IN THE MATTER OF	*	**BEFORE THE**
MICHAEL ROMBRO, P.D.	*	**MARYLAND STATE**
LICENSE NO. 09849	*	**BOARD OF PHARMACY**
Respondent	*	

* * * * * * * * * * * *

FINAL DECISION AND ORDER

Background

This case arose out of allegations that Michael Rombro, P.D. (the "Respondent") failed to maintain adequate prescription records for approximately 25 Medicaid patients, and that two PCS insurance audits of the Respondent's pharmacy practice uncovered sizable discrepancies in the insurance claims submitted by the Respondent.

Specifically, the Respondent was charged with: (1) fraudulently or deceptively obtaining or attempting to obtain a license for the applicant or licensee or for another; (2) fraudulently or deceptively using a license; (3) submitting a false statement to collect a fee; (4) willfully making or filing a false report or record as part of practicing pharmacy; (5) willfully failing to file or record any report that is required by law; (6) refilling a prescription for any drug for which a prescription is required, without authorization from an authorized prescriber; and, (7) being professionally, physically or mentally incompetent. (State's Ex. 2B)

Based upon its investigation, on December 29, 2000, the Board of Pharmacy (the "Board") issued a Notice of Charges. On February 8, 2001, a case resolution conference was scheduled; however the Board and the Respondent were not able to reach a settlement of the matter.

A contested case hearing was held under the Administrative Procedure Act, Md. Code Ann., State Gov't §10-201 *et seq.*, before a quorum of the Board on September 26 and November 21, 2001. On November 21, 2001, the same quorum of the Board convened to deliberate and voted to uphold some of the charges against the Respondent, dismiss the remainder of the charges, and to impose the sanctions contained in this Final Decision and Order.

SUMMARY OF THE EVIDENCE

A. Documents.

The following documents were admitted into evidence.

State's Exhibit No. 1	-	Computer Printout of Licensure Information
State's Exhibit No. 2A	-	Letter of Procedure, dated December 29, 2000
B	-	Charges
C	-	Summons
D	-	Patient Identification List
E	-	Ballard Notice of Rescheduled hearing, dated June 21, 2001
State's Exhibit No. 3A	-	Consent Order dated May 9, 1999
B	-	Fax Cover from Andoll to Gill, w/ attachments
State's Exhibit No. 4	-	Motion & Order for Disclosure of Grand Jury Materials
State's Exhibit No. 5A	-	Patient A: Receipt + 20 slips from 11/5/92 thru 10/29/93
B	-	Patient B: 20 slips from 7/18/94 thru 1/26/95
C	-	Patient C: Receipt + 23 slips from 11/4/93 thru 1/24/95
D	-	Patient D: Receipt + 116 slips from 6/18/92 thru 1/28/95; letter from Dr. Fulop
E	-	Patient E: Receipt + 62 slips from 6/18/92 thru 1/7/95
F	-	Patient F: 80 slips from 4/20/93 thru 1/10/95
G	-	Patient G: Receipt + 34 slips from 2/16/93 thru

		12/22/94
H	-	Patient H: Receipt + 76 slips from unknown date To 6/14/94
I	-	Patient I: Receipt + 40 slips from 6/29/92 thru 7/27/94
J	-	Patient J: 39 slips from 7/22/93 thru 12/13/94
K	-	Patient K: Receipt + 80 slips from 2/1/93 thru 2/14/95; letter from Dr. Fulop
L	-	Patient L: Receipt + 70 slips from 3/22/93 thru 2/3/95
M	-	Patient M: Receipt + 38 slip from unknown date thru 6/21/93
N	-	Patient N: Receipt + 48 slips from 2/9/93 thru 1/19/95
O	-	Patient O: 64 slips from unknown date to 10/7/94
P	-	Patient P: Receipt + 43 slips from 1/8/93 thru 1/24/95
Q	-	Patient Q: Receipt + 33 slips from 6/29/92 thru 9/28/93
R	-	Patient R: Receipt + 46 slips from 12/11/92 thru 6/12/93; medication plan; letter from Dr. Fulop
S	-	Patient S: Receipt + 33 slips from 9/29/92 thru 1/30/95
T	-	Patient T: 140 slips from 10/14/92 thru 1/12/95
U	-	Patient U: Receipt + 44 slips from 7/1/92 thru 12/26/94
V	-	Patient V: 45 slips from unknown date thru 1/6/95
W	-	Patient W: 76 slips from unknown date thru 12/29/94
X	-	Patient X: 21 slip from 2/18/94 thru 8/5/94
Y	-	Patient Y: 16 slips from 7/11/94 thru 1/9/95
State's Exhibit No. 6A	-	6/22/99 Memo from Freedman to Pease
B	-	1/19/99 letter from PCS to Respondent, w/ documentation guidelines
C	-	1/19/99 Report
D	-	Sample letters to MD's, etc.: PCS Audit Summary
E	-	PCS Audit Summary of former employee
F	-	PCS Termination letter, dated 4/12/99

