IN THE MATTER OF	*	**BEFORE THE**
RAKESH K. MATHUR, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D39170		**Case Numbers: 2011-0073 & 2011-0430**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

The Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of Rakesh K. Mathur, M.D., (the "Respondent") (D.O.B. 07/31/1954), license number D39170, to practice medicine in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Gov't Code Ann. § 10-226(c)(2009 Repl. Vol.) concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:[1]

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on October 11, 1989.

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

The Respondent holds inactive licenses in Delaware, Pennsylvania and Virginia.

2. The Respondent is certified by the American Board of Anesthesiology and is certified in the Critical Care Medicine sub-specialty.

3. At all times relevant to the events stated herein, the Respondent maintained a pain management practice, the "Intractable Pain Clinic," located at 2112 Bel Air Road, Bel Air, Maryland 21047.

Allegations of Fact[2]

Case Number 2011-0073

4. On or about July 28, 2010, the Board received correspondence from the Drug Enforcement Administration ("DEA") to which was attached a July 26, 2010 letter from a medical products provider[3] regulatory specialist ("Provider"). The Provider's letter stated that the Respondent's account had been "pended" because of his large orders for oxycodone, a Schedule II narcotic analgesic. The Provider reported the Respondent's orders to the DEA and noted they were "suspicious."

5. By letter dated March 9, 2011, the Respondent was notified of the Board's investigation of this matter. By letter dated March 21, 2011, the Respondent stated, *inter alia,* that he maintains a dispensary in his office

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[3] Names of individuals and facilities are confidential. The Respondent may obtain this information upon request.

for which he had solicited the Provider to provide medications.[4] On July 19, 2010, the Respondent ordered 50 bottles (100 tablets each; a total of 5,000 tablets) of oxycodone 20 mg. After receiving the Provider's July 26, 2010 letter advising that his account had been pended, the Respondent obtained from another company the same amount of oxycodone that he had ordered from the Provider.

6. The Respondent further explained that "different vendors have different permissible thresholds of allowance of Class [Schedule] 2 medications at any one given time." The Respondent stated that the order at issue had been his first with the Provider and "we may have crossed their threshold...thereby triggering a cautious communication to the [DEA] Lead Diversion Investigator."

Case Number 2011-0430

7. On or about December 14, 2010, the Board received a complaint from a senior investigator ("Investigator") from a national health care plan which included the report of an on-site audit conducted of the Respondent's office. In the complaint, the Investigator reported that the health care plan's Investigative Unit had detected that a large quantity of narcotic prescriptions were billed from the Respondent's practice and that the Respondent prescribed an "unusually high amount of narcotics for the majority of his patients."

[4] The Respondent stated that he had obtained from the Board a permit for his in-office dispensary.

8. As a result of these findings, the health care plan reviewed the Respondent's records for ten patients. Review of the records revealed that the Respondent documented minimal information to substantiate his reported diagnoses and failed to document a treatment plan other than there is "no cure" for the patient's medical condition and that "therapy is likely to continue indefinitely." The Respondent maintained his records electronically; he documented repetitive phrases in all of the records and made minimal or no changes during multiple visits with the exception of different dates of service and vital signs.

9. The Investigator and his partner thereafter conducted an on-site audit of the Respondent's practice. The Respondent requested a postponement a day before the audit was initially scheduled, claiming that it was "inconvenient." The audit was conducted on November 18, 2010. The findings of the health care plan audit included:

    a. The only examination room in the Respondent's office was cluttered and appeared to be unused;

    b. The Investigators observed the Respondent interact with a patient on the office's closed circuit television. The Respondent saw the patient in his office; he remained seated behind his desk during the entire visit and did not physically examine the patient. The Respondent saw the patient for no more than five minutes, after which the patient went to the office dispensary. A female, ("Person

A") who is not licensed as a pharmacy technician,[5] filled the patient's prescription and gave it to the patient.

c. The Investigators later observed Person A enter the Respondent's office while he was present, open the unlocked cabinet in which the Respondent stores Controlled Dangerous Substances ("CDS"), retrieve a medication and return to the dispensary to fill a prescription.

10. During the on-site audit, the Investigators interviewed the Respondent. The Respondent's statements included:

a. The Respondent believes that he has a "different" philosophy of pain management and is ostracized by his peers as a result. According to the Respondent, on a pain scale of one to ten, he tries to keep his patients between levels three and five so they can function. He prescribes most of his patients both a short-acting and long-acting analgesic, unless they are poor, in which case he prescribes only one medication. The Respondent avoids referring patients for surgery because it does not always fix the problem and more often than not increases a patient's pain.

b. The Respondent told the Investigators that he sees approximately 25 patients a day, the same number other physicians see in one

[5] The Investigators were advised that Person A was in the process of obtaining her pharmacy technician certification. When interviewed by Board staff in November 2011, Person A acknowledged that she was not a registered pharmacy technician. Person A had gone to cosmetology school and had cut the Respondent's hair before he hired her to work in his office. As of the date of this document, Person A was not listed on the Maryland Board of Pharmacy's website as a registered pharmacy technician.

