IN THE MATTER OF	*	**BEFORE THE MARYLAND**
Okechukwu A. Nwodim, D.O.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: H58158	*	**Case Number: 2014-0672A**

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CONSENT ORDER

On September 9, 2015, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") charged Okechukwu A. Nwodim, D.O. (the "Respondent"), License Number H58158, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 14-404(a) (2014 Repl. Vol.).

The pertinent provision of the Act provides:

> (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:
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> ...
>
> (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[.]

On December 2, 2015, Disciplinary Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

I. FINDINGS OF FACT

Disciplinary Panel A finds the following:

BACKGROUND

1. .At all times relevant to these charges, the Respondent was a physician licensed to practice medicine in the State of Maryland. The Respondent was initially licensed in Maryland on or about November 19, 2001, and she is presently licensed through September, 30, 2015.

2. On June 23, 2009, the Board charged the Respondent with several grounds under the Act based on allegations of excessive and inappropriate insurance billing relating to five patients who had allegedly sustained injuries from a motor vehicle accident. The Board resolved the Charges through a December 2009 Consent Order imposing a six month suspension of the Respondent's medical license, that was immediately stayed, and two years of probation with conditions. The terms of the Consent Order were terminated on January 7, 2013.

3. The Respondent is board-certified by the American Osteopathic Association in Family Medicine. She is not board-certified by the American Board of Medical Specialties ("ABMS").

4. The Respondent holds inactive medical licenses in Virginia, the District of Columbia, West Virginia and Pennsylvania.

PRESENT FINDINGS

5. At all times relevant to these charges, the Respondent practiced from July 2012 through March 2014 at Practice A, a chronic pain management practice.[1]

6. On or about February 24, 2014, the Board received a complaint from the State Division of Drug Control ("DDC") alleging that during a routine pharmacy inspection of Pharmacy A, the Respondent had repeatedly prescribed oxycodone[2] 30 mg, for the prior eight months before the inspection had been conducted.

7. Shortly after receiving the complaint, the Board initiated an investigation of the Respondent's practice.

8. On or about May 1, 2014, the Board's staff notified the Respondent of its investigation, and subpoenaed ten patient records.

9. On or about June 30, 2014, the Board's staff reissued the subpoena for patient records along with a letter requesting the records be submitted to the Board no later than July 11, 2014.

10. On July 7, 2014, by telephone and in writing, the Respondent notified the Board that she was no longer employed at Practice A and did not have access to Practice A's records.

11. On or about July 7, 2014, the Board issued a subpoena to Practice A for the ten patient records referred to in ¶ 8. On receipt of the records, on or about July 18, 2014, the Board provided copies of the medical records to the Respondent, requesting she return written summaries of care for all ten patients.

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[1] In order to maintain confidentiality, facility and patient names will not be used in this document, but will be provided to the Respondent on request.

[2] A Schedule II Controlled Dangerous Substance ("CDS").

12. On or about August 14, 2014, the Respondent submitted a written response to the allegations, along with the summaries of care that had been requested by the Board's staff.

13. On September 9, 2014, the Board's staff interviewed the Respondent under oath regarding the pending allegations.

14. In furtherance of its investigation, on January 13, 2015, the Board's staff transmitted the ten patient records and relevant investigative documents to two peer reviewers board-certified in pain medicine and physical medicine and rehabilitation (the "reviewers"), for the purpose of conducting a peer review. The results of the peer review are set forth below.

15. On or about March 16, 2015, the reviewers submitted their respective peer review reports to the Board.

16. On or about March 17, 2015, the Board's staff sent the Respondent copies of the peer review reports, providing her with an opportunity to file a supplemental response to the allegations.

17. On or about April 3, 2015, the Respondent filed a supplemental response to the peer review reports stating that she had complied with the standards of care for each patient.

PATIENT-RELATED FINDINGS

PATIENT 1

18. On or about October 4, 2012, Patient 1, a female in her 30s, presented to the Respondent with a chief complaint of low back pain sustained from a trampoline

accident. Prior to being seen by the Respondent, Patient 1 had seen other providers at Practice A.

