treatment of opioid dependence.

Respondent held hospital privileges at Hospital A.[4]

5. The charges were a combination of two cases received by the Board sequentially. The first case, case number 2014-0535, was initiated based on a complaint from a patient of Respondent's, regarding questionable quality care and questionable lack of professionalism in regard to Respondent's behavior and the physical conditions of his office. This complaint resulted is a practice review of Respondent's care of eight patients, as well as an onsite review of Respondent's office.

6. The second case, case number 2015-0499, was opened as a result of a "10 Day Report[5]" from Hospital A stating that on January 12, 2015, Respondent resigned his hospital privileges.

## II. Case No. 2014-0535 – Patient Complaint

7. On or about December 18, 2013, the Board received two complaints, both from a patient of Respondent, (the Complainant"), identified herein as Patient 4,[6] who presented to Respondent on November 14, 2013 during "walk-in" hours to have Respondent complete her Social Security Disability Insurance ("SSDI") forms. The first complaint stated that Respondent's waiting room was "very unsanitary," that Respondent "shouted out" her private medical and criminal information, and that he grabbed her arm and forced her out of the office. The Complainant also reported that Respondent prescribes Suboxone but does not make sure the patients go to a

[4] The name of the hospital is not used in the Consent Order. Respondent is aware of the identity of Hospital A.

[5] Pursuant to Health Occ. § 14-413(a) a hospital is required to report to the Board if a licensed physician who has privileges with the hospital has had staff privileges changed, if the change is for reasons that might be grounds for disciplinary action. The hospital shall submit the report within 10 days of the action.

[6] Patient names are confidential and are not used in the Consent Order. Respondent has been provided with a Confidential Patient Identification List, listing the name of each patient and corresponding number.

counselor and that he is never present during the posted office hours of operation.

8. The second complaint from Patient 4, also dated December 18, 2013, reiterated essentially the same concerns, adding that Respondent liberally prescribes CDS (controlled dangerous substances).

## III. Investigation

9. On January 8, 2014, the Board issued subpoenas to three national chain drug stores and to one local pharmacy in the vicinity of Respondent's office for computer printouts of controlled substances prescribed by Respondent from March 2013 to the date of the subpoena.

10. On February 24, 2014, based on the review of the printouts, the Board issued a subpoena to Respondent for medical records for four identified patients, Patients 1, 2, 3, and 4 (the Complainant), and requested that Respondent prepare a summary of his care of each of the patients.

11. On March 13, 2014, Respondent responded stating that he "never formed a doctor/patient relationship" with Patients 3 and 4 and he did not have any records to produce. Respondent provided the medical records and a summary of care of the other two patients, Patients 1 and 2.

12. On May 1, 2014, the Board issued a subpoena for copies of medical and billing records[7] for eight patients: Patients 3,[8] 4,[9] and 5 through 10.

13. On June 4, 2014, Board staff conducted an unannounced site visit during

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[7] Respondent did not submit any billing records.

[8] Patient 3's name had been misspelled in the earlier subpoena. With the corrected name, Respondent submitted medical records for Patient 3.

[9] Initially, Respondent stated he did not have any records to produce in regard to Patient 4; however, in response to the second subpoena, Respondent submitted some records for Patient 4.

which Board staff:

a) Hand delivered a letter requesting Respondent to respond to the allegations of the complaints;

b) Hand delivered a subpoena for the medical records of eight patients;

c) Requested summaries of care of each of the patients; and

d) Took photographs of the areas of Respondent's office where patients are seen.

14. On May 12, 2014, Board staff interviewed the Complainant, Patient 4, under oath.

15. On June 18, 2014, Board staff interviewed Respondent under oath.

16. On August 15, 2014, the Board sent the complaints, transcripts of the interviews of the Complainant and Respondent, Respondent's written response to the complaints, the ten medical records and summaries of care, and pharmacy computer printouts to two physicians, both board-certified in internal medicine, to conduct independent peer reviews.

17. By September 2014, the Board received the peer review reports. The peer reviewers concurred that with regard to eight of the ten patients reviewed Respondent failed to meet the appropriate standards for the delivery of quality medical care and failed to keep adequate medical records.

18. On February 23, 2015, the Board sent copies of the peer review reports to Respondent with the names of the reviewers redacted requesting a Supplemental Response.