week, because he does not perform invasive procedures such as blocks. He claimed that he saves insurance companies money because his procedures are cost-effective and less expensive.

c. The Respondent also told the Investigators that he believed a female patient whom he had discharged had a "vendetta" against him and had spread rumors that he was causing patients to become addicted to narcotics.

d. According to the Respondent, pharmacists in the area questioned his prescribing practices. One pharmacist reported him to the Board of Pharmacy whose inspectors inspected his office on two occasions.[6] As a result, the Respondent decided to maintain a dispensary in his office to avoid issues with pharmacists and other physicians.[7]

e. The Respondent stocks only generic narcotics because the profit margin on them is higher than brand name narcotics.

The Respondent's In-Office Dispensary

11. In or around February 2008, the Respondent applied for and was issued a dispensing permit by the Board (Dispensing Permit #1913). The permit allows the Respondent to dispense prescription drugs to patients in his office.

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[6] The Respondent told Investigators that he passed both inspections; however, on the first inspection the Board's inspectors notified him of deficiencies which he corrected by the second inspection.

[7] The Investigators observed that a handicap-accessible pharmacy was located across the parking lot from the Respondent's office. COMAR 10.13.01.04J provides that a licensee shall dispense prescription drugs to a patient only when a pharmacy is not conveniently available to the patient. The regulation further provides that the decision whether a pharmacy is "conveniently available" is the patient's, to be determined on factors "solely in the discretion of the patient."

12. A form entitled "Pharmacy Acceptance Form" or a similar document appears in all of the fifteen records reviewed. The form states:

> I hereby acknowledge the presence of a "Pharmacy" in [the Respondent]'s office who is my Pain Management physician. It is my decision to use it for the purpose of filling my prescriptions as it is very convenient for me, and it provides my physician better control of my pain medications.

13. An earlier iteration of the form states:

> I hereby agree to have my prescriptions filled at the office of [the Respondent] having made the determination that a pharmacy is not conveniently available to me and this pharmacy is more convenient for me.

14. COMAR 10.13.01.04 sets forth dispensing regulations for permit holders. Subsection J of that regulation provides that a "licensee shall dispense prescription drugs to a patient only when a pharmacy is not conveniently available to the patient." The decision whether a pharmacy is convenient is "based upon factors to be determined solely in the discretion of the patient."

15. During their on-site visits of the Respondent's office, both the Investigators and Board staff observed that an actual pharmacy, which is handicap-accessible, is located in the same business office park as the Respondent's office, approximately 25 to 30 feet from the Respondent's office.

16. On or about October 25, 2010, the Division of Drug Control notified the Board that a former patient of the Respondent ("Patient A") had reported that the Respondent required her to get one of the prescriptions he wrote

for her filled at his in-office dispensary as a condition of remaining his patient.

17. In furtherance of its investigation, Board staff obtained Patient A's record from the Respondent and interviewed Patient A and her caregiver, Person B.

18. Patient A is a female born in 1943. The Respondent's record indicates that she began seeing him in June 2009 with complaints of back and neck pain. Patient A is unable to walk without assistance secondary to spasms, weakness and neuropathy. On Patient A's first visit, the Respondent prescribed Kadian[8] 100 mg (two tables every twelve hours) and Percocet 10/325[9] (one to two tablets every six hours as needed). At Patient A's subsequent monthly visits he discontinued Percocet and started oxycodone, increasing the dosage to 20 mg.

19. On March 10, 2010, the Respondent discontinued Kadian and prescribed morphine ER 100 mg.

20. At the March 2010 visit, the Respondent informed Patient A that she was required to get her prescriptions filled at his dispensary. Patient A protested, stating that he was not authorized under her health care plans to dispense her prescriptions.

21. The Respondent responded that she would have to pick one of her prescriptions to fill at his dispensary. The Respondent, who was holding

[8] A Schedule II CDS – oral morphine preparation.
[9] A Schedule II CDS – oxycodone and acetaminophen.

one of Patient A's prescriptions, stated that he was the only physician who could get oxycodone 20 mg, and tore the prescription in half.

22. Patient A agreed to pay for the prescription and the Respondent re-wrote it.

23. Receipts provided by Patient A reveal that on March 10, 2010, Patient A paid $84.18 for 60 tablets of morphine ER[10] and $168.27 for 180 tablets of oxycodone 20 mg at the Respondent's dispensary. In April and May 2010, she paid $223.86 each month for 240 tablets of oxycodone 20 mg.

24. Patient A told Board staff that she felt that the Respondent bribed her and that if she did not get her prescriptions filled at his dispensary, he would no longer write them for her.