19. Patient 1's record included a February 2011 MRI of the lumbar spine that showed small to moderate disk protrusion.

20. The Respondent prescribed oxycodone 30 mg[3] and Naproxen[4] to Patient 1 on approximately a monthly basis from her initial visit through March 20, 2014. She initially prescribed Soma,[5] however, after the initial visit, discontinued it.

21. The Respondent continued to order an MRI of the lumbar spine on several dates: December 27, 2013, January 23, 2014, February 20, 2014 and March 20, 2014. There is no evidence in the record that Patient 1 complied, yet the Respondent continued to prescribe opioids to her.

22. The Respondent documented that Patient 1 had lumbar radiculopathy; however, this was not substantiated by history, exam or radiology studies.

23. The Respondent failed to refer Patient 1 to a specialist in order to be evaluated for "lumbar radiculopathy."

24. There are no urine toxicology screen results in Patient 1's record or any other mechanism to evaluate for abuse or diversion of the opioids.[6]

25. The Respondent failed to meet the standard of quality care for Patient 1 for reasons including but not limited to the following:

a. The Respondent prescribed high dose short-acting narcotics over a period of years without adequate justification;

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[3] In January 2014, the Respondent decreased the number of tablets to 116 from 120; however, the frequency remained the same at 30 mg. every six hours.
[4] A nonsteroidal anti-inflammatory medication used to treat pain and inflammation.
[5] A Schedule IV muscle relaxant.
[6] The sole urine toxicology screen is dated April 17, 2014, which is after the Respondent left Practice A.

b. The Respondent failed to adequately use different modalities and adjuvant therapies including non-narcotic medications for treatment;

c. The Respondent failed to use long-acting pain medications as the primary therapy and adding short-acting opioids for breakthrough pain;

d. The Respondent failed to formulate an adequate plan to transition Patient 1 off of opioids;

e. The Respondent failed to refer Patient 1 to a specialist for evaluation of "lumbar radiculopathy"; and/or

f. The Respondent failed to adequately monitor Patient 1 with urine toxicology screening or other modalities to evaluate her for abuse and diversion.

PATIENT 2

26. On or about April 1, 2013, Patient 2, a male in his 20s, presented to the Respondent with a chief complaint of low back pain for eight years after a fall at work. Patient 2 had been seen by other providers at Practice A prior to being seen by the Respondent.

27. Patient 2's January 2013 MRI of the lumbar spine showed moderate L4-5 central stenosis producing L5 impingement and L5 to S1 disc protrusion.

28. During the initial visit on April 1, the Respondent referred Patient 2 to physical therapy and prescribed oxycodone 15 mg three times daily as needed, providing him with "114" tablets along with Flexeril[7] and ibuprofen.

29. On April 29, 2013, without documenting a rationale for doing so, the Respondent increased Patient 2's oxycodone prescription to 30 mg (90 tablets), to be taken three times daily as needed.

[7] A muscle relaxant.

30. On June 24, 2013 through March 26, 2014, the Respondent continued the oxycodone 30 mg three times daily as needed, but increased the number of tablets to 112.

31. Patient 2 completed a pain assessment during his visits with the Respondent and was asked to complete on a form, the current medications he was taking. Beginning on June 24, 2013, Patient 2, documented that he was taking oxycodone 30 mg four times daily, and this continued through March 26, 2014.

32. The Respondent did not refer Patient 2 to a specialist including an interventional pain specialist or a neurosurgeon.

33. The Respondent failed to meet the standard of quality care for Patient 2 for reasons including but not limited to the following:

a. The Respondent's continued prescription of high dose short-acting opioids for Patient 2 without an appropriate medical workup;

b. The Respondent failed to use long-acting pain medications as the primary therapy and adding short-acting opioids for breakthrough pain;

c. The Respondent failed to adequately use different modalities and adjuvant therapies including non-narcotic medications for treatment;

d. The Respondent did not formulate an adequate treatment plan to include a transition off of opioids; and/or

e. The Respondent failed to refer Patient 2 to an appropriate specialist.

