IN THE MATTER OF	*	**BEFORE THE MARYLAND**
ANDREW MROWIEC, M.D.	*	**STATE BOARD**
RESPONDENT	*	**OF PHYSICIANS**
LICENSE NO.: D47804	*	**CASE NO.: 2012-0841**

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CONSENT ORDER

On July 29, 2013, the Maryland State Board of Physicians (the "Board") charged Andrew Mrowiec, M.D. (the "Respondent"), License No. D47804, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("Health Occ.") §14-401 *et seq.*

The pertinent provisions of Health Occ. §14-404(a) under which the Board voted to charge the Respondent provide the following:

> (22) Fails to meet the appropriate standards as determined by the 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 [.]

FINDINGS OF FACT

The Board makes the following findings of fact:

I. Background

1. At all times relevant hereto, Respondent was licensed to practice medicine in Maryland. Respondent was originally licensed to practice medicine on August 2, 1995 under license number D47804. Respondent last renewed his license in or about September 2011, which will expire on September 30, 2013.

2. In July 1996, Respondent became board certified in family medicine by the American Board of Family Medicine. Respondent has continuously renewed this certification, which will expire on December 31, 2016.

3. Respondent has active hospital privileges at Upper Chesapeake Medical Center and Harford Memorial Hospital.

4. Respondent maintains an office for the solo practice of medicine known as Aberdeen Health Center in Aberdeen, Maryland.

II. Complaint

5. On May 14, 2012, the Board received a complaint against Respondent from the grandmother of one of Respondent's patients, Patient 1[1]. The grandmother stated that her grandson has become addicted to medications prescribed by Respondent. According to Complainant, Respondent failed to order any laboratory tests to discern the amount or effects of the drugs prescribed for Patient 1. Complainant alleged that Respondent's prescribing methods for an "unspecified back problem" has turned Patient 1 into a "non-functioning addict." Complainant stated that Respondent should have been alerted to drug-seeking behavior by the frequency of refills needed by Patient 1.

6. On June 21, 2012 Respondent submitted a written response to the complaint. Respondent stated that Patient 1's pain complaints were consistent with physical examinations and he had no indication of drug abuse.

III. Investigation

7. On April 6, 2012, the Board issued a subpoena to several national

[1] Patient names are confidential and are not used in the consent order. Respondent is aware of the identity of the patients identified herein.

chain pharmacies and a local pharmacy for all controlled dangerous substance ("CDS") prescriptions issued by Respondent from January 2012 to April 6, 2012.

8. Thereafter, based on the pharmacy surveys, Board staff selected the names of ten (10) patients for whom Respondent had been frequently prescribing high quantities of CDS.

9. On September 26, 2012, the Board issued a subpoena to Respondent for the medical records of the ten (10) patients. Board staff requested that Respondent provide a summary of care of each of the ten (10) patients.

10. On January 8, 2013, the Board transmitted the following documents to Permedion, an independent peer review agency, requesting independent peer review by two board certified family practice physicians:

a. The complaint;
b. Respondent's response to the complaint;
c. Transcript of interview of Respondent;
d. Ten (10) patient medical records;
e. Nine (9)[2] summaries of care from Respondent; and
f. Drug surveys from area pharmacies.

11. On March 5, 2013, the completed peer review was received by the Board. The peer reviewers concurred that Respondent failed to meets standards of quality care in four (4) out of ten (10) cases and failed to maintain adequate medical record keeping in five (5) out of ten (10) cases.

12. The Board sent copies of the peer review reports with the names of the reviewers redacted, to Respondent requesting a Supplemental Response.

[2] The Board used the Respondent's response to the complaint as the summary of care for the index case, Patient 1. The remaining nine (9) charts submitted for peer review had accompanying separate summary of care documents.

13. On March 28, 2013, the Board received Respondent's Supplemental Response to the peer review report, which was subsequently reviewed by the peer reviewers.

IV. Patient Specific Findings[3]

Patient 1

14. On July 21, 2008, Patient 1, then a 17 year old male, initially presented with a complaint of "Bad back. Painful mole on face." Patient 1 stated that he has had scoliosis for the past four years. Respondent noted low back pain when standing, and complaint of pain on and off for last 2 years. Respondent documented a review of systems and a limited physical examination of the back. Respondent documented that Patient 1 had a history of bipolar disorder and marijuana use. Respondent referred Patient 1 to a surgeon for consultation in regard to the lesion. Respondent also referred Patient 1 to two different pain management specialists.[4]

15. On December 4, 2008, Patient 1 next presented with a complaint of back pain which started to worsen when he went to work. Respondent prescribed Flexeril[5] 10 mg.