25. Board staff interviewed the Respondent's former "pharmacy technician" ("Person C"). Person C had not completed training as a pharmacy technician and was originally hired by the Respondent as a medical assistant. The Respondent later assigned her to dispense medications. According to Person C, the Respondent accepted major health insurance plans but not Medicare or Medicaid in his dispensary. Person C informed Board staff that, in her opinion, the Respondent used his power as a physician to persuade patients to complete the Pharmacy Acceptance form and to fill some of their prescriptions at his dispensary.

Peer Review of the Respondent' s Practice

26. By letters dated March 11, 2011 and April 27, 2011, Board staff notified the Respondent that the Board had initiated an investigation of his practice

[10] A Schedule II CDS – extended release morphine.

and subpoenaed a total of fifteen patient records. The Respondent was also requested to provide a summary of care for each patient.

27. The Board then referred the matter to a peer review entity for review of the Respondent's practice. The peer reviewers were provided with both the Respondent's records and his summaries of care. The peer reviewers concurred that the Respondent failed to meet the standard of quality care in ten of the fifteen cases and that he failed to maintain adequate medical records in all fifteen cases. The findings of the peer reviewers are set forth below.

Summary of Standard of Quality Care and Medical Record-Keeping Deficiencies

In general, the standard of quality medical care for patients with pain management issues includes but is not limited to the following:

a) An initial detailed and comprehensive evaluation of the patient, including a physical examination and a medical history including a pain history and a review of past medical records;

b) An individualized treatment plan that states the objective of treatment, which is used to determine the success of the treatment, including assessments of pain relief, laboratory studies and effects on function. The treatment plan should be updated as needed after periodic reviews;

c) Follow-up reviews that assess the patient's progress toward the objectives of the treatment plan;

d) Consideration of and referral to other modalities of treatment and to specialists prior to instituting narcotic therapy;

e) Prescription of CDS that is proportionate to the assessment of the patient's pain and pathology;

f) Random urine screens to detect misuse or diversion of narcotics. Misuse or diversion is be documented and addressed; and

g) Accurate and complete documentation of physical examinations, diagnostic results, consultations regarding risks and benefits and periodic review.

Based upon their review of the Respondent's records, the peer reviewers found that the Respondent's practice deficiencies include, but are not limited to the following:

a) Fails to conduct and document adequate physical examinations;

b) Prescribes excessive quantities of CDS that are disproportionate to the patient's symptoms and/or pathology;

c) Prescribes excessive and medically unjustified quantities of CDS, and often multiple types of CDS, in the absence of documented treatment rationale;

d) Changes dosages of CDS indiscriminately and typically without documented medical necessity;

e) Prescribes multiple long-acting CDS at the same time;

f) Makes diagnoses without sufficient clinical indication;

g) Fails to refer patients to specialists when needed and instead simply increases quantities of CDS prescribed;

h) Fails to advise patients of alternate treatments;

i) Fails to accurately document his findings, treatment rationale and treatment; the Respondent's documentation is very similar from patient to patient. In or around June 2009, the Respondent began maintaining electronic records ("EMR"). Although each EMR office note consists of two or three pages of single line type and appear to be comprehensive, they are merely a repetitious template, and with the exception of patient's vital signs and CDS prescriptions, rarely change from visit to visit;

j) Starts and stops patients' CDS regimens, in the absence of documented treatment rationale. The Respondent frequently changed medications despite having consistently noted in previous visits: "[patient] is able to perform ADL's [activities of daily living. [He/she] is doing ok on current medications." The Respondent sometimes noted his reasons for his medication changes in his summaries of care; however, he failed to document those reasons in the patients' records.

Patient-Specific Allegations – Standard of Quality Care and Documentation Violations

Patient 1

28. Patient 1, a female born in 1950, initially presented to the Respondent on December 12, 2003. Her past medical history

included: three lumbar surgeries and hip, hand and bilateral knee pain secondary to osteoarthritis. Her medication regimen at the time of her first visit included OxyContin[11] 40 mg twice a day and hydrocodone[12] 7.5 or 10 mg, eight to ten tablets daily.

29. On Patient 1's first visit, the Respondent noted that his plan was to switch her from OxyContin to a Duragesic patch[13] "slowly." The Respondent failed to document his treatment rationale for this change.

30. In April 2004, the Respondent increased Patient 1's Duragesic patch from 25 mcg to 100 mcg and added Percocet 10/325 to her regimen.

31. During Patient 1's course of treatment, through March 2011, the Respondent performed hip, knee and epidural injections and lumbar medial nerve blocks. He obtained multiple studies including x-rays, electromyelograms ("EMG"), magnetic resonance imaging ("MRI"), bone scans and laboratory studies that indicated moderate pathology.

32. As with all the patients whose care was reviewed, the Respondent saw Patient 1 on a monthly basis. During her course of treatment he started and stopped different Schedule II CDSs, including Roxicodone, oxycodone, Palladone, Avinza and OxyContin, and failed to document his treatment rationale.

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[11] A Schedule II CDS.
[12] A Schedule III CDS.
[13] Contains fentanyl, a Schedule II CDS, which is 100 times more potent than morphine.