B. Summary of Pertinent Witness Testimony.

Steve Capobianco, an investigator for the Medicaid Fraud Control Unit ("MFCU") in the Office of the Attorney General, testified that MFCU received a complaint that the Respondent was dispensing a large number of controlled dangerous substances. (Vol. 1, T. 12-14). This complaint caused MFCU to initiate an investigation to determine whether the Respondent's Medicaid claims were legitimate. (Vol. 1, T. 16).

Mr. Capobianco testified that MFCU obtained a Grand Jury subpoena of the Respondent's pharmacy records. (Vol. 1, T. 15). Although a substantial number of the subpoeanaed records were missing, of those records that were produced, Mr. Capobianco noted several deficiencies. (Vol. 1, T. 19-21).

Mr. Capobianco's fraud investigation focused upon a sampling of ten patients. (Vol. 1, T. 25). Mr. Capobianco attempted to verify the Respondent's claims by contacting the patients for whom the claims were submitted. However, Mr. Capobianco discovered that most of the Respondent's patients were either deceased, terminally ill, or psychotic. (Vol. 1, T. 16-17). Thus, Mr. Capobianco contacted the patients' physicians to verify the Respondent's claims. Mr. Capobianco stated that in many cases, the physicians verified that the prescriptions dispensed by the Respondent were authorized. (Vol. 1, T. 17).

Mr. Capobianco, therefore, determined that MFCU could not establish a pattern of fraud by the Respondent because there was insufficient evidence to prove that the Respondent did not provide a service for which the Respondent billed Medicaid. (Vol. 1, T. 17). Mr. Capobianco explained that MFCU only investigates and prosecutes the criminal act of Medicaid fraud. (Vol. 1, T. 34). Thus, Mr. Capobianco forwarded the

Respondent's case to the Board of Pharmacy for possible administrative discipline regarding the vast irregularities in the Respondent's pharmacy records. (Vol. 1, T. 26-26).

Michelle Andoll, Compliance Officer for the Board of Pharmacy, testified that the Respondent is a pharmacist duly licensed in Maryland. Ms. Andoll stated that the Respondent entered into a Final Consent Order in 1999 by which the Respondent was placed on probation for one year and was subject to a monthly audit of his Schedule II controlled dangerous substances inventory by a board-approved monitor. (Vol. 1, T. 45-46).

Ms. Andoll further testified that the Board received the Respondent's pharmacy records, for the period 1992-1995, for purposes of review and investigation. Based on her review, Ms. Andoll testified in-depth regarding the myriad deficiencies in the Respondent's recordkeeping. Ms. Andoll reviewed the Respondent's records for each of the 25 Medicaid patients listed in the charging document, specifically pointing out the errors and omissions in each record. The areas in which the Respondent's violations were most salient are as follows:

1. Prescriptions were not assigned an Rx number to enable a person to trace the prescription after it was dispensed to the patient. (*See, e.g.*, Vol. 1, T. 52, 56, 63, 69, 72, 78, 90, 100-01, 108, 117).
2. Hard copies of prescriptions did not have labels affixed to them. Without having dispensing information on the hard copy of the prescription, a person cannot obtain the necessary information regarding the amount or dosage of the medication dispensed, date the medication was dispensed, and the initials

for the dispensing pharmacist. (*See, e.g.*, Vol. 1, T. 51-52, 60, 63, 67, 69-71, 75-76, 78, 81-82, 85, 87-88, 90, 95, 102-04).