16. On June 30, 2009, Patient 1 presented again with complaints of

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[3] Patients 1, 2, 4, and 10 are the four patients on which the reviewers concurred in regard to standard of quality medical care and documentation issues. The reviewers also concurred on Patient 8 that Respondent's documentation was inadequate.

[4] In his response to the complaint, Respondent stated that the pain specialists did not take Patient 1's health insurance. Respondent did not document communication with the pain specialists.

[5] Flexeril is the brand name of a muscle relaxant medication used to relieve skeletal muscle spasms and associated pain in acute musculoskeletal conditions.

back pain and some leg pain. Respondent referred Patient 1 to physical therapy ("PT").[6]

17. On August 17, 2009, Patient 1 presented with a complaint that back pain was worsening and extended to the ribs. Respondent prescribed a TENS unit,[7] as recommended by the physical therapist, continued the prescription for Flexeril, and referred Patient 1 for an x-ray of the lumbar spine.

18. On August 20, 2009, after receipt of the x-ray report, Respondent diagnosed Patient 1 with Degenerative Disk Disease at L5- S1. Respondent prescribed Tramadol[8] to Patient 1.

19. On September 4, 2009, Respondent prescribed Darvocet[9] to Patient 1.

20. On September 15, 2009, Respondent changed Tylenol #3 to Tylenol #4.[10] Respondent did not document when he initially prescribed Tylenol #3.

21. In or around 2010, Respondent prescribed Oxycodone[11] IR (immediate release) for Patient 1 in addition to Tylenol #4, Meloxicam,[12]

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[6] Patient 1 participated in PT approximately 2 times a week for approximately 6 weeks, after which time the physical therapist determined that further PT may not be beneficial and referred Patient 1 back to Respondent with the recommendation of a TENS unit.

[7] A TENS unit is a Transcutaneous electrical nerve stimulation device which uses electric current to stimulate the nerves for therapeutic purposes.

[8] Tramadol is an analgesic used to treat moderate to moderately severe pain.

[9] Darvocet, a combination of acetaminophen and propoxyphene, is used to relieve mild to moderate pain. It was withdrawn from the U.S. market in November 2010.

[10] Tylenol 3 is acetaminophen combined with codeine, a naturally occurring opiate or narcotic. Tylenol 4 contains a higher amount of codeine.

Tramadol, hydrocodone with acetaminophen,[13] and Lidoderm patches.[14] Respondent did not document the dose or frequency of the medications, including the CDS.

22. Respondent continued to see Patient 1 for monthly refills of these medications from 2010 until in or around May 2012.

23. In May 2011, Patient 1's father called Respondent's office and left a message inquiring about Patient 1's diagnosis and Respondent's treatment plan. Respondent documented that he spoke with Patient 1 about the call, who stated that he did not want his father involved in his health care.

24. In or around July 2011, Respondent prescribed Percocet[15] in addition to continuing hydrocodone and oxycodone IR.

25. In or around July 2011 Respondent discontinued prescribing Tylenol #4. Respondent did not document his rationale for this change.

26. On June 22, 2011, Respondent ordered Patient 1's first urine drug screen since Patient 1 came under Respondent's care. Patient 1's urine was positive for hydrocodone and oxycodone, both of which Respondent prescribed for Patient 1.

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[11] Oxycodone, a semi-synthetic opioid, is a narcotic analgesic generally indicated for relief of moderate to severe pain.

[12] Meloxicam is a nonsteroidal anti-inflammatory drug (NSAID).

[13] Hydrocodone is a semi-synthetic opioid derived from codeine used as a narcotic analgesic to treat moderate to severe pain.

[14] Lidoderm patches contain the local anesthetic lidocaine and are used for relief of pain associated with post-herpetic neuralgia.

[15] Percocet is a combination of acetaminophen and oxycodone used to relieve moderate to severe pain.

27. In July 2011, Patient 1 had an MRI of the lumbar-sacral spine.[16] Respondent reiterated his diagnosis of Degenerative Disk Disease.

28. In November 2011, Respondent discontinued prescribing Oxycodone IR but continued the prescription for Percocet until at least January 2012.[17]

29. Respondent provided Patient 1 with an undated "Consent for Opioid Treatment" form, which Patient 1 signed.[18]

30. In January 2012, Respondent last treated Patient 1, who informed Respondent he was moving to Montana with his father.