33. The Respondent inconsistently adjusted the dosages of the CDS he prescribed, also in the absence of documented treatment rationale. For example, on August 24, 2010, the Respondent increased the frequency of Patient 1's oxycodone 30 mg from one tablet every four hours to one tablet every three hours without documenting the reason. Likewise, on September 28, 2010, he increased Patient 1's dosage of OxyContin from 40 mg to 60 mg, despite having documented at her August visit that "she is doing ok on current medications."

34. On several occasions, the Respondent prescribed excessive quantities of oxycodone. For example, on June 15, 2009, the Respondent prescribed a monthly supply totaling 330 tablets of oxycodone 15 mg, in addition to 120 tablets of OxyContin 40 mg. On September 15, 2009, the Respondent prescribed oxycodone 15 mg (one tablet every four hours prn[14] – 180 tablets) and oxycodone 30 mg (one tablet every four hours prn – 180 tablets) in addition to OxyContin 40 mg (two tablets every 12 hours).

35. The Respondent rarely conducted a comprehensive physical examination of Patient 1. This was especially true when he began maintaining patient records by EMR.

36. The Respondent prescribed an excessive quantity of CDS to Patient 1 in the absence of medical necessity.

[14] The abbreviation for "as needed."

Patient 2

37. Patient 2, a female born in 1967, initially presented to the Respondent on July 23, 2008 with complaints of pelvic and perineal pain for several years secondary to interstitial cystitis. Patient 2's medications at the time of her first visit included Vicodin, a Schedule III CDS.

38. The Respondent saw Patient 2 monthly. On her second visit in August 2008, the Respondent prescribed Lortab[15] and Reglan (to treat heartburn). Thereafter, he prescribed Duragesic patches 12 mcg every 72 hours, but discontinued them because of Patient 2's complaints of a rash and itching.

39. In February 2009, the Respondent replaced the Duragesic patch with extended release morphine (MS ER) 15 mg, three times daily.

40. On October 5, 2009 the Respondent discontinued Patient 2's morphine and started oxycodone without a documented explanation. In the Respondent's summary of care, written in March 2011, he noted that he made the change because Patient 2 reported nausea and itching when taking morphine.

41. On Patient 2's next visit, November 2, 2009, the Respondent discontinued morphine and added oxycodone, again failing to document his treatment rationale.

[15] A Schedule III CDS.

42. On February 1, 2010, the Respondent added OxyContin 15 mg and Xanax[16] to Patient 2's regimen; again failing to document his treatment rationale and despite consistently noting for all her visits that "[s]he is doing ok on current medications."

43. Patient 2 produced several urine drug screens that were inconsistent with the medication regimen the Respondent had prescribed. For example, on May 14, 2009 and September 8, 2009, Patient 2's urine tested positive for oxycodone and negative for morphine and hydrocodone, although the Respondent was prescribing MS ER 15 mg three times a day and Lortab four times a day. On January 11, 2011, she tested negative for oxycodone although the Respondent was prescribing to her oxycodone 15 mg four to five times a day. The Respondent noted that the September 8, 2009 was a "false positive," but otherwise did not address drug diversion or misuse with Patient 2.

44. The Respondent's documentation of Patient 2's monthly visits is repetitive and, with the exception of her vital signs, rarely changes from visit to visit. He prescribed an excessive quantity of CDS to Patient 2 in the absence of medical necessity.

Patient 3

45. Patient 3, a female born in 1972, initially presented to the Respondent on November 3, 2009 with complaints of neck pain and radicular pain after cervical discectomy and fusion the previous

[16] A Schedule IV benzodiazepine.

year. She had tried interventional blocks and physical therapy without success. When referred to the Respondent for pain management, her medication regimen included Percocet, Lortab and Xanax (at night). On a Drug Use Questionnaire, Patient 3 acknowledged using marijuana.

46. The Respondent started Patient C on Percocet 10/350 (every four hours) and Gabapentin.[17]

47. On November 13, 2009, Patient 3 tested positive for THC (marijuana) on a urine drug screen ("UDS"). The Respondent questioned whether her use was recreational or for pain control and counseled against further use. The following month, he increased the number of Percocet tablets he prescribed (from 180 to 210) without a documented explanation.

48. On March 15, 2010, the Respondent added morphine SR[18] (sustained release) to Patient 3's regimen, noting that her reported pain had increased, but that "she is doing ok on current medications. On this date, Patient 3 again tested positive for THC. The Respondent noted that he gave her a "last warning," but continued to prescribe to her.

49. On May 10, 2010, the Respondent wrote two separate 30-day prescriptions for morphine SR: one tablet every eight hours (#90)

[17] An anti-convulsant medication.
[18] A Schedule II CDS.

and one to two tablets every twelve hours (#100), for a total of 190 tablets for 30 days.

50. On August 3, 2010, the Respondent doubled Patient 3's dosage of morphine from 30 mg to 60 mg without a documented explanation and despite Patient 3's report that her pain level had not changed from the previous month.