19. On March 9, 2015, the Board received Respondent's Supplemental Response, which was subsequently reviewed by the two peer reviewers, prior to the

issuance of Charges.

## IV. General Findings of Violation of Health Occ. § 14-404(a)(22) and (40)

20. According to the two independent peer reviewers, based on their review of the medical records, Respondent fails to meet standards of quality medical care and fails to maintain adequate documentation in regard to his care and treatment of all ten patients reviewed for reasons including but not limited to that:

a. Respondent's documentation is extremely sparse, vague, and illegible, such that without the summaries of patient care which Respondent prepared with knowledge that the Board was investigating his care of these patients, the reviewers were not able to ascertain the patients' complaints, Respondent's examinations or objective findings, his assessment, and his plan of care;

b. Respondent documents the names of medications, including CDS, in the margins of his office note, but does not relate his prescribing to the findings during the office visit;

c. Respondent fails to consistently document the milligram strength, dosage, and frequency of administration of the medicines he is prescribing;

d. Respondent fails to use a medication flow sheet;

e. Respondent fails to support patients' medical conditions with relevant laboratory testing; and

f. Respondent fails to sign his office notes.

## V. Patient Specific Findings of Violation Health Occ. § 14-404(a)(22) and (40)

21. In addition to the above general allegations which apply to all of the patients, the reviewers found the following deficiencies for each specific patient.

### Patient 1

22. Since approximately 1984, Patient 1, now in his late 30s, has been a

patient in Respondent's practice. In May 2010, Respondent began to treat Patient 1 on a regular basis for "pain management" of his headaches, neuralgia, and chronic pain.

23. Patient 1 has a history of neurosurgery and nerve blocks.

24. Since approximately 2011, Respondent has been prescribing Lortab 10/325 #100 tablets for Patient 1. Respondent does not document the frequency of administration.

25. Respondent fails to meet appropriate standards for the delivery of quality medical and surgical care and fails to keep adequate medical records in regard to his care and treatment of Patent 1 in that he:

a. Fails to adequately document in his office notes sufficient information to understand objective findings and the plan of care;

b. Fails to document a pain treatment plan, especially in light of consultation with neurologists and neurosurgeons;

a. Fails to obtain a pain contract;

b. Fails to document ongoing assessment of the achievement versus failure of the treatment plan;

c. Fails to assess Patient 1 for potential abuse of CDS and/or diversion by the use of random toxicology screens; and

d. Fails to document the results of Patient 1's consultation with neurosurgery and or neurology.

**Patient 2**

26. Patient 2 has been a patient of Respondent's medical office since at least 1968, originally being treated by Respondent's father. Respondent's office notes are unsigned; therefore, a reviewer cannot determine when Respondent began treating Patient 2. According to Respondent's summary of care, prepared solely for the Board

and written after Respondent received notice that the Board was investigating his care, Respondent initially saw Patient 2 for medical issues. In 2004, Patient 2 switched his "pain management" care from another physician to Respondent.

27. Respondent has treated Patient 2 for back pain, high blood pressure, cessation of smoking, chronic respiratory infection, and depression.

28. Patient 2 has a history of L2-L4 lumbar fusion with surgical decompression as well as instrumentation.

29. Since approximately 2005, Respondent has prescribed Percocet. Initially Respondent prescribed Percocet 5 mg, then 7.5 mg. Since late 2011, Respondent has been prescribing Percocet 10 mg. #90 tablets on an average of every 21 days.

30. Respondent fails to meet appropriate standards for the delivery of quality medical and surgical care and fails to keep adequate medical records in regard to his care and treatment of Patent 2 in that he:

a. Fails to adequately document a clinical examination, including a neurological examination;

b. Fails to consistently document the clinical status of Patient 2's symptoms, *i.e.* whether Patient 2 is stable, improving, or worsening;

c. Fails to document whether Patient 2 has been evaluated by a specialist in orthopedics, physical therapy, and neurosurgery; or referred for physical therapy;

d. Fails to obtain a pain contract; and

e. Fails to monitor Patient 2 using random urine toxicology screens.

