STANDARD OF QUALITY CARE – PEER REVIEW FORM
MARYLAND BOARD OF PHYSICIANS
Maryland Department of Health
4201 Patterson Avenue, Baltimore, Maryland 21215-0095

A. CASE BACKGROUND

Licensee Name and Specialty: [redacted]
MBP Case Number:
License Number:
Type of Peer Review Requested: Pain Management
Number of charts to be reviewed: 10

B. PEER REVIEWER INFORMATION

Physician Reviewer's Name: [redacted]
Physician Reviewer's License #:
Physician Reviewer's ABMS/AOA Certification: Pain Management

C. Focus of the Peer Review:

The Board has requested that the peer review report should address the following concerns, based on the care provided after July 11, 2016:

1) **Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016? Health Occupations §14-404 (a)(22)**

2) **Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016? Health Occupations §14-404(a)(40)**

D. Chart Reviews:

Chart #1:- Patient – SH

1) **Provide a synopsis of the care provided by the Respondent:**

The patient is a 68 year old male. The Respondent reports treating the patient for multiple pain generators including Lumbar Degenerative Disc Disease (DDD), left shoulder tendonitis, left inguinal hernia, severe osteoarthritis of the hands and knees, and tongue lesion (cancer). He acknowledges the fact that he has the patient on high dose prescription opioids but justifies the dose because of the pain pathology and the development of tolerance to the medication. The pain regimen was: Methadone 10 milligrams (mg), every six hours (Q6H), 40mg daily and Oxycodone 30mg, four times

daily (QID), 120mg daily. The patient also had liver failure due to cirrhosis from alcohol dependency.

2) **Provide the components of the Standard of Quality Care required in treating this patient.**

   a. **Establish a proper diagnosis for pain etiology, and treatment Plan.**

   b. **Obtain and review medical records from previous and current treating medical providers relevant to the patient's pain management treatment.**

   c. **Use of Opioid Risk Assessment Screening Tools.**

   d. **Prior to initiating Opioid therapy, discuss the risk and benefits of treatment using Prescription Opioids, including establishing realistic expectations and possibly termination of therapy. After initiating opioid therapy, documentation of routine re-assessments to determine efficacy of treatment, appropriate need to continue therapy, reasons to adjust therapy or discontinue therapy. Assess substance abuse history.**

   e. **Discuss the current standard being applied for treatment with opioids in non-cancer pain of less than 90 mg equivalent of oral Morphine daily (90 MME/day) starting around mid-late 2016.**

   f. **Prescribe naloxone for prevention of unintentional opioid overdose in patients who are on high dose opioids.**

   g. **Check Prescription Drug Monitoring Program (PDMP), starting in 2014 when it became available in Maryland.**

   h. **Discuss and sign Opioid and Pain Management Treatment Contract.**

   i. **Perform Random Drug Testing.**

3) **A. Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016?**

   No.

   B. Provide specific examples and note the page number where this can be found:

   The main issue regarding the Respondent not meeting the standard of care is that he has this patient is on high dose opioids (GS0188) and the justification is the patient's multifactorial pain and has developed tolerance over the years and the benefits outweigh the side effects and he also notes that the patient does not have symptoms of respiratory depression or altered mental status (GS0192). The patient by his own calculation is on 500MME/day (GS0355-61). The patient has liver cirrhosis from alcohol abuse (GS0412) and both opioids Methadone and Oxycodone are metabolized by the liver and the doses should be adjusted/lowered when there is clearly hepatic impairment. There is an occasion where the Respondent, noted the patient having confusion (GS0206) but did not make any adjustments to the pain regimen. Drug testing was done but not routinely, only two drug tests documented on 8/18/2016 (GS0264) and 2/7/2017 (GS0365). The Respondent did not specifically check a 12 lead electrocardiogram (EKG) for the risk of QTc prolongation with the patient chronically on Methadone. It appears that the EKG that was ordered was for complaints of chest pain. It appears that the Respondent did not have a strategy for dealing with the development of opioid tolerance, such as rotating to