51. On October 5, 2010, the Respondent discontinued Patient 3's morphine and started Fentanyl patches. The next month, November 2, 2010, the Respondent switched Patient 3 back to morphine SR 60 mg. The Respondent failed to document his treatment rationale for these changes.

52. The Respondent continued to prescribe morphine 60 mg and oxycodone 15 mg to Patient 3 for the remainder of the review period (March 2011).

53. The standard of quality care for a patient suffering from post-cervical fusion syndrome with residual pain and radiculopathy includes a steady regimen of an anti-convulsant or anti-depressant, not on an as-needed basis. The Respondent initially prescribed Gabapentin; however, he failed to do so on a consistent basis. He prescribed inappropriate and excessive quantities of opioids to Patient 3 in the absence of medical necessity.

Patient 4

54. Patient 4, a female born in 1966, initially presented to the Respondent on January 30, 2006, with complaints of abdominal pain. Patient 4's past medical history included Irritable Bowel Syndrome ("IBS"), abdominal adhesions secondary to multiple cesarean sections and depression. Patient 4 had been worked up extensively prior to seeing the Respondent; computed tomography ("CT") scans of her pelvis and abdomen were negative, as were ultrasound and HIDA[19] studies. Her past medical treatment included: chiropractic therapy, homeopathy, herbal medications, Bentyl,[20] Klonopin,[21] Xanax, Percocet and Nortriptyline.[22]

55. The Respondent started Patient 4 on moderate doses of Percocet. In later months, the Respondent added methadone[23] and discontinued Percocet.

56. On July 7, 2009, the Respondent wrote two separate prescriptions for methadone: two tablets five times a day for 30 day(#280) and two tablets every six hours for 25 days (#200), for a total of 480 tablets in one month.

57. On November 23, 2009, Patient 4 underwent an MRI of her cervical and lumbar spine which revealed a tiny central disc bulge at C6 – 7

[19] Abbreviation for Hepatobiliary Iminodiacetic Acid Scan, creates pictures of liver, gallbladder, bile ducts and small intestine.
[20] The trade name for dicyclomine, an anticholingeric, indicated for treating IBS symptoms, including muscle spasms in the gastrointestinal tract.
[21] A benzodiazepine used to treat seizures.
[22] An antidepressant indicated for treating depression and chronic pain.
[23] A Schedule II synthetic opioid.

with no neural compromise and mild degenerative disc disease ("DDD").

58. In January 2010, the Respondent added oxycodone (15 mg, 1 tablet every four hours) to Patient 4's methadone regimen (10 mg, two tablets every six hours).

59. On February 23, 2010, the Respondent added Soma,[24] presumably as a result of the results of Patient 4's electromyelogram ("EMG") conducted the previous month that revealed bilateral carpal tunnel syndrome, although he failed to document his treatment rationale.

60. In September 2010, the Respondent added Fentanyl patches to Patient 4's regimen and in November 2010, he added morphine SR 30 mg. The Respondent sometimes wrote two prescriptions for Fentanyl patches, each with different instructions for use.

61. The Respondent's November 5, 2010 note indicates that he prescribed three long-acting opioids (Fentanyl, methadone and morphine) to Patient 4 at the same time.

62. On December 8, 2010, the Respondent discontinued Patient 4's Fentanyl. In his summary of care, he stated that Patient 4 developed a "severe skin rash due to the [Fentanyl] patch[,]" and he substituted morphine. The Respondent failed, however, to document Patient 4's skin rash in her record.

63. At the end of the review period, the Respondent was prescribing methadone 10 mg and morphine SR 60 mg to Patient 4.

[24] A muscle relaxant.

64. The Respondent failed to utilize a symptom-focused approach to treat Patient 4's complaints of abdominal pain. He prescribed inappropriate and excessive quantities of opioids to Patient 4 in the absence of medical necessity.

Patient 5

65. Patient 5, a male born in 1958, initially presented to the Respondent on August 2, 2002 with complaints of lower back pain following lumbar spine surgery and fusion. Patient 5's medication regimen at the time of his referral included hydrocodone (twice daily) and Skelaxin, a muscle relaxant.

66. On Patient 5's first visit, the Respondent discontinued Skelaxin and started MS Contin[25] (15mg, every 12 hours), Neurontin[26] and Soma.

67. Over several months, the Respondent tried several long-acting opioids including Duragesic patches and Kadian with Lortab and Percocet for breakthrough pain. The Respondent increased dosages without documenting his treatment rationale.

68. On July 6, 2004, the Respondent discontinued Duragesic, noting that it was "not as effective." The Respondent switched to Kadian 60 mg (twice a day).

[25] A Schedule II CDS.
[26] Generic name for Gabapentin, an anti-seizure medication.

69. On July 12, 2004, the Respondent increased Patient 5's Kadian to 100 mg (twice a day) and added morphine sulfate immediate release ("MSIR) (15 mg) for breakthrough pain.