3. Hard copies of prescriptions for Schedule II controlled dangerous substances were not retained. (*See, e.g.*, Vol. 1, T. 72-73, 91-92, 102-03, 105, 116).

4. Prescriptions were dated after the Respondent had dispensed the medications, with no explanation in the records as to whether the Respondent dispensed the medication in an emergency situation. (*See, e.g.,* Vol. 1, T. 55, 64-66, 69-70, 72, 76, 80, 84, 86-87, 91).

5. Prescriptions for Clozaril did not contain documentation that the Respondent had followed the protocol by verifying laboratory results of patients' white blood cell counts. (Vol. 1, T. 53-55).

6. Prescriptions for controlled dangerous substances did not contain the requisite patient address or physician address information. (*See, e.g.,* Vol. 1, T. 57, 72-73, 86-87, 90-91, 99-107, 108- 113, 114-117).

7. The prescribing physician on the prescription was not the same physician documented in the Respondent's pharmacy records. (*See, e.g.*, Vol. 1, T. 67, 100, 110).

8. Different prescriptions were assigned the same prescription number. (*See, e.g.*, Vol. 1, T. 59-60, 63-64, 71, 79, 83-84, 86, 88-89, 91, 95).

9. Medication, dosage, and/or quantity prescribed was different than what was dispensed by the Respondent. (*See, e.g.*, Vol. 1, T. 60-65, 67-68, 74, 81-82, 85, 90, 113).

10. Medications were dispensed more than 120 days after the prescription was issued. (*See, e.g.*, Vol. 1, T. 67, 90, 95).

Additionally, in furtherance of her investigation, Ms. Andoll testified that she acquired records of two PCS audits of the Respondent's pharmacy practice from Jack Freedman, Chief of the Division of Drug Control. (Vol. 1, T. 119). Ms. Andoll testified that the PCS audits indicated major discrepancies between the claims submitted to PCS by the Respondent and the Respondent's records substantiating such claims. The audit indicated a $105,378 discrepancy on the 1/15/99 audit and a $26,123 discrepancy on the 4/6/99 audit. (T. 120-123; States Ex. 6B-E). The PCS records indicate that because PCS was unable to verify physician authorization for 308 of the 486 claims submitted, it terminated its contract with the Respondent on May 1, 1999. (Vol. 1, T. 123, State's Ex. 6F).

The Respondent testified on his own behalf. The Respondent conceded that his pharmacy records ostensibly evidenced that: (1) medications were dispensed before they were prescribed; (2) medications were dispensed more than 120 days after the dates of the prescriptions; (3) medications dispensed varied from the prescriptions; (4) CDS prescriptions were not authorized; and (5) laboratory results were not checked prior to dispensing Clozaril. (Vol. 1, T. 155). However, the Respondent explained each deficiency essentially by stating that although his recordkeeping was lacking, he never dispensed medication without proper authorization. (Vol. 1, T. 161, 172). The Respondent testified that he had merely continued the poor recordkeeping practice that was in place when he purchased Towson Pharmacy in 1992. (Vol. 1, T. 155).

With respect to the numerous prescriptions which seemed to postdate the date of dispensing, the Respondent testified that many prescriptions were phoned in by various staff members at halfway houses and mental health facilities serviced by the Respondent. These telephone prescriptions were supposed to be followed up with hard copy prescriptions dated the same date of the telephone authorization; yet, as the Respondent testified, oftentimes the hard copy prescription would be incorrectly dated several days later or never come at all. This complicated an already faulty tracking system making it nearly impossible to properly correlate prescription labels with the hard copies of the prescriptions. The Respondent also attributes the lack of hard copy prescriptions for CDS to his lack of diligence in following up on telephone prescriptions. (Vol. 1, T. 155-56, 159-160).