**Patient 3**

31. Since 2008, Respondent has treated Patient 3 for severe rheumatoid arthritis and chronic pain.

32. Respondent prescribed Percocet 10 mg. # 100 and Xanax .25 mg #30 once a month.

33. Respondent prescribed DMARDs,[10] methotrexate,[11] and prednisone[12] on a regular basis.

34. Respondent fails to meet appropriate standards for the delivery of quality medical and surgical care and fails to keep adequate medical records in regard to his care and treatment of Patent 3 in that he:

a. Fails to document a pain treatment plan;

b. Fails to consistently document the clinical status of Patient 3's symptoms, *i.e.* whether Patient 3 is stable, improving, or worsening;

c. Fails to document an ongoing assessment of the achievement versus failure of the treatment plan;

d. Fails to document an assessment of potential abuse or diversion of CDS;

e. Fails to obtain a pain contract and perform random toxicology screens; and

f. Fails to obtain regular blood work and dexa scans to rule out liver dysfunction and osteoporosis, as a result of anti-rheumatic medications.

**Patient 4**

35. Patient 4 is the Complainant in this case. Respondent's office records indicate that Patient 4 presented to Respondent's office on two occasions.

36. On December 27, 2011, Patient 4 completed Respondent's office form

[10] DMARDs are disease-modifying anti-rheumatic drugs which are used for the treatment of rheumatoid arthritis to slow the progression of joint damage.

[11] Methotrexate is a drug that is used to treat rheumatoid arthritis.

[12] Prednisone is a synthetic corticosteroid drug that is used to treat rheumatoid arthritis.

for "Patient Consent to Use and Disclose Protected Health Information ("PHI form").[13]" Respondent did not, however, document an office visit on this date.

37. In his summary of patient care, Respondent stated that in approximately January 2014, [14] Patient 4 presented with a non-specific complaint of pain. Respondent stated that he reviewed Patient 4's medical records at a hospital in the vicinity of his office and noted that Patient 4 had more than ten emergency room visits within a short period of time for vague descriptions of severe pain and with a specific request for narcotic pain medication. Respondent stated that Patient 4 reported to him a non-specific complaint of abdominal pain so he referred her to either OB/GYN or to the emergency room if the pain was in her upper abdomen. Respondent stated that he "did not accept" Patient 4 as a patient.

38. In his response to Patient 4's complaint, Respondent noted that he reviewed Patient 4's MRI and nerve conduction studies which did not show any obvious abnormality.

39. On November 14, 2013, Respondent documented an office visit which is not legible.[15]

40. Respondent fails to meet appropriate standards for the delivery of quality medical and surgical care and fails to keep adequate medical records in regard to his care and treatment of Patient 4 in that he:

a. Fails to recognize that Patient 4 was his patient since he saw her in his office on more than one occasion, reviewed her hospital records, made a

[13] This form contains admonitions to patients in language that is highly unprofessional.

[14] The Respondent may be referring to Patient 4's December 21, 2011 office visit.

[15] This is likely the office visit which generated Patient 4's complaint that she submitted to the Board on December 18, 2013.

referral, and apparently completed SSDI eligibility forms for her;

b. Fails to document each encounter with Patient 4; including his review of her hospital records, including MRI and nerve conduction studies;

c. Fails to document his decision not to treat her, the basis for that decision, and that he is referring her;

d. Fails to retain copies of SSDI forms that he completed; and

e. Utilized a PHI form which contains highly unprofessional language.

**Patient 5**

41. Respondent did not maintain any office notes of any encounter with Patient 5.

42. Respondent's file contained multiple pages of imaging including a head scan, abdominal can, spine imaging, brain imaging, and x rays that were performed over several years. Respondent is listed as the physician on only a few of these studies so it is not understood how Respondent obtained the other reports.

43. Respondent noted in his care summary that Patient 5 has a history of multiple sclerosis and degenerative spine disease, having come to his practice about 10 years ago. Respondent noted that he is treating Patient 5 with Oxycodone 50 mg. per day. Patient 5 is also followed by a neurologist.

44. Respondent fails to meet appropriate standards for the delivery of quality medical and surgical care and fails to keep adequate medical records in regard to his care and treatment of Patent 5 in that he:

a. Fails to maintain any documentation of care during approximately 10 years;

b. Fails to obtain imaging studies such as serial MRIs; and failed to

make referrals including neurology consultation, regular laboratory work, physical therapy and/or occupational therapy; and

c. Fails to obtain a pain contract, urine toxicology screen or pain management referral.