70. On May 7, 2007, the Respondent increased Patient 5's MSIR to 60 mg twice a day.

71. On August 27, 2007, the Respondent discontinued Patient 5's MSIR without a documented explanation and started Roxicodone[27] (#120) and then Percocet (#180) in September 2007, noting "increase in medication for optimum pain control," although Patient 5's reports of pain had not increased.

72. In June 2008, Patient 5 underwent a "re-do" of his lumbar surgery. The Respondent noted that "metal" was removed from Patient 5's back. In the Respondent's summary of care, he noted that the revision surgery "helped with the worsening of pain, but his baseline pain remained the same."

73. On July 6, 2009, after prescribing Kadian (100 mg, twice a day) and Percocet (10/325, every four to six hours) for several months, the Respondent prescribed two prescriptions for Kadian with different dosages and different instructions: 1) 100 mg, two to three capsules every 12 hours (#140); 2) 60 mg, two to three capsules every 12 hours (#140). The Respondent also prescribed two prescriptions for Percocet for a total of 390 tablets.

[27] A trade name for Oxycodone hydrochloride, a Schedule II CDS.

74. On September 14, 2009, the Respondent added morphine SR (#120) to Patient 5's regimen notwithstanding his typical note that, "[patient] is doing ok on current medications," and with no other documented explanation.

75. Thereafter, the Respondent discontinued Kadian with no explanation and maintained Patient 5 on morphine SR (60 mg – two tablets twice a day) and Percocet (10/325, one tablet every four hours as needed).

76. On December 8, 2009, the Respondent added Soma in the absence of a documented treatment rationale. Several months later, he added a benzodiazepine, triazolam, again without a documented explanation.

77. Patient 5 tested positive for methamphetamine[28] on three separate urine screens: July 2007, March 17, 2008, and September 2, 2008. Other than noting that the July 2, 2007 result was a "false positive" and possibly due to Tylenol PM, the Respondent failed to address the results. Indeed, in his summary of care, the Respondent noted, "[h]is urine drug screens have been satisfactory and he has not shown any evidence of aberrant behavior."

78. Throughout Patient 5's course of treatment, the Respondent prescribed excessive amounts of opioids that were not justified by the patient's pathology and increased dosages without explanation. The Respondent failed to try other interventional procedures such

[28] A Schedule II CDS.

as a spinal cord stimulator, facet injections and/or epidural steroid injections to decrease the total amount of medications.

Patient 6

79. Patient 6, a female born in 1963, initially presented to the Respondent on June 11, 2002 with multiple complaints of neck, jaw, left shoulder and right knee pain. Patient 6 was involved in a motor vehicle accident in 1998 and had been diagnosed with thoracic outlet syndrome and cervical disc herniation. She underwent surgeries, but continued to complain of pain. The Respondent's initial assessment included: post-cervical fusion syndrome, myofascial pain; obesity; sleep apnea; new onset diabetes; depression/anxiety disorder; and GERD/IBS.[29]

80. The Respondent started Patient 6 on MS Contin 15 mg (one to two tablets twice a day) and continued her on Neurontin, diazepam[30] and Pamelor.[31]

81. By August 2002, the Respondent had increased Patient 6's MS Contin dosage to 60 mg. and had added Soma.

82. On November 26, 2002, the Respondent discontinued MS Contin and started Patient 6 on Kadian (60 mg) documenting only that Patient 6 was "amenable to being switched..."

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[29] Gastroesophageal Reflux Disease/Inflammatory Bowel Disease.
[30] Generic name for Valium. A benzodiazepine with central nervous system depressant properties.
[31] A trade name for nortriptyline.

83. On February 21, 2003, the Respondent added MS IR (15 mg) to Patient 6's regimen without documenting his treatment rationale.

84. In December 2003, the Respondent increased Patient 6's dosage of Kadian from 60 mg to 100 mg, noting that she was having residual pain during the day.

85. In August 2007, the Respondent discontinued Patient 6's MS ER because her health insurance had changed and she could no longer afford it and started MS IR (30 mg, 1 tablet every four to six hours) and Roxicodone (15 mg, one to two tablets every three to four hours) in its place.

86. The Respondent maintained Patient 6 on this regimen until January 2009, when he increased her dosage of Roxicodone form 15 mg to 30 mg, noting that "meds last only 2 – 3 hrs, not 4 – 6 anymore."

87. In later visits, the Respondent added Klonopin[32] and Soma. By August 2010, the Respondent was prescribing Klonopin, Meloxicam,[33] oxycodone, Soma and Fentanyl patches on a monthly basis to Patient 6.

88. The standard of quality care for an obese patient with sleep apnea requires careful prescribing of opioids to avoid the risk of respiratory depression. The Respondent prescribed excessive quantities of opioids to this patient. He failed to document changes in her function, he simply noted her pain scores.

[32] A benzodiazepine.
[33] A non-steroidal anti-inflammatory ("NSAID") medication.