In instances in which dispensing labels indicate that a different medication or different amount was dispensed than what was prescribed, or instances in which two different prescriptions were assigned the same prescription number, the Respondent explains that these were examples of errors in matching up labels with hard copies after the fact. The Respondent testified that he compiled these records in haste after receiving a Grand Jury subpoena from MFCU. (Vol. 1, T. 160-62; Vol. 2, T. 25-27).

With respect to the lack of documentation on the Clozaril prescriptions, the Respondent explained that he did, in fact, check laboratory reports to verify that patients' white blood cell counts were at acceptable levels, and then forwarded that information to either the Clozaril National Registry or Maryland's Clozaril network. The Respondent testified that there is no documentation of the laboratory reports before the Board because

MFCU never subpoenaed those documents, and therefore those documents were never forwarded to the Board. (Vol. 2, T. 29-30).

The Respondent testified that these records evidenced his poor practice in 1992-1995, but that he has since remedied the deficiencies as evidenced by his satisfactory completion of his probationary conditions imposed by the Board in its 1999 Final Consent Order. The Respondent testified that the Board appointed monitor, Dr. Ralph Small, inspected his pharmacy records over a one year period and submitted favorable reports on the Respondent's overall pharmacy practice. (Vol. 1, T. 168-171; Vol. 2, T. 15-16; State's Ex. 3B).

The Respondent testified that the PCS issue was merely a vendor dispute. (Vol. 1, T. 173-74). The Respondent further testified that the PCS audits were forwarded to the Division of Drug Control by a former employee, Sharon Yutzy, with whom he had terminated a personal relationship because of his suspicion that she was stealing drugs and money from the pharmacy. (Vol. 1, T. 174-75). The Respondent claims that PCS was unfair in the manner in which it terminated its contract with the Respondent by not allowing him sufficient opportunity to address the deficiencies. The Respondent testified that he reimbursed PCS for the amount found deficient, but denied any wrongdoing other than poor recordkeeping. (Vol. 2, 62-63).

Lastly, the Respondent explained that he erroneously completed the Board's renewal application form by stating that he had not been disciplined by the Board because the Respondent did not believe that probation or a consent order constituted discipline. (Vol. 2, T. 49).

FINDINGS OF FACT

Based upon the testimony and documentary evidence presented at the evidentiary hearing, the Board finds that the following facts are true:

1. The Respondent was at all relevant times licensed to practice pharmacy in the State of Maryland. The Respondent was originally licensed by the Board on July 27, 1982. The Respondent last renewed his license on October 15, 1999. (State's Ex. 1).
2. The Respondent is the owner and chief dispensing pharmacist at Towson Pharmacy in Baltimore County, Maryland. (Vol. 1, T. 152).
3. As a result of having excessive overages and shortages in his inventory and allowing an unlicensed person to operate the pharmacy, the Respondent was charged with violations of the Pharmacy Act on or about January 20, 1999. Subsequently, the Respondent entered into a Consent Order with the Board on May 19, 1999, whereby the Respondent was placed on probation for one year and agreed to have his pharmacy practice supervised by a Board appointed monitor. (State's Ex. 3A.).
4. The Respondent completed the terms of probation contained in the May 19, 1999 Consent Order by receiving satisfactory monitor reports, securing the pharmacy area, and creating a perpetual inventory for Schedule II controlled dangerous substances. (State's Ex. 3B).
5. Prior to execution of the May 19, 1999 Consent Order, the Board received information that the Medicaid Fraud Control Unit ("MFCU") had obtained, by way of a Grand Jury subpoena, pharmacy records of the Respondent which

evidenced possible violations of the Pharmacy Act. The MFCU forwarded the pharmacy records for 25 Medicaid patients to the Board pursuant to a court order authorizing the release of such information. (State's Ex. 4).