**Patient 6**[16]

45. Respondent has treated Patient 6, a patient with multiple medical and psychiatric issues since approximately 2006.

46. Respondent's records contain a lumbar MRI which shows multiple degenerative changes. A CT scan of Patient 6's head shows an old cerebella infarct. Patient 6 has multiple co-morbidities including diabetes, decubitus ulcers, stroke, as well as anxiety.

47. Respondent noted in his summary of care that Patient 6 has severe diabetic neuropathy, history of stroke, lumbar pain, which he is treating with narcotics, and anxiety about her son who is in an active war zone, which he is treating with Valium. Respondent ordered a second lumbar MRI which showed significant lumbar disk disease and a kidney mass, which he is further evaluating.

48. Respondent prescribes benzodiazepines (Valium 2 mg.) and narcotic pain medications (Percocet).

49. Respondent fails to meet appropriate standards for the delivery of quality medical and surgical care and fails to keep adequate medical records in regard to his care and treatment of Patent 6 in that he:

a. Fails to document the clinical indication for prescribing CDS;

[16] Patients 6 and 7 are husband and wife.

b. Fails to document a pain treatment plan;

c. Fails to have a pain contract;

d. Fails to document an ongoing assessment of achievement versus failure of the treatment plan;

e. Fails to document whether he considered referring Patient 6 to a pain management specialist;

f. Fails to follow a protocol for treating diabetes, including obtaining regular blood and urine analysis every 3 months;

g. Fails to refer Patient 6 to an ophthalmologist based her history of diabetes and diabetic neuropathy;

h. Fails to adequately document Patient 6's complaints or concerns; and

i. Fails to refer to Patient 6 to a psychiatrist, therapist, or counselor.

**Patient 7**

50. Patient 7 has been treated in Respondent's practice for over 30 years.

51. Respondent prescribes Percocet #90 tablets and Soma #100 tablets once every 3-4 weeks.

52. Respondent noted in his summary of care that he assumed care of Patient 7 in 1998. Respondent stated that Patient 7 has COPD (chronic obstructive pulmonary disease), intermittent atrial fibrillation, hypertension, cervical disc disease with a history of spinal fusion, cervical radiculopathy, degenerative joint disease, carpal tunnel syndrome and osteoporosis.

53. Respondent fails to meet appropriate standards for the delivery of quality medical and surgical care and fails to keep adequate medical records in regard to his care and treatment of Patient 7 in that he:

a. Fails to document a treatment plan;

b. Fails to document an ongoing assessment of achievement versus failure of the treatment plan;

c. Fails to document the need for oxygen, aggressive pulmonary rehabilitation, bronchodilators, and steroid treatment when indicated for COPD;

d. Fails to document vital signs and cardiac monitoring closely by obtaining echo or stress testing; and

e. Fails to document whether he discussed with Patient 7 a referral to specialist in pain management regarding his DJD and carpal tunnel syndrome.

**Patient 8**

54. Respondent stated in his summary of care that Patient 8 has been a patient of "the practice" for over 20 years. Respondent also noted in the summary of care, that Patient 8 has a history of DVTs (deep vein thrombosis), poorly controlled seizures, and rotator cuff injury.

55. Respondent's first documentation of office visits with Patient 8 is on November 19, 2012 and November 17, 2012. On the same sheet of paper, Respondent documented an office visit on January 10, 2014.

56. There is an unsigned form in Respondent's records, dated May 18, 1987, which states that Patient 8 has a history of "epilepsy, rotator cuff (problems), blood clots, stomach and COPD."

57. From late 2012 until mid 2014, Respondent documented office visits approximately every 4 weeks.

58. On one page of paper, Respondent documented monthly office visits in January, February, and March 2013; and the rest of the page contained notes of visits in January, February and March 2014. Separate sheets of paper contained

Respondent's notes of monthly visits between May 2013 and December 2013, although not in chronological order.