Patient 7

89. Patient 7, a male born in 1978, initially presented to the Respondent on January 29, 2009 with complaints of neck pain and paresthesias in his upper right extremity secondary to a motor vehicle accident in 2001. He had received cervical epidural steroid injections in the past. In 2008, an MRI revealed disc herniation with narrowing. He was evaluated by a neurosurgeon who suggested surgery and prescribed Lortab (twice a day) and Neurontin.

90. On Patient 7's initial visit, the Respondent prescribed Percocet 10/325, one tablet every four to six hours (#150). On Patient 7's next visit in February 2009, he prescribed Roxicodone 30 mg, one tablet every four to six hours, tripling the dosage of oxycodone.

91. On April 21, 2009, the Respondent increased the quantity of Roxicodone from 150 to 240 a month without documenting his treatment rationale. An individual other than the Respondent noted that Patient 7 complained that his pain was not suppressed.

92. In September 2009 and April 2010, Patient 7's UDS tested negative for oxycodone despite the large quantities the Respondent was prescribing. The Respondent failed to address the negative results with Patient 7 and continued to prescribe excessive amounts of oxycodone.

93. On June 22, 2010, the Respondent added Morphine SR 30 mg (one to two tablets every 12 hours) to Patient 7's regimen without

documenting his treatment rationale. The Respondent wrote two prescriptions on that date for a total of 200 tablets.

94. Also on June 22, 2010, the Respondent documented that he informed Patient 7 that, "due to the high incidence of diversion of oxycodone and the alarming rise in the incidence of prescription drug abuse in teens, all patients will be treated with an SRO [slow release opioid] and with IR combination *(sic).* Patient desired to continue with Monotherapy and reluctantly agreed to comply."

95. Patient 7 did not return to the Respondent after the June 2010 visit.

Patient 8

96. Patient 8, a female born in 1958, initially presented to the Respondent on March 23, 2004, complaining of neck pain and fatigue. She had previously undergone nerve blocks with minimal relief. Her prior medications included: Neurontin, Flexeril,[34] OxyContin and Duragesic patches. The Respondent diagnosed her with fibromyalgia, anxiety disorder and carpal tunnel syndrome.

97. The Respondent started Patient 8 on Norco (one tablet every four to six hours),[35] but in May 2004, added Kadian 20 mg (once a day).

98. By September 2004, the Respondent had increased the dosage of Kadian to 100 mg (twice a day), noting "[p]ain has been worse...Wants to consider disability."

[34] A muscle relaxant.
[35] Hydrocodone and acetaminophen, a Schedule III CDS.

99. The Respondent continued to prescribe Kadian 100 mg to Patient 8 and stopped and started varying dosages of hydrocodone and Roxicodone with no documented treatment rationale. The Respondent also prescribed Xanax on occasion.

100. On September 15, 2008, the Respondent noted that Patient 8 was trying to "wean off meds." After only one month, however, the Respondent noted, "Pain ↑↑ now desires to be put on meds again." He resumed prescribing Kadian 100 mg and Roxicodone and in subsequent months increased the daily dosage of both. The Respondent failed to properly attempt to wean Patient 8 from opioids and thereafter prescribed even larger quantities despite the lack of change in Patient 8's history or symptoms.

101. Throughout Patient 8's course of treatment, the Respondent prescribed excessive amounts of opioids that were not justified by the patient's pathology and increased dosages without explanation.

Patient 9

102. Patient 9, a male born in 1950, initially presented to the Respondent in January 2002 with complaints of left foot, ankle and thigh pain secondary to a 30-foot fall. He reportedly sustained a left calcaneal fracture, left ankle fracture, muscle flap surgery and vertebral compression. At Patient 9's first visit, the Respondent started OxyContin (20 mg, one to two tablets every 12 hours) and Percocet 5/325 (one tablet every six to eight hours).

103. By November 2003, the Respondent had increased Patient 9's dosage of OxyContin to 80 mg (one tablet every eight hours) and increase the dosage of Percocet to 10/325 (two tablets every eight hours), noting that Patient 9 was "consuming too many Percocets/day" but that Roxicodone was not as effective."

104. During Patient 9's course of treatment, the Respondent stopped and started opioids, sometimes at the patient's request (cost was often a factor), but typically without documenting his treatment rationale.

105. From September 2004 until May 12, 2006, Patient 9 "was lost to follow-up." When he returned, the Respondent started Roxicodone (30 mg, one tablet every 4 hours). The Respondent noted that Patient 9 had been taken off OxyContin and "occasionally took pain meds from friends."

106. On October 11, 2007, the Respondent noted that Patient 9 reported relief from pain lasted only two to two and one-half hours. The Respondent added Duragesic patches (50 mcg, one patch every three days).

107. At Patient 9's next visit, on November 8, 2007, the Respondent noted that he "[t]olerated Duragesic well," and increased the dosage to 100 mcg.

108. Although the Respondent regularly prescribed Fentanyl/Duragesic patches to Patient 9, several of Patient 9's USD in 2010 and 2011

did not reflect its presence in his urine. The Respondent failed to address abuse or diversion with Patient 9; indeed, in his summary of care, the Respondent noted that, "[Patient 9] has not shown any aberrant drug behavior and is urine drug screens have been satisfactory."