6. The Respondent's pharmacy records indicated the following deficiencies:

   a. Prescriptions were dispensed more than 120 days after issuance although prohibited under Health Occ. Art. §12-503, (Bates 160, 368, 437-39);

   b. Records lacked dispensing labels or other documentation to indicate what was actually dispensed, (Bates 67-69, 95, 97-97, 141-43, 160, 164, 191-92, 213, 236, 252-53, 257, 259, 270, 287-89, 291, 294, 305, 323-26, 328, 338, 356, 369, 371-72, 375, 377, 382, 385, 387-88, 391-92, 396, 439, 498, 549, 602);

   c. Medications were dispensed prior to the date on the prescription, in violation of Health Occ. Art. §12-506, (Bates 61, 67, 90, 96-97, 132, 154, 193, 200, 252-53, 295, 303, 306, 329, 341, 352, 360, 401-02);

   d. The same prescription numbers were assigned to different prescriptions, (Bates 82, 96, 103, 114, 205, 285, 307, 309, 326, 340, 352, 368, 373-74, 379, 397, 444);

   e. Prescriptions for controlled dangerous substances did not contain the patient's address or physician's address as required by COMAR 10.19.07.03E and 21CFR §1306.05, (Bates 71, 213, 217, 229-30, 236, 340, 354-55, 360, 387, 391, 393, 396, 400, 453, 457-58, 464, 490, 492-95, 497-98, 500-02, 505-12, 517, 527-29, 531, 549, 551-52, 554-55,

557-58, 560-62, 564-66, 568, 571, 574, 577-78, 581-82, 584, 586-88, 600, 602);

f. Medications dispensed differed, in dosage, amount, or type of medication, from the prescription, (Bates 84, 88-89, 110, 132, 147, 160, 217, 321, 324, 338, 400, 550);

g. Prescriptions for Clozaril lacked supporting documentation to verify that protocol was being followed, (Vol. 1, T. 53-55);

h. Hard copy prescriptions were not obtained or retained for schedule II controlled dangerous substances as required by COMAR 10.13.03.07H and 21 CFR §1306.11, (Bates 215, 236, 406, 424-26, 497, 500, 512, 516, 595-96, 600);

i. The prescribing physician on the prescription was not the same physician noted in the Respondent's records, (Bates 462, 464, 558).

7. The Board received copies of two audits conducted by PCS Health Systems from Jack Freedman, Chief of the Division of Drug Control. Mr. Friedman had acquired the audits from Sharon Yutzy, a former employee of the Respondent with whom the Respondent had recently terminated a personal relationship. (Vol. 1, T. 119-120; Vol. 2, T. 174-75).

8. The documents indicate that PCS performed audits of the Respondent's practice on 1/15/99 and 4/6/99. The PCS audits uncovered major discrepancies between the claims submitted by the Respondent and the records retained by the Respondent to substantiate those claims. As a result of the audits, the Respondent reimbursed PCS $105,387 and $26,123.

Thereafter, PCS terminated its contract with the Respondent. (State's Ex. 6B-F).

9. The Respondent submitted to the Board a renewal application in August 1999. The Respondent failed to honestly answer question 2a on the application by answering "no" in response to the question, "Has any State licensing or disciplinary Board or comparable body in the Armed Services denied your license or taken any action against your license, including revocation or suspension?" The Respondent failed to disclose that he entered into a Final Consent Order with the Board in May 1999, whereby the Respondent was reprimanded, placed on probation and subjected to various probationary conditions. (Vol. 2, T. 49).

OPINION

The crux of the issue before the Board is whether the Respondent's pharmacy practice is so deficient as to warrant formal sanction. The answer is a resounding, yes. Although the Board understands that maintaining adequate and organized pharmacy records perhaps is not the most exciting aspect of pharmacy practice, it is, nonetheless, a necessary and integral part.

The Respondent's pharmacy records from 1992-1995 evidence total incompetence with regard to maintaining any semblance of an organized practice. A review of the Respondent's records alone reflect a dangerous and illegal practice. For example, the Respondent did not possess hard copy prescriptions for many Schedule II controlled dangerous substances which could possibly lead one to believe that he was

distributing narcotics for profit. Although the Board does not believe this is the case, based on a review of the Respondent's records alone, one would have no information to the contrary. Furthermore, the Respondent's records are replete with examples in which the requisite information (i.e., physician's address, patient's address) was not obtained for CDS prescriptions. The fact that the Respondent had ongoing relationships with most of the physicians and patients does not excuse these omissions.