59. Since approximately 2012, Respondent has prescribed #90 tabs of Percocet at each visit and Coumadin.

60. Respondent's records contain an MRI report and an x-ray report which document degenerative changes.

61. Respondent fails to meet appropriate standards for the delivery of quality medical and surgical care and fails to keep adequate medical records in regard to his care and treatment of Patient 8 in that he:

a. Failed to document INR checks every 4 – 6 weeks done either in Respondent's office or at a Coumadin clinic;

b. Failed to document Patient 8's last seizure activity or imaging studies, Neurology referral, or EEG;

c. Failed to document if and when Patient 8 may return to driving;

d. Fails to document any office visits prior to December 2012 although Respondent began treating Patient 8 in approximately 1994; and

e. Fails to maintain notes of office visits in chronological order.

**Patient 9**

62. In or around November 2003, Respondent initially saw Patient 9. The note is not legible.

63. On January 14, 2004, Respondent noted "hip pain w/ standing" and "knee...lumbar fusion 2002." Respondent prescribed Soma and Percocet 7.5/325 # 80.

64. On March 19, 2004, Respondent prescribed Percocet 7.5/325 #90.

65. On May 13, 2004, Respondent documented sciatica pain and

COPD. Respondent documented "pain management" and prescribed Percocet 7.5 # 80.

66. Respondent saw Patient 9 for periodic follow-up although his documentation is illegible and not in chronological order. Some dates of service were written on sheets of paper that had dates of service from prior years. Respondent's records show office visits as follows: two visits in 2004, five visits in 2005, five visits in 2006, one visit in 2007, no visits in 2008[17], one visit in 2009, two visits in 2010, seven visits in 2011, eleven visits in 2012, monthly visits in 2013 and three visits in 2014.

67. Beginning June 2011, Respondent increased the narcotic to Percocet 10 mg and has continued to prescribe at this level through present. Respondent does not document the frequency of dosing.

68. Respondent fails to meet appropriate standards for the delivery of quality medical and surgical care and fails to keep adequate medical records in regard to his care and treatment of Patient 9 in that he:

a. Failed to document a pain treatment plan;

b. Failed to perform an ongoing assessment of achievement versus failure of the treatment plan;

c. Failed to obtain pulmonary functions tests, bronchodilators, pulmonary rehab and medical treatment of COPD exacerbations when indicated along with immunizations on schedule; and

d. Failed to maintain documentation in chronological order.

**Patient 10**

69. Respondent documented four office visits with Patient 10, a person in her early

[17] These records may be missing.

thirties. Respondent's notes of the four visits are contained on one sheet of paper.

70. On March 18, 2013, Respondent documented "fusion messed up." The remainder of the noted is illegible.

71. On April 8, 2013, Respondent's documentation is illegible other than "Fentanyl 50."

72. On July 2, 2013, Respondent documented "car accident...eval in ER ...stable fusion but pain..." The rest of Respondent's note is illegible. Respondent prescribed Oxycodone.

73. On July 23, 2013, Respondent's documentation is illegible.

74. Respondent prescribed Oxycodone 100 tablets along with Fentanyl patches every 2 weeks to Patient 10.

75. In his summary of care, Respondent noted that he "had suspicions from the start" in regard to Patient 10. Respondent noted that Patient 10's presentation and findings were consistent with her MRI, but Respondent was not comfortable with her narcotic use. Respondent stated that he checked with Patient 10's pharmacies and confirmed that he was continuing previous therapy and not overlapping with other providers during the first year patient 10 was his patient. Respondent references a second year of treatment during which he checked CRISP[18] and found that Patient 10 was seeing multiple providers. Respondent stated that he terminated Patient 10 from his practice on April 11, 2014

76. Respondent's file does not contain documentation of any office visits after July 23, 2013; and does not contain a copy of a letter of termination.

77. Respondent fails to meet appropriate standards for the delivery of quality medical and surgical care and fails to keep adequate medical records in

[18] CRISP (Chesapeake Regional Information System for our Patients), is a regional health information exchange serving Maryland and the District of Columbia.

regard to his care and treatment of Patient 10 in that he:

a. Fails to document his evaluation of imaging studies and surgeries done in the past;

b. Fails to document having counseled Patient 10 regarding his suspicions of drug overuse, drug dependence, and /or drug abuse;

c. Fails to refer Patient 10 to a physical medicine rehabilitation specialist and counseling; and

d. Fails to send Patient 10 a certified letter terminating his care with enough written notice so she can be established with another primary care provider within the next 30 days.