31. In May 2012, Patient 1 contacted Respondent from Montana requesting refills of Tylenol #3. Respondent stated he was no longer able to treat Patient 1 and referred him to Urgent Care.

32. Respondent fails to meet appropriate standards for the delivery of quality medical care in regard to his care and treatment of Patient 1 in violation of Health Occ. § 14-404(a)(22) for reasons including, but not limited to:

a. Failing to follow-through with referrals to a pain management specialist, neurosurgical or other spinal consult;

b. Failing to obtain standard liver or kidney laboratory testing to determine any damage from long-term opioid and analgesic use;

c. Maintaining a young adult on chronic opiate medications, without referral to a specialist;

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[16] Respondent did not document whether he, or another physician, ordered the MRI.

[17] Respondent's records are not legible enough to show whether Patient 1's prescription for Percocet was continued past this time.

[18] If the Respondent maintained the medical records in the order in which they were created, the consent was signed in or around May 2012.

d. Failing to return Patient 1's father's telephone contact to listen to his concerns about Patient 1;

e. Failing to reassess ongoing usage pattern and need for narcotic medications; and

f. Failing to obtain routine urine drug screens to ensure opioid compliance.

33. Respondent fails to keep adequate medical records for Patient 1 in violation of Health Occ. § 14-404(a)(40) for reasons including, but not limited to:

a. Failing to legibly document progress notes and medication flow sheets in Patient 1's chart;

b. Failing to document the assessments and future treatment plans during each visit;

c. Failing to obtain and document Patient 1's history, including prior treatment for pain, past or current substance abuse, or mental health history;

d. Failing to document when he prescribed or discontinued pain medications;

e. Failing to document the dose and frequency of prescribed pain medications; and

e. Failing at the onset of opioid treatment to obtain a "Consent for Opioid Treatment" form, which discusses the side effects of CDS, precautions, the addictive nature, and illegality of diversion.

Patient 2[19]

34. In or around October 2007, Patient 2, then a mid-50s year old male, on disability, presented to Respondent after being referred by a pain specialist for primary care and maintenance of pain medication for knee and shoulder pain. Respondent provided Patient 2 with a "Consent for Chronic Opioid Therapy" form, which Patient 2 signed on October 19, 2007.

[19] Patient 2 is the father of Patient 4.

35. Respondent continued Patient 2 on pain medications prescribed by the referring pain specialist: MS Contin[20] (long-acting) 100 mg tid and MS Contin IR (Immediate Release) 30 mg up to five times daily.

36. In or around December 2011, Respondent prescribed MS Contin IR 30 mg twice a day for shoulder and knee pain, in addition to the MS Contin 100 mg and MS Contin IR 30 mg that was prescribed initially.

37. On April 9, 2012, "Prescription Solutions by Optum RX," the prescription drug provider for Patient 2 through his UnitedHealthcare Medicaid insurance, sent a letter to Respondent outlining Prescriptions Solutions' concerns relating to Patient 2. The letter included Narcotic Drug Utilization Review reports from June 1, 2011 to August 31, 2011 and from October 1, 2011 to December 31, 2011 which raised concerns as to the amount of narcotics being received by Patient 2. Prescription Solutions urged Respondent to consider the report in evaluating Patient 2's medications and any possibility of drug abuse, diversion, or other inappropriate use.

38. Respondent saw Patient 2 on a monthly basis for refills of the pain medication until in or around at least September 2012.[21]

39. Respondent fails to meet appropriate standards for the delivery of quality medical care in regard to his care and treatment of Patient 2 in violation of Health Occ. § 14-404(a)(22) for reasons including but not limited to:

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[20] MS Contin is the brand name for morphine sulfate.

[21] On October 15, 2012, the Board received the medical records of Patient 2 and others from Respondent pursuant to the subpoena issued by the Board. Therefore, the reviewers could not determine if the care continued past this date.

a. Failing to obtain a complete medical history of prior care and treatment;

b. Failing to perform a complete physical examination;

c. Failing to perform urine drug screens to ensure narcotics compliance;

d. Failing to obtain routine monitoring laboratory testing for hepatic or renal injury as a result of long term multiple pain medication use;

e. Failing to reassess ongoing usage pattern and need for narcotic medications; and

f. Failing to check Patient 2 for drug abuse or diversion, document a rationale for his prescribing, or alter his prescribing, in response to the notice from the insurance company.