PATIENT 3

34. On or about December 12, 2012, Patient 3, a female in her 40s, presented to the Respondent with complaints of back and neck pain from a history of gymnastics and cheerleading. She had been treated by a prior physician at Practice A with oxycodone 15 mg and 30 mg.

35. The Respondent diagnosed Patient 3 with lumbar and cervical radiculopathy, although there were no studies in Patient 3's records to support this diagnosis. A September 2010 MRI study of her cervical spine showed mild diffuse hypertrophic spondylosis and degenerative disc disease, and a September 2010 MRI study of her lumbar spine showed small disc herniation and some chronic facet joint arthritis.

36. The Respondent re-ordered an MRI of Patient 3's lumbar spine on August 7, 2013, but there are no results in the chart.[8]

37. The Respondent failed to adequately elicit an adequate history or perform a physical examination to assess the severity of Patient 3's disease.

38. From the initial visit through at least November 1, 2013, prescriptions reflect the Respondent prescribed oxycodone 30 mg, 114 tablets monthly, which provided 3 to 4 tablets daily.

39. Progress notes dated monthly from December 13, 2013 through March 7, 2014 document that the Respondent saw Patient 3 for pain management and continued to prescribe oxycodone 30 mg.

40. From December 12, 2012 through August 7, 2013, the Respondent also prescribed Soma 350 mg, 1 tablet at bedtime.

41. On October 4, 2013 the Respondent ordered a urine toxicology screen be conducted.

42. Also, there is another undated illegible entry that appears to reflect that another urine toxicology screen was ordered.

43. The Respondent failed to refer Patient 3 to an appropriate specialist.

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[8] Another provider on May 2, 2014 documented, "Needs MRI."

44. The Respondent failed to transition Patient 3 from short acting opioids to a long-acting opioid.

45. The Respondent failed to document an adequate treatment plan for Patient 3.

46. The Respondent failed to meet the standard of quality care for Patient 3 for reasons including but not limited to the following:

a. The Respondent continued to prescribe high dose short-acting opioids for Patient 3 without appropriate pathology or findings on physical examination, and without the plan to transition off of these addictive substances;

b. The Respondent continued to prescribe high dose short-acting opioids for Patient 3 without an adequate treatment plan;

c. The Respondent failed to use long-acting pain medications as the primary therapy and adding short acting opioids for breakthrough pain;

d. The Respondent failed to adequately use different modalities and adjuvant therapies including non-narcotic medications for treatment;

e. The Respondent failed to refer Patient 3 to an adequate specialist such as an interventional pain specialist or a neurosurgeon; and/or

f. The Respondent failed to adequately monitor Patient 3 with urine toxicology screening or other modalities to evaluate for possible abuse or diversion.

PATIENT 4

47. On or about September 21, 2012, Patient 4, a female in her 20s, was initially seen by the Respondent with complaints of hip and low back pain. She had been seen previously by other providers at Practice A.

48. Patient 4's record contained a November 2009 MRI of her lumbar spine which showed disc herniation, and a follow-up MRI conducted on September 4, 2012 showed

minimal bulging discs at L1-3 with no disc herniation, and a broad based central disc herniation.

49. A September 4, 2012 MRI of Patient 4's left hip was unchanged from 1999 and unremarkable. An MRI of her right hip showed some postsurgical change and hip dysplasia.

50. From October 18, 2012 through March 4, 2014, the Respondent prescribed monthly oxycodone 30 mg. Initially, from October 18, 2012 through June 26, 2013, she prescribed between 120 and 130 tablets monthly. From July 26, 2013 through March 4, 2014, she prescribed 114 tablets monthly.

51. The Respondent failed to adequately elicit a history or perform a physical examination to assess the severity of Patient 4's disease.

52. In notes between January and May 2013, the Respondent documented that Patient 4 was followed by "ortho." She failed to specify the name of the orthopedist, or the proposed surgical procedure.

53. In notes between June and August, 2013, the Respondent specified that it was Patient 4's "hip" that was "getting worse" and that she (Patient 4) was contemplating surgery.

54. On September 20, 2013, Patient 4 stated that she had had a metal rod implant inserted. There is no documentation of any communication with the orthopedic surgeon in Patient 4's record, nor is there an operative report.