## VI. Findings of Violation of Health Occ. § 14-404(a)(3) Unprofessional Conduct Based on Office Conditions

78. On June 4, 2014, at approximately 10:00 a.m., based on Patient 4's complaint that Respondent's office was "unsanitary" and a "disgusting, filthy place," Board staff conducted an unannounced site visit. (See paragraph 13 above.) No patients had arrived. Board staff took photographs of Respondent's office, which were subsequently viewed by both peer reviewers.

79. The photographs show:

a. Exterior signage with Respondent's deceased father's name on the signpost and the mail box;

b. Exterior cigarette container with many butts inside and more butts and a cigarette lighter on the ground;

c. The reception area contained:

i. large square portable electric space heater plugged in with cord around a "capped" gas line protruding from the floor;

ii. Dirty and stained carpeting and uneven ceiling tiles;

iii. Framed certificate from Respondent's father's medical school alumni association;

vi. Two unlocked metal files cabinets behind the receptionist desk which had piles of papers and objects in disarray on top and hanging over the edges, including a glass cover for a hurricane lamp, an old rolodex, a bowl, an unplugged phone, spiral notebooks, many 5" x 8" index cards in "sleeves" with patient names, lots of assorted papers; and a small leather pouch; and

vii. Receptionist's desk with multiple 5" x 8" cards containing patient names, social security numbers, and medical notations in plain view and an open box of Celebrex.

viii. There is no computer, copier, or facsimile machine in the office.

d. The unlocked metal file cabinets each had two drawers, side by side, which were filled with worn and frayed 5" x 8" index cards in sleeves. These are Respondent's medical records;

e. The patient examination room contained:

i. An examination table made out of plywood covered with a thin vinyl mat with torn edges. There was no roll of disposal paper sheeting to cover the mat. There was a pillow with a dirty pillow case;

ii. There are no disposable examination gloves or a sink in the examination room;

iii. Antique painted white metal chair and stool with chipped and worn off paint;

iv. Antique "Detecto" scale with peeled paint and rust;

v. Antiquated blood pressure cuff with a mercury indicator and blood pressure cuff with a meter;

vi. A stethoscope without rubber ear tips; another stethoscope on the floor, wrapped around a floor lamp base, without rubber ear tips; and a third stethoscope with just one ear tip;

vii. (Strewn about the room) An old hospital handset phone (unplugged), empty glass antique bottle, old brown glass liquid medication bottle, old wooden crutches, a mop, small space heater, medical scissors and a hand held fire extinguisher that was not hung on the wall;

viii. Piles of papers in plain view and in disarray, including handwritten appointment logs, a handwritten list of patient names, loose medical records, subpoena from the Board

ix. A small wooden cabinet with shelves behind unlocked double doors. The upper cupboard contained medication samples and loose papers. The unlocked drawer contained loose patient medical records. The lower unlocked cupboard contained expired medication samples (one of which expired in 2009) and several expired prescription bottles with patient names on them;

x. A small refrigerator containing a couple of vials of medication along with a container of sour cream, parmesan cheese, carrots, and soda. The freezer had large ice formation. The plastic on the inside of the door was cracked and torn off and the insulation was exposed;

xi. Respondent's father's framed license to practice medicine in Pennsylvania;

xii. Dirty carpeting and dirt on painted door; and

xiii. An unlocked door in the patient examination room which provides access in and out of the adjoining residence.

f. The bathroom contained:

i. Unwrapped speculum, unidentifiable stainless metal instrument, stainless metal bowl and covered tray, and white metal tray;

ii. Corroded sink faucets and dirty sink; and

iii. Trash in the thrash can that had not been removed from the previous day.

g. Respondent's office contained:

i. Antique white metal examination table with chipped and peeled paint;

ii. A credenza covered with several stethoscopes (without rubber ear tips), a can opener, unmounted smoke detector, approximately 50 empty vacutainers, a red sharps container

which was overflowing with used syringes and a square "Glad" plastic container that was also filled with used syringes, and loose uncapped syringes;

iii. Respondent's deceased father's name plate at the front of Respondent's desk. On the desk were disorganized piles of papers including unfiled patient records. One of the papers was a laboratory slip for blood work for a patient that was dated "2/17/84."