40. Respondent fails to keep adequate medical records for Patient 2 in violation of Health Occ. § 14-404(a)(40) for reasons including, but not limited to:

a. Failing to legibly document progress notes and medication flow sheets in Patient 2's chart;

b. Failing to document the assessments and future treatment plans during each visit;

c. Failing to document Patient 2's medication history before continuing on high levels of CDS; and

d. Failing to document a complete physical examination.

Patient 4[22]

41. In or around 2007, Patient 4, then an 18 year old female, presented to Respondent for treatment of dry skin. Respondent did not document a complete history or physical examination during the initial visit or subsequently.

42. On May 17, 2007, Patient 4 underwent arthroscopic ankle surgery for ankle pain.

[22] Patient 4 is the daughter of Patient 2.

43. In or around 2007, Respondent prescribed Endocet[23] 10/325 as needed for Patient 4 for low back and ankle pain. Respondent continued this medication until 2009.

44. In or around October 2009, Respondent prescribed oxycodone 15mg. Respondent discontinued Endocet. Respondent crossed out multiple prescription amounts so it is not clear when exactly Endocet was actually discontinued.

44. October 3, 2012 is the last documented date the Respondent saw Patient 4 for an appointment.[24]

45. Respondent fails to meet appropriate standards for the delivery of quality medical care in regard to his care and treatment of Patient 4 in violation of Health Occ. § 14-404(a)(22) for reasons including but not limited to:

a. Failing to follow-up with, or obtain medical records from the orthopedist who previously operated on Patient 4, or the pain specialist who previously treated Patient 4;

b. Failing to obtain a complete medical history;

c. Failing to order urine drug tests to ensure narcotics compliance;

d. Failing to reassess ongoing usage pattern and need for narcotic medications; and

e. Maintaining a young adult on chronic opiate medications, without referral back to the orthopedist or pain specialist, or consideration of a non-narcotic modality.

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[23] Endocet is a combination of acetaminophen and oxycodone used to relieve moderate to severe pain.

[24] On October 15, 2012, the Board received the medical records of Patient 4 and others from Respondent pursuant to the subpoena issued by the Board. Therefore, the reviewers could not determine if the care continued past this date

46. Respondent fails to keep adequate medical records for Patient 4 in violation of Health Occ. § 14-404(a)(40) for reasons including, but not limited to:

a. Failing to legibly document progress notes and medication flow sheets in Patient 4's chart;

b. Failing to document the assessments and future treatment plans during each visit;

c. Failing to document a complete medical history and/or physical examination; and

d. Failing at the onset of opioid treatment to obtain a "Consent for Opioid Treatment" form, which discusses the side effects of CDS, precautions, the addictive nature, and illegality of diversion.

Patient 8

47. In or around 2003, Patient 8, then an early 40's year old male, presented to Respondent requesting a primary care provider. Respondent began seeing Patient 8 for treatment of multiple long-term conditions, including hypertension, hyperlipidemia, hypogonadism, carpal tunnel syndrome, bipolar disorder, attention deficit disorder (ADD), insomnia, and chronic neck, back and shoulder pain.

48. Respondent did not obtain Patient 8's medical history at intake, or otherwise.

49. In November 2003, Respondent saw Patient 8 on a monthly basis and prescribed Percocet 10/325mg every 4-6 hours and Adderall[25] 20 mg tid, as well as several other non-narcotic medications through, at least, September

[25] Adderall is an amphetamine used to treat narcolepsy and attention deficit hyperactivity disorder (ADHD).

2012.[26]

50. Respondent fails to keep adequate medical records for Patient 8 in violation of Health Occ. § 14-404(a)(40) as outlined in pertinent part above for reasons including, but not limited to:

a. Failing to obtain an initial history;

b. Failing to obtain prior medical records;

c. Failing to legibly document progress notes and medication flow sheets in Patient 8's chart;

d. Failing to document the assessments and future treatment plans during each visit; and

e. Failing at the onset of opioid treatment to obtain a "Consent for Opioid Treatment" form, which discusses the side effects of CDS, precautions, discussion of addictive nature, and illegality of diversion.

Patient 10

51. On July 20, 2011, Patient 10, then an early 40s year old female presented to Respondent for treatment. Patient 10 had a history of low back pain and Respondent also diagnosed Patient 10 with obesity, hyperlipidemia, right shoulder pain, chronic obstructive pulmonary disease, and diabetes.

52. In or around September 2011, Respondent prescribed the narcotics MS Contin 60 mg twice a day and MS Contin IR 30 mg as needed, as well as several other non-narcotic medications. Respondent continued these prescriptions until in or around April 2012.