another opioid. The Respondent, also lacks the understanding that even if the patient did not have a side effect to the high dose opioids being prescribed, this does not reduce the risk of an adverse event, especially with the patient suffering from hepatic failure. When the patient was being discharged from Anne Arundel Medical Center, his pain medication regimen was decreased by the provider's there due to concerns about hypotension and sedation. The Methadone was decreased from 10mg, every six hours (Q6H) to every eight hours (Q8H) per recommendations from the Pharmacist, and the Oxycodone was given with parameters associated with the patient's blood pressure and it was noted that the patient had not been receiving Oxycodone prior to discharge, additionally it was recommended that he see pain management after discharge (GS0453).The patient's pain was adequately controlled on a lower regimen of pain medications and when he was in the nursing home (GS0684). There was no prescription drug monitoring program (PDMP) check.

4) **A. Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016?**

Yes.

B. Provide specific examples and note the page number where this can be found:

The Respondent saw the patient routinely and documented the details of the visits (GS0187-219). The Respondent documented drug tests (GS0364-6), Opioid Contract (GS0355-8), and Medications (GS0184-6).

Chart #2:- Patient – RH

1) **Provide a synopsis of the care provided by the Respondent:**

The patient is a 58 year old male patient, being treated for cervical degenerative disc disease, Lumbar DDD, bilateral knee osteoarthritis, groin pain. Muscle spasms and anxiety with panic attacks. The pain regimen was Oxycodone 30mg QID. He was also prescribed Valium 10mg twice daily (BID), for anxiety, panic attacks and muscle spasms.

2) **Provide the components of the Standard of Quality Care required in treating this patient.**

a. **Establish a proper diagnosis for pain etiology, and treatment Plan.**

b. **Obtain and review medical records from previous and current treating medical providers relevant to the patient's pain management treatment.**

c. **Use of Opioid Risk Assessment Screening Tools.**

d. **Prior to initiating Opioid therapy, discuss the risk and benefits of treatment using Prescription Opioids, including establishing realistic expectations and possibly termination of therapy. After initiating opioid therapy, documentation of routine re-assessments to determine efficacy of treatment, appropriate need to continue therapy, reasons to adjust therapy or discontinue therapy. Assess substance abuse history.**

e. **Discuss the current standard being applied for treatment with opioids in non-cancer pain of less than 90 mg equivalent of oral Morphine daily (90 MME/day) starting around mid-late 2016.**

f. **Prescribe naloxone for prevention of unintentional opioid overdose in patients who are on high dose opioids.**

g. **Check Prescription Drug Monitoring Program (PDMP), starting in 2014 when it became available in Maryland.**

h. **Discuss and sign Opioid and Pain Management Treatment Contract.**

i. **Perform Random Drug Testing**

3) **A. Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016?**

No.

B. Provide specific examples and note the page number where this can be found:

The standard of care for use of chronic opioid therapy when the Respondent started treatment of this patient's in 2018 had been established for safety purposes at equal or less than 90 MME/day. The Respondent set a goal of less than 200 MME/day (GS0927). The Respondent inherited the patient on a high opioid regimen of Oxycodone 30mg, QID (GS0926) which equates to 180 MME/day which is double the target of 90MME/day. The Respondent notes the patient had failed physical therapy, chiropractic therapy, transcutaneous electrical nerve stimulation (TENs) unit, Lyrica and Flexeril (GS0919) and was using Valium as a muscle relaxant and anxiety medication (GS0926).