80. The peer reviewers found Respondent's office to be "significantly substandard" and not consistent with standards of professional conduct in the practice of medicine.

## VII. Case No. 2015-0499 - Complaint from Hospital A

81. On January 26, 2015, while the complaint from Patient 4 was still being investigated, the Board received a "Mandated 10-day Report" from Hospital A stating that Respondent resigned his hospital privileges "while under investigation." The Report further stated:

> While in the process of a "Focused Professional Practice Evaluate" (sic) (FPPE) for behavioral and quality issues, Dr. Wachsman resigned his medical staff privileges at [Hospital A].

## VIII. Investigation of Complaint from Hospital A

82. On January 30, 2015, the Board issued a subpoena to Hospital A for a complete copy of the quality assurance/risk management ("QA/RM") file of Respondent for the last five years.

83. On March 19, 2015, the Board issued a second subpoena to Hospital A for additional records.

84. On April 1, 2015, Respondent submitted a response to the "10 Day Report."

## IX. Findings of Violation of Health Occ. § 14-404(a)(3) Unprofessional Conduct Based on Hospital A's Report to the Board

85. As part of its investigation of the "10 Day Report" from Hospital A, the Board received the QA/RM files from Hospital A.

86. Respondent was being monitored by Hospital A under a FPPE.

87. On January 12, 2015, while under the FPPE, Respondent resigned his clinical privileges at Hospital A.[19]

## CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel B of the Board concludes as a matter of law that Respondent violated Health Occ. § 14-404(a)(3)(ii) (unprofessional conduct in the practice of medicine), (a) 22) (fails to meets standards of quality medical care); and (a)(40) (inadequate medical record keeping.)

## ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby:

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

**ORDERED** effective the date of this Consent Order, Respondent is placed on **PROBATION** for a minimum of two (2) years effective the date of this Consent Order, subject to the following terms and conditions:

1. Within ninety (90) days from the date of the Consent Order, Respondent shall relocate or close his practice of medicine at its current location in Havre de Grace, Maryland;

2. Within ninety (90) days from relocating, Respondent shall notify the Probation Unit of the Board in writing of the new location of his practice. This requirement is in addition to the statutory requirement that every

[19] The QA/RM information is confidential peer review material and is not included in the Consent Order. Respondent was provided a copy of the information from the administrative prosecutor.

licensee notify the Licensing Unit of the Board of any change in the licensee's address within 60 days after the change;

3. During the probationary period, Respondent will be subject to periodic unannounced on-site visits by a staff member of the Board, at the discretion of the Board, to ensure Respondent's office organization, management, cleanliness, maintenance of patient records is professional and in compliance with HIPAA;

4. Within sixty (60) days from the date of the Consent Order, Respondent shall revise, and submit for Board approval, his office form entitled "Patient Consent for Use and Disclosure of Protected Health Information;"

5. Within three (3) months of the date of this Order, Respondent shall enroll in, and within nine (9) months of the date of this Order, Respondent shall successfully complete, a Board-approved 8 to 10 hour review course in medical record keeping;

6. Respondent shall maintain all current medical records regarding each patient in a single 8 ½" x 11" patient file or on an office computer. Respondent shall not maintain patient medical records on his home computer. All of Respondent's patient medical records, whether hard copy or electronic shall be securely stored according to HIPAA requirements;

7. The above course in medical record keeping course will not count toward fulfilling the continuing education requirements that Respondent must fulfill in order to renew his license to practice medicine;

8. Within three (3) months of the date of re-location of his practice, Respondent shall begin supervision with a Board-approved supervisor who is Board-certified in Internal Medicine. Respondent shall obtain prior approval from the Board of the supervisor before entering into the supervisory arrangement. As part of the approval process, Respondent shall provide the Board with the curriculum vitae and any other information requested by the Board regarding the qualifications of the physician who is submitted for approval. The supervisory arrangement shall continue as described for a minimum of one (1) year, subject to the following:

   a. The supervisor shall have no personal, professional relationship with Respondent;

   b. The supervisor shall notify Board in writing of acceptance of the supervisory role with Respondent;