[26] On October 15, 2012, the Board received the medical records of Patient 8 and others from Respondent pursuant to the subpoena issued by the Board. Therefore, the reviewers could not determine if the care continued past this date.

53. In or around August 2011, laboratory testing showed that Patient 10 had a glucose level of 255. Respondent did not obtain further testing despite this "extremely high" result. In September 2011, Patient 10 developed a foot ulcer.

54. In or around July 2012, Respondent discharged Patient 10 due to a urine drug screen recording the presence of drugs (amphetamines and methadone) not prescribed by Respondent.

55. Respondent did not obtain urine drug screens prior to the one leading to Patient 10's discharge in July 2012.

56. Respondent fails to meet appropriate standards for the delivery of quality medical care in regard to his care and treatment of Patient 10 in violation of Health Occ. § 14-404(a)(22) for reasons including but not limited to:

a. Failing to perform routine drug screens to ensure CDS compliance; and

b. Failing to perform follow-up testing or care for Patient 10's diabetes after Respondent documented highly elevated glucose levels.

57. Respondent fails to keep adequate medical records for Patient 10 constituting a violation of Health Occ. § 14-404(a)(40) for reasons including, but not limited to:

a. Failing to legibly document progress notes and medication flow sheets in Patient 10's chart.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that Respondent violated Health Occ. § 14-404(a)(22) (Fails to meet appropriate standards...for quality medical care.) and (40)(Fails to keep adequate medical records.)

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by a majority of a quorum of the Board considering this case hereby:

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

ORDERED that Respondent is placed on **PROBATION** for a minimum of **one (1) year** from the effective date of this Consent Order under the following conditions:

1. Within two (2) months of the effective date of this Consent Order, Respondent shall initiate either dictation and transcription or an electronic medical records system for all of his medical records;

2. Within two (2) months of the effective date of this Consent Order, Respondent shall enroll in, and within six (6) months of the effective date of this Consent Order, Respondent shall successfully complete, a Board-approved course in medical record keeping;

3. Within two (2) months of the effective date of this Consent Order, Respondent shall enroll in, and within six (6) months of the effective date of this Consent Order, Respondent shall successfully complete, a Board-approved course which covers both prescribing of controlled dangerous substances and pain management;

4. The course shall be in addition to any continuing education requirements mandated for continuing licensure. Any continuing education credit earned shall not count toward fulfilling continuing education requirements that Respondent must fulfill in order to renew his license to practice medicine;

5. Within six (6) months after the completion of the courses, Respondent's practice of chronic pain management 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;

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

7. An unsatisfactory peer review by an appropriate peer review entity, shall be deemed a violation of probation;

8. Any violation of the terms of this Consent Order may be deemed a violation of this Consent Order; and be it further

ORDERED that Respondent shall comply with the Maryland Medical Practice Act and all laws, statutes and regulations pertaining to the practice of medicine; and be it further

ORDERED that if Respondent violates any of the terms or conditions of probation or this Consent Order, the Board or Board panel, in its discretion, after notice and an opportunity for a show cause hearing before the Board or Board panel, 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 the Board may have imposed in this case under §§ 14-404(a) and 14-405.1of the Medical Practice Act, including an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty; and it is further

ORDERED that after a minimum of one (1) year of probation, and after the conclusion of a satisfactory peer review, Respondent may file a written petition for termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board or designated Board committee or panel. The Board, or designated Board committee or panel, will grant termination if 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 be it further

ORDERED that this Consent Order is a public document pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.* (2009 Repl. Vol. and 2013 Supp.).

10/23/13
Date

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

CONSENT

I, Andrew Mrowiec, M.D., License No. D47804, by affixing my signature hereto, acknowledge that:

1. I have consulted with counsel, Thomas Marriner, 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 (2009 Repl. Vol. & 2013 Cum. Supp.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2009 Repl. Vol. & 2013 Cum. Supp.).

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 any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

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

09/20/2013
Date

Andrew Mrowiec, M.D.
Respondent

LINDA S. INSLEY
NOTARY PUBLIC
MY COMMISSION EXPIRES 5/23/2017
HARFORD COUNTY, MD

NOTARY

STATE OF Maryland
CITY/COUNTY OF Harford

I HEREBY CERTIFY that on this 20th day of September, 2013 before me, a Notary Public of the State and County aforesaid, personally appeared Andrew Mrowiec, M.D, License number D47804, 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.

Linda S Insley
Notary Public

My commission expires 5/23/2017