55. The Respondent failed to meet the standard of quality care of Patient 4 for reasons including but not limited to the following:

a. The Respondent continued to prescribe high dose short-acting opioids for Patient 4 without adequate justification based on her evaluation;

b. The Respondent failed to refer Patient 4 to a pain management specialist;

c. The Respondent continued to prescribe high dose short-acting opioids for Patient 3 without an adequate treatment plan;

d. The Respondent failed to use long-acting pain medications as the primary therapy and adding short-acting opioids for breakthrough pain; and/or

e. The Respondent failed to adequately use different modalities and adjuvant therapies including non-narcotic medications for treatment.

PATIENT 5

56. On or about April 2, 2013, Patient 5, a male in his 50s presented to the Respondent with complaints of non-specific back pain, cervical degenerative disc disease and a history of Hodgkin's disease. Beginning around 2011, Patient 5 had been seen by other physicians (at Practice A and elsewhere) who had prescribed opioids and who had referred Patient 5 for physical therapy.

57. A March 2011 cervical spine MRI showed mild degenerative changes, and a lumbar spine MRI showed Grade 1 spondylolisthesis and severe bilateral foraminal narrowing.

58. The Respondent failed to adequately elicit a history or perform a physical examination to assess the severity of Patient 5's disease.

59. On April 2, 2013, the Respondent treated Patient 5 with oxycodone 30 mg, Naproxen twice daily and Soma once daily.

60. The Respondent continued prescribing on a monthly basis through March 26, 2014, 112 to 120 tablets of oxycodone, along with the Naproxen. She continued prescribing Soma monthly through August 19, 2013.

61. In August 2013, the Respondent ordered an MRI that showed mild degenerative disc disease and spondylolisthesis.

62. There is an illegible undated copy of a urine toxicology screen that was provided in proximity to Patient 5's September 16, 2013 office visit. The next urine toxicology screen in Patient 5's chart was ordered after the Respondent left the practice, on April 22, 2014.

63. The Respondent did not refer Patient 5 to any specialists or order any non-opioid interventions.

64. The Respondent did not adequately attempt to decrease the dosage of the oxycodone. She decreased the number of monthly tablets by 8 over the course of a few months.

65. The Respondent failed to meet the standard of quality care of Patient 5 for reasons including but not limited to the following:

a. There was inadequate justification for the Respondent to continue prescribing high doses of short-acting opioids to Patient 5; and/or

b. The Respondent failed to formulate a plan to transition Patient 5 off of short-acting opioids;

c. The Respondent continued to prescribe high dose short-acting opioids for Patient 3 without an adequate treatment plan;

d. The Respondent failed to use long-acting pain medications as the primary therapy and adding short-acting opioids for breakthrough pain;

e. The Respondent failed to refer Patient 5 to a pain management specialist and/or

f. The Respondent failed to adequately monitor Patient 5 for compliance with the opioid prescriptions with random urine toxicology screening or other modalities.

PATIENT 6

66. On or about February 23, 2013, the Respondent initially saw Patient 6, a male in his 40s, for complaints of neck and lower back pain. The Respondent diagnosed him with cervical and lumbar radiculopathy, although there was an insufficient confirmation of this diagnosis recorded in Patient 6's medical records through physical examination or radiology studies.

67. On February 23, 2013, by note, the Respondent documented that a lumbar MRI showed a disc bulge. The records did not contain the MRI report.

68. The Respondent began prescribing oxycodone 30 mg (114 tablets monthly), ibuprofen and Flexeril to Patient 6 during his initial visit, and continued prescribing these medications through March 21, 2014.

69. The Respondent's history and physical examination of Patient 6 was insufficient to support the severity of the disease that justified initiating and continuing Patient 6 on the dosage of opioids prescribed.

70. The sole urine toxicology screen in Patient 6's chart was obtained on April 28, 2014, after the Respondent had left Practice A. There were no other urine toxicology results in Patient 6's chart.