Additionally, the Respondent's careless manner in affixing prescription labels to scraps of paper to constitute a "hard copy" of the prescription is not an acceptable standard of practice. The manner in which the Respondent maintained his pharmacy records evidences his incompetence with respect to recordkeeping, although the Board does not find that the Respondent actually engaged in the conduct reflected by the pharmacy records.

The Respondent defended against the allegations that he dispensed medication before he had a prescription, or that he dispensed incorrect medication, dosages or quantities, by explaining that the records were merely compiled in error. The Respondent assured the Board that he always dispensed the correct medication with proper authorization. However, the only tangible evidence the Board can review is the Respondent's records, which do not provide any support for the Respondent's assertions. It is a pharmacist's responsibility to maintain accurate dispensing information so that there is a record of what was actually dispensed to a patient. Documentation is an integral part of pharmacy practice because without it, there is no way to insure that a patient received the proper medication. The Respondent's records contain innumerable examples of prescriptions that lack any information regarding the dosage, amount, brand

or type of medication actually dispensed. In these instances, there is no way to verify the medication given to a patient. This can worsen an already dangerous situation if a patient is dispensed the incorrect medication or if a manufacturer institutes a recall of a certain drug.

The PCS audits provide further evidence that the Respondent's recordkeeping practice continues to be deficient. Although the Respondent argues that the Board's monitor, Dr. Small, reviewed his records in 1999 and found them to be in order, the PCS audit evidences the contrary. The PCS audits found that the Respondent did not have documentation to substantiate the majority of claims he submitted. Again, this is in the same vein as the deficiencies existent in the Respondent's 1992-95 pharmacy records.

The Respondent needs to be able to implement and follow a system or procedure by which appropriate hard copies for Medicaid and CDS prescriptions are retained, accurate records of dispensing information are maintained, discussions with physicians authorizing a change in the prescription are documented, and appropriate physician and patient information for CDS prescriptions are obtained.

With respect to the Respondent's false answer on his renewal application to the Board, the Board finds that the Respondent attempted to deceptively obtain a license. A public final consent order, subject to the Administrative Procedures Act and filed with the Health Integrity and Protection data bank, clearly constitutes "action" against a license. The Board does not find persuasive the Respondent's defense that he did not believe a reprimand and probation qualified as discipline. Such a belief is simply not rational.

For all of the above reasons, the Board finds the Respondent lacks competence with respect to maintaining pharmacy records as required by state and federal law, and the standards governing pharmacy practice.

CONCLUSION

Based upon the foregoing summary of evidence, findings of fact, and opinion, the Board concludes that the Respondent is in violation of Health Occupations Article, §§ 12-313(1), (5), (15), and (20). The Board finds insufficient evidence to affirm the remainder of the charges and therefore dismisses the charges that the Respondent violated Health Occupations Article §§12-313(2), (6) and (7).

SANCTIONS

The Respondent's pharmacy records, as a whole, depict a complete lack of competence in the Respondent's ability to maintain adequate records in his pharmacy practice. The Board considers the Respondent's ineptitude to be a serious and potentially harmful deficiency in his practice. As the record reflects that most of the Respondent's patients are people are who mentally ill and thus more vulnerable, it is imperative that the Respondent exercise diligence in the manner in which he practices pharmacy.

The Respondent's pharmacy practice, as evidenced in the record, is completely unacceptable and must be rectified in order for the Respondent to be able to continue to practice. Although the Respondent has conceded that he was deficient in his recordkeeping in 1992-1995, he maintains that his current practice is within the standard

of practice. The results of the PCS audit cause the Board to doubt the Respondent's assertions.

The Board shall issue a fine, an indefinite suspension, all stayed, and an indefinite probation, with the opportunity to petition the Board for release from probation after one year, provided that the Respondent has satisfied all of the probationary conditions. During the period of probation, random inspections of the Respondent's pharmacy practice, including his recordkeeping, shall be performed at least quarterly. In addition, the Respondent shall take and pass a law examination prepared by the Board.