   c. Respondent shall agree that the Board will provide the supervisor with a copy of this Consent Order, and any other documents from

the investigation file that the Board deems relevant, including the Peer Review Reports of September, 2014;

d. Respondent shall meet in person with the supervisor on a monthly basis who will review a random selection of Respondent's medical charts. The supervisor will assess and provide feedback to Respondent with regard to the quality of his medical care and whether the documentation is adequate and sufficiently legible;

e. Respondent shall ensure that the supervisor submits written reports to the Board on a quarterly basis regarding his/her assessment of Respondent's compliance with appropriate standards of care and appropriate documentation;

f. Respondent shall have sole responsibility for ensuring that the supervisor submits the required quarterly reports to the Board in a timely manner; and

g. Respondent may petition the Board for a decrease in the frequency of supervisory meetings after six(6) months of supervision;

9. Within thirty (30) days of this Consent Order, Respondent shall enroll in the Maryland Professional Rehabilitation Program ("MPRP");

a. Respondent shall undergo an evaluation by the MPRP or its agents to determine what conditions and treatment should be ordered to ensure that Respondent's conduct relating to the practice of medicine and interacting with patients and professional colleagues is appropriate and professional;

b. Respondent shall fully cooperate in the evaluation, including complying with all of the MPRP's referrals and recommendations, including its recommendation for a practice manager. Respondent shall provide the MPRP with all records and information requested by the MPRP and Respondent shall sign all releases and consent forms to ensure that the MPRP is able to obtain all records and information, including mental health records and information, necessary for a complete and thorough evaluation. Respondent shall also sign all releases and consent forms to ensure that the Board receives all necessary documents and information from the MPRP;

c. Failure to comply with the referrals and recommendations of MPRP, including recommendations and referrals for treatment and therapy, is a violation of the Consent Order;

10. Within six (6) months after the completion of the course on medical record keeping, Respondent's practice shall be subject to peer review by an appropriate peer review entity, or a chart review by a Board designee, to be determined at the discretion of the Board;

11. An unsatisfactory peer review by an appropriate peer review entity shall be deemed a violation of probation, as described below;

12. Respondent shall be responsible for all costs associated with fulfilling the terms and conditions of this Consent Order;

13. Respondent shall practice according to the Maryland Medical Practice Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of medicine. Failure to do so shall constitute a violation of this Consent Order;

14. Any violation of the terms or conditions of this Consent Order may be deemed a violation of this Consent Order;

15. There shall be no early termination of probation; and be it further

**ORDERED** that If Respondent violates any of the terms and conditions of probation or this Consent Order, the a disciplinary panel of the Board, in its discretion, after notice and an opportunity for a show cause hearing before a disciplinary panel of the Board, or opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, may impose any sanction which Disciplinary Panel B of the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation of the terms and conditions being proved by a preponderance of the evidence; and be it further

**ORDERED** that after a minimum of two (2) years, and after the conclusion of a satisfactory peer review and satisfactory reports from MPRP, Respondent may file a

written petition for termination of the probationary conditions of this Consent Order, but only if Respondent has satisfactorily complied with all conditions of this Consent Order, and if there are no pending complaints regarding Respondent before the Board; and be it further

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

11/12/2015
Date

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

## CONSENT

I, Matthew Wachsman, M.D., License No. D40922, by affixing my signature hereto, acknowledge that:

1. I have consulted with counsel, Jay ~~Levy~~ Miller, Esquire, and knowingly and voluntarily elect to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 14-405 (2014 Repl. Vol.) and Md. State Gov't Code Ann. §§ 10-201 *et seq.* (2014 Repl. Vol.).

3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I am waiving those procedural and substantive protections.

4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and my right to appeal any adverse ruling of a Disciplinary Panel of the Board that might have followed any such hearing, and any right to appeal this Consent Order.

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

11-5-15
Date

Matthew Wachsman, M.D., Respondent

**NOTARY**

STATE OF Maryland

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 5TH day of November, 2015 before me, a Notary Public of the State and County aforesaid, personally appeared Matthew Wachsman, M.D, License number D40922, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Sandra L. Gross
Notary Public

My commission expires 12/15/16

SANDRA L. GROSS
NOTARY
PUBLIC
BALTIMORE COUNTY, MD