71. The Respondent did not refer Patient 6 to a pain management specialist.

72. The Respondent failed to meet the standard of quality medical care for Patient 6 for reasons including but not limited to the following:

a. The Respondent prescribed short-acting opioids to Patient 6 for an extended period of time without adequate justification;

b. The Respondent failed to use long acting pain medications as the primary therapy and adding short acting opioids for breakthrough pain

c. The Respondent failed to refer Patient 6 to a pain management specialist;

d. The Respondent failed to adequately use different modalities and adjuvant therapies including non-narcotic medications for treatment; and/or

e. The Respondent failed to adequately monitor Patient 6 for compliance with the opioid prescriptions with random urine toxicology screening or other modalities.

PATIENT 7

73. On or about August 8, 2012, the Respondent initially saw Patient 7, a male in his 20s, for complaints of low back pain and right shoulder pain. Previously, Patient 7 had been treated by a provider in Florida with high doses of oxycodone without evidence of a specific serious diagnosis or previous surgery. A drug screen had been conducted in Florida that was positive for oxycodone, benzodiazepines and THC.

74. An October 2010 MRI of the lumbar spine reflected that Patient 7 had bilateral foraminal herniated discs in the L4-5 disc space and the L5 to S1 disc space demonstrated a focal central herniated disc protrusion.

75. The Respondent prescribed oxycodone 30 mg, #120 to Patient 7 at the initial visit, and continued prescribing oxycodone through March 28, 2014 (monthly tablets varied between 114-132).[9] The Respondent also prescribed monthly Flexeril and Motrin.

76. The Respondent prescribed Soma, 250 mg, at bedtime beginning in January 2013, through August 27, 2013.

77. On August 2 and 27, 2013 and February 28, and March 28, 2014, the Respondent ordered an MRI of the lumbar spine, however, there is no report or

[9] On September 5, 2012, the Respondent ordered for Patient 7, 1130 tablets, however, that appears to be a clerical error.

documentation in the Respondent's progress note(s) that it was completed. Despite Patient 7's noncompliance, the Respondent continued prescribing oxycodone.

78. There is an undated, illegible page between the December 2013 and January 2014 visits that appears to be a urine toxicology screen; however, the results are not documented in Patient 7's chart. There are no additional urine toxicology screens or evidence in Patient 7's chart of any other method to evaluate him for abuse and/or diversion.

79. The Respondent failed to refer Patient 7 to a pain management specialist.

80. The Respondent did not significantly decrease the dosage of oxycodone she prescribed for Patient 7 over the course of 19 months.

81. The Respondent failed to meet the standard of quality care for Patient 7 for reasons including but not limited to the following:

a. There was inadequate justification for the Respondent to continue the long-term prescription of large dose short-acting opioids to Patient 7;

b. The Respondent failed to prescribe rotating long and short-acting opioids to Patient 7 to decrease the risk of abuse or diversion;

c. The Respondent failed to adequately use different modalities and adjuvant therapies including non-narcotic medications for treatment;

d. The Respondent failed to adequately evaluate Patient 7 for possible abuse or diversion with random urine drug screening or any other modality such as through pill counts; and/or

e. The Respondent failed to refer Patient 7 to a pain management specialist.

PATIENT 8

82. Patient 8, a male in his 30s, initially saw the Respondent on July 30, 2012 for complaints of lower back pain and left shoulder pain as a result of a motor vehicle accident ("MVA").

83. An August 2011 MRI of the lumbar spine showed a small disc herniation at L5-S1, and at L4-5 broad based bulging with disk herniation.

84. The Respondent prescribed oxycodone 30 mg, from the initial visit in July 2012 through March 19, 2014. She prescribed between 116 and 132 tablets monthly. Additionally, the Respondent prescribed Soma, at bedtime, from Patient 8's initial visit through September 2013 (40 tablets monthly).

85. The Respondent's history and physical examination of Patient 8 was insufficient to support the severity of the disease that justified initiating and continuing Patient 8 on the dosage of opioids prescribed.

86. Sometime in 2013, the Respondent ordered a urine toxicology screen. The results in Patient 8's record are illegible. There were no other urine toxicology screens included in Patient 8's record until after the Respondent left the practice.