ORDER

Based on the foregoing Findings of Fact, Opinion, and Conclusion, by a unanimous decision of a quorum of the Board it is hereby:

ORDERED that the Respondent is fined a total of TEN THOUSAND DOLLARS ($10,000.00), which fine shall be submitted to the Board within one year of the date of this Order and may be paid in installments; and be it further,

ORDERED that the Respondent be SUSPENDED INDEFINITELY, all stayed; and be it further,

ORDERED that the Respondent shall immediately be placed on INDEFINITE PROBATION subject to the following conditions:

1. Take and pass a law examination prepared by the Board; and
2. Submit to and fully cooperate with random inspections of the Respondent's entire pharmacy practice, including the Respondent's recordkeeping, on at least a quarterly basis; and be it further,

ORDERED that the Respondent may petition the Board for release from probation after one year, provided that the Respondent has satisfied the probationary terms herein; and be it further,

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

1/30/02
Date

W. Irving Lottier, Jr., P.D.
Secretary, Board of Pharmacy

NOTICE OF RIGHT TO APPEAL

Pursuant to Md. Code Ann., Health Occ. Art., §12-316, you have the right to take a direct judicial appeal. A petition for appeal shall be filed within thirty days of your receipt of this Final Decision and Order and shall be made as provided for judicial review of a final decision in the Maryland Administrative Act, Md. Code Ann., State Gov't Art., §§10-201, *et seq.*, and Title 7, Chapter 200 of the Maryland Rules.

ORDERED that the Respondent may petition the Board for release from probation after one year, provided that the Respondent has satisfied the probationary terms herein; and be it further,

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

1/30/02
Date

W. Irving Lottier, Jr., P.D.
Secretary, Board of Pharmacy

NOTICE OF RIGHT TO APPEAL

Pursuant to Md. Code Ann., Health Occ. Art., §12-316, you have the right to take a direct judicial appeal. A petition for appeal shall be filed within thirty days of your receipt of this Final Decision and Order and shall be made as provided for judicial review of a final decision in the Maryland Administrative Act, Md. Code Ann., State Gov't Art., §§10-201, *et seq.*, and Title 7, Chapter 200 of the Maryland Rules.

,RRAN, JR.
GENERAL

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BALTIMORE, MARYLAND 21201
AREA CODE 410-767-1861

May 6, 1999

Allan H. Rombro, Esquire
1305 Court Square Building
200 East Lexington Street
Baltimore, Maryland 21202

RE: Michael Rombro, P.D. and
Towson Pharmacy

Dear Mr. Rombro:

Enclosed for your review and approval are the Consent Orders with regard to the above-referenced matters. After you have reviewed, please have your client sign, notarize and deliver the Consent Orders to the attention of Norene Pease, Executive Director, Board of Pharmacy, 4201 Patterson Avenue, Baltimore, MD 21215.

Thank you.

Sincerely,

Roberta Gill /gjt

Roberta L. Gill
Assistant Attorney General
Administrative Prosecutor

RLG/gjt

Enclosures

c: Norene Pease (w/o encl.)
Paul Ballard, Assistant Attorney General
Board Counsel (w/encl.)
Timothy J. Paulus (w/o encl.)

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State of Maryland
Department of Health and Mental Hygiene

Parris N. Glendening, Governor - Martin P. Wasserman, M.D., J.D., Secretary

State Board of Pharmacy

May 21, 1999

Allen H. Rombro
1305 Court Square Building
200 East Lexington Street
Baltimore, Maryland 21202

Re: Michael Rombro, P.D and
Towson Pharmacy

Dear Mr. Rombro:

Enclosed are the Final Consent Orders for Michael Rombro, Licence number 09849 and Towson Pharmacy, permit number P01710.

You should begin submitting the materials required by the Orders as soon as possible. The Board has approved former Board Secretary, Ralph Small, P.D. to work as the Monitor named in the Order. Please assist Dr. Small so that he may perform his duties as described in the Order. Dr. Small's fee will be the responsibility of you and Towson Pharmacy.

If you have any questions, please call our office at the number listed below.

Very truly yours,

Norene F. Pease
Executive Director

NP/ww

cc: Michael Rombro, P.D.

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