109. On June 1 and June 29, 2009, the Respondent prescribed 60 Fentanyl/Duragesic patches for Patient 9 for one month, triple the correct number, and failed to document an explanation.

110. Throughout Patient 9's course of treatment, the Respondent prescribed excessive amounts of opioids that were not justified by the patient's pathology and increased dosages without explanation.

Patient 10

111. Patient 10, a male born in 1931, initially presented to the Respondent on January 16, 2006 with complaints of bilateral buttock pain radiating into his legs and feet. He reported that this pain started after having received epidural anesthesia for right knee replacement in 1996. The Respondent documented that Patient 10's medical history included: obesity, sleep apnea, depression, diabetes mellitus, diabetic neuropathy, cardiac dysrhythmia and osteoarthritis. Patient 10 prior medication regimen included NSAIDS, Gabapentin, pregabalin,[36] carbamazepine,[37] Opana[38] and

[36] Generic for Lyrica, an anti-seizure drug indicated for neuropathic pain.
[37] Generic for Tegretol, an anti-seizure drug.
[38] Oxymorphone, a Schedule II CDS.

Ultram.[39] An MRI performed in 1997 was suggestive for disc bulges at L4 – L5 and L5 – S1, with mild left foramen stenosis and borderline stenosis at L3 – 4.

112. At Patient 10's first visit, the Respondent started Perocet 10/325.(one tablet every three to four hours) Several days later, he performed trigger point injections.

113. In February 2006, the Respondent started OxyContin 40 mg (one tablet every eight hours).[40] On Patient 10's next visit, in March 2006, the Respondent added Roxicodone 15 mg (one tablet every eight hours).

114. The Respondent maintained Patient 10 on OxyContin 40 mg (three times a day) and Roxycodone in varying dosages (15 – 30 mg) through December 2009. In the latter part of 2009, the Respondent added Ambien and Xanax but failed to document his treatment rationale.

115. On January 25, 2010, the Respondent discontinued OxyContin and added Fentanyl 50mcg patches (one every three days) with no documented explanation.

116. On March 17, 2011, the Respondent prescribed Opana to Patient 10 in addition to Fentanyl and Oxycodone. The Respondent improperly prescribed two long-acting CDS (Opana and Fentanyl) to an elderly obese patient who suffers from sleep apnea. Patient

[39] Trade name for tramadol, a non-CDS analgesic.
[40] Although the Respondent apparently started OxyContin at the February 2006 visit, he noted, "Better by 75% on OxyContin" at that visit.

10's pain score had not changed nor did the Respondent document any other treatment rationale, yet he prescribed a regimen which presented a high risk of respiratory depression.

117. Throughout Patient 10's course of treatment, the Respondent prescribed excessive amounts of opioids and increased dosages without explanation. Patient 10 had diagnoses of lumbar stenosis. The Respondent failed to try anticonvulsant or antidepressants, nor did he attempt any interventional therapy other than trigger point injections.[41]

CONCLUSION OF LAW

Based on the foregoing facts, the Board concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226 (c) (2) (i) (2009 Repl. Vol.).

ORDER

Based on the foregoing, it is this 1st day of February, 2012, by a majority of the quorum of the Board:

ORDERED that pursuant to the authority vested by Md. State Gov't Code Ann., § 10-226(c)(2), the Respondent's license to practice medicine in the State of Maryland be and is hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that a post-deprivation hearing in accordance with Code Md. Regs. tit. 10, § 32.02.05.B (7) and E on the Summary Suspension has been scheduled for **Wednesday, February 22, 2010**, at **3:00 p.m.,** at the Maryland

[41] The peer reviewers concurred that the Respondent maintained inadequate records for all fifteen patients. His record-keeping deficiencies include those outlined in the summary, *supra.*

State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and be it further

ORDERED that at the conclusion of the **SUMMARY SUSPENSION** hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be held within thirty (30) days of the request, before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and be it further

ORDERED that on presentation of this Order, the Respondent **SHALL SURRENDER** to the Board's Compliance Analyst, the following items:

(1) the Respondent's original Maryland License D39170;

(2) the Respondent's current renewal certificate;

(3) the Respondent's Maryland Controlled Dangerous Substance Registration;

(4) all controlled dangerous substances in the Respondent's possession and/or practice;

(5) all Medical Assistance prescription forms;

(6) all prescription forms and pads in the Respondent's possession and/or practice; and

(7) Any and all prescription pads on which his name and DEA number are imprinted; and be it further

ORDERED that a copy of this Order of Summary Suspension shall be filed with the Board in accordance with Md. Health Occ. Code Ann. § 14-407 (2009 Repl. Vol.); and be it further

ORDERED that this is a Final Order of the Board and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.*

2/7/2012
Date

John T. Papavasiliou
Deputy Director
Maryland State Board of Physicians