87. On November 15, 2013, December 18, 2013, January 16, 2014 and again on February 19, 2014 and March 19, 2014, the Respondent ordered an MRI of the lumbar spine. There is no report or documentation that Patient 8 had the study. Nonetheless, each month between November 2013 through March 2014, the Respondent continued to refill Patient 8's opioid prescriptions.

88. The Respondent did not refer Patient 8 to a pain management specialist.

89. The Respondent failed to meet the standard of quality care for Patient 8 for reasons including but not limited to the following:

a. There was inadequate justification to prescribe long term short-acting opioids to Patient 8 based on the medical findings;

b. The Respondent failed to prescribe rotating long and short-acting opioids to Patient 8 to decrease the risk of abuse or diversion;

c. The Respondent failed to adequately use different modalities and adjuvant therapies including non-narcotic medications for treatment;

d. The Respondent failed to order adequate random urine toxicology screening or any other modality to evaluate for possible abuse or diversion; and/or

e. The Respondent failed to refer Patient 8 to a pain management specialist.

PATIENT 9

90. Patient 9, a male in his 20s, initially saw the Respondent on December 20, 2012 for complaints of non-specific low back pain from a sports-related injury. The Respondent noted he was in no apparent distress, and her plan was to refer him to physical therapy.[10]

91. A September 1, 2011 MRI of the lumbar spine showed mild disc herniation at L5 to S1.

92. Patient 9's record contained what appeared to be the nonspecific results of a urine toxicology screen that had been ordered in September 2012 that stated "all neg." In close proximity to records from October 2013, the record contains an illegible undated copy of a blank strip.[11]

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[10] There is no documentation in Patient 9's record that he received physical therapy.

[11] There is a urine toxicology screen that was obtained on April 16, 2014; however, this was after the Respondent left Practice A.

93. During the initial visit, the Respondent prescribed oxycodone 30 mg, Motrin and Flexeril. Between December 2012 and March 18, 2014, the Respondent prescribed between 114 to 132 tablets oxycodone monthly.

94. The Respondent's history and physical examination of Patient 9 was insufficient to support the severity of the disease that justified initiating and continuing Patient 9 on the dosage of opioids prescribed.

95. On November 25, 2013, December 23, 2013, January 21, 2014, February 18, 2014, and March 18, 2014, the Respondent ordered an MRI of the lumbar spine. Neither the report nor any documentation was present in Patient 9's record supporting that Patient 9 had undergone the MRI. The Respondent continued to prescribe oxycodone from November 2013 through March 2014, despite Patient 9's noncompliance.

96. The Respondent failed to refer Patient 9 to a pain management or other appropriate consulting physician.

97. The Respondent failed to meet the standard of quality care for Patient 9 for reasons including but not limited to the following:

a. There was inadequate justification to prescribe long term short-acting opioids to Patient 9 based on the medical findings;

b. The Respondent failed to prescribe rotating long and short-acting opioids to Patient 9 to decrease the risk of abuse or diversion;

c. The Respondent failed to adequately use different modalities and adjuvant therapies including non-narcotic medications for treatment;

d. The Respondent failed to refer Patient 9 to a pain management physician; and/or

e. The Respondent failed to order adequate random urine drug screening or any other modality to evaluate for possible abuse or diversion.

PATIENT 10

98. Patient 10, a male in his 30s, began seeing the Respondent on or about July 19, 2012. The initial progress note was dated December 3, 2012 and documented that he was seeking pain management for complaints of low back pain. The Respondent diagnosed Patient 10 with low pain and lumbar radiculopathy. Patient 10 had seen other providers at Practice A prior to seeing the Respondent for pain management.

99. Pharmacy printouts in Patient 10's record reflected that he had a history of obtaining large quantities of oxycodone 30 mg from different providers, and that he paid in cash.

100. On July 19, 2012, the Respondent prescribed oxycodone 30 mg, 140 tablets. Between July 2012 and March 10, 2014, the Respondent prescribed to Patient 10, 126 to 140 tablets of oxycodone monthly. The Respondent also prescribed Soma to Patient 10 from July 2012 through August 8, 2013, and Tramadol[12] 50 mg twice daily, from October 11, 2012 to March 29, 2013.

101. A September 2011 MRI of Patient 10's lumbar spine showed mild bulging discs. Over a period of several months beginning in October 2013, the Respondent repeatedly ordered another MRI on the following dates: October 1, 28, November 20, and December 19, 2013; and January 15, February 10 and March 10, 2014. Despite Patient 10's noncompliance, the Respondent continued to prescribe opioids to him.

102. The Respondent's history and physical examination of Patient 10 was insufficient to support the severity of the disease that justified initiating and continuing Patient 10 on the dosage of opioids prescribed.

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[12] An opioid medication that was scheduled by the DEA effective August 2014.

103. The Respondent did not refer Patient 10 to any specialists.

104. The Respondent failed to meet the standard of quality care for Patient 10 for reasons including but limited to the following:

a. The Respondent prescribed high dose long term short-acting opioid medication with Tramadol without adequate justification;

b. The Respondent failed to use long-acting pain medications as the primary therapy and adding short acting opioids for breakthrough pain;

c. The Respondent failed to adequately use different modalities and adjuvant therapies including non-narcotic medications for treatment;

d. The Respondent failed to obtaining the appropriate testing and appropriately investigate the cause of the pain; and/or

e. The Respondent failed to refer Patient 10 to a pain management specialist;

II. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Disciplinary Panel A concludes as a matter of law that the Respondent's actions and inactions constitute violations of Health Occ. § 14-404(a) (22).

III. ORDER

Based upon the findings of fact and conclusions of law, it is, by Disciplinary Panel A, hereby:

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

ORDERED that the Respondent shall cease the practice of chronic pain management. The Respondent shall not prescribe any opioids to a patient for more than three days and only in an emergency situation. After a minimum period of **TWO (2) YEARS**, should the Respondent wish to resume the prescribing of opioids in the

practice of chronic pain management, the Respondent shall petition the Board or a Disciplinary Panel of the Board in writing to obtain approval. The Respondent shall reappear before the Board or a Disciplinary Panel of the Board in order to obtain such approval and the Board or Disciplinary Panel in its discretion may grant the approval with any terms and conditions including but not limited to coursework, chart and/or peer review and/or an additional term of probation; and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **TWELVE (12) MONTHS**, and shall comply with all laws governing the practice of medicine under the Maryland Medical Practice Act and all rules and regulations promulgated thereunder; and it is further

ORDERED that if the Respondent fails to comply with any of the terms and conditions of probation or of this Consent Order, a Disciplinary Panel or Board, in its discretion, after notice and opportunity for a show cause hearing before a Disciplinary Panel or Board, or an evidentiary hearing at the Office of Administrative Hearings, may impose additional sanctions authorized under the Medical Practice Act, including a reprimand, suspension, an additional period of probation, revocation and/or a monetary fine; and it is further

ORDERED that after **TWELVE (12) MONTHS** from the effective date of this Consent Order, the Respondent may submit a written petition to the Board requesting termination of her probation. After consideration of the petition, the probation may be terminated, through an order of the Board or Disciplinary Panel. The Board, or designated Disciplinary Panel, will grant the termination if the Respondent has fully and

satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

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

ORDERED that this Consent Order shall be a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101-4-601 (2014).

01/04/2016
Date

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

CONSENT

I, Okechukwu A. Nwodim, D.O. acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, 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 law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board 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 the Board that I might have filed after any such hearing.

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

12/24/15
Date

Okechukwu A. Nwodim, D.O.

Reviewed and Approved by:

Kevin A. Dunne, Esquire

STATE OF MARYLAND

CITY/COUNTY OF:

I HEREBY CERTIFY that on this 24th day of December, 2015, before me, a Notary Public of the State and County aforesaid, personally appeared Okechukwu A. Nwodim, D.O.and gave oath in due form of law that the foregoing Consent Order was her voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

THELMA CECILIA KAMARA
Notary Public
Prince George's County
Maryland
My Commission Expires Jul 12, 2017

My commission expires: July 12, 2017