The Respondent acknowledges the risk of concomitant use of a benzodiazepine along with opioids, but states the benefits out weight the risk (GS0927). He also notes that the patient is aware of the risk and is in agreement with using both together (GS0922). The Respondent does not rationalize how he came to the conclusion at his initial encounter with the patient, that the benefit outweighs the risk of using the benzodiazepine along with high dose opioids. He does not document what he discussed as the actual risk of concomitant use of benzodiazepines and opioids. There is no discussion of a trial of safer alternatives. Even if the patient accepts the risk, the Respondent is responsible for this decision and mitigating the risk. On one encounter, the Respondent documents that the patient has been cutting his medications in half and is satisfactory (GS0920), but he never attempted to reduce either the opioid or the benzodiazepine. The Respondent notes the patient has groin pain, where he previously had hernia repair (GS0924), but he does not go any further in terms of a workup or a referral to a general surgeon to evaluate any post-op pathology. The PDMP was not routinely checked.

4) **A. Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016?**

Yes.

B. Provide specific examples and note the page number where this can be found:

The Respondent documented the history and physical (H & P [GS0926]), follow-up visits (GS0918-25), drug test (GS0932), brief pain inventory (GS0929-30), radiology reports (GS0938-GS0939), past medical records (GS0940-4), prescribing Narcan (GS0927), and opioid treatment contract (GS0914-6).

Chart #3:- Patient - NH

1) **Provide a synopsis of the care provided by the Respondent:**

The patient is a 60 year old male. The Respondent started treating this patient on 9/11/2017, for chronic lower back pain due to lumbar DDD and right leg pain associated with osteomyelitis and a right ankle fracture. The patient had a history of lumbar surgeries and anxiety. The Respondent noted that the patient was being treated by a provider who had stopped prescribing opioids, then saw a pain specialist who decreased his medication the month prior, then the patient started treatment with the Respondent. The patient did not tolerate the adjustment and came to the Respondent for pain management. The Respondent treated the patient with Methadone 10mg, 2 tablets (tabs), three times daily (TID) and Oxycodone 30mg, TID. He also prescribed Alprazolam 1mg, 1.5 tabs, daily, for anxiety.

2) **Provide the components of the Standard of Quality Care required in treating this patient.**

   a. **Establish a proper diagnosis for pain etiology, and treatment Plan.**

   b. **Obtain and review medical records from previous and current treating medical providers relevant to the patient's pain management treatment.**

   c. **Use of Opioid Risk Assessment Screening Tools.**

   d. **Prior to initiating Opioid therapy, discuss the risk and benefits of treatment using Prescription Opioids, including establishing realistic expectations and possibly termination of therapy. After initiating opioid therapy, documentation of routine re-assessments to determine efficacy of treatment, appropriate need to continue therapy, reasons to adjust therapy or discontinue therapy. Assess substance abuse history.**

   e. **Discuss the current standard being applied for treatment with opioids in non-cancer pain of less than 90 mg equivalent of oral Morphine daily (90 MME/day) starting around mid-late 2016.**

   f. **Prescribe naloxone for prevention of unintentional opioid overdose in patients who are on high dose opioids.**

   g. **Check Prescription Drug Monitoring Program (PDMP), starting in 2014 when it became available in Maryland.**

   h. **Discuss and sign Opioid and Pain Management Treatment Contract.**

   i. **Perform Random Drug Testing**

3) **A. Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016?**

No.

B. Provide specific examples and note the page number where this can be found:

The Respondent did not document review of any past records. He notes the patient was not content with the decrease in his opioid regimen by a pain specialist (GS1001), but did not attempt contacting the prior pain specialist or obtain records from the encounter to

understand why the adjustment was made. The Respondent was treating the patient with high dose Methadone, but did not obtain a 12 lead EKG, to assess the risk of prolonged QTc or discuss this risk with the patient. It is noted in the documents that at the time of the initial encounter, the last EKG was done six months prior (GS0954) but there is no attempt to obtain the result and check the QTc segment for prolongation. The Respondent documents that the patient was informed that he do a pill count the following month (GS0986). The patient should not be notified in advance of when a random pill count will be done. The Respondent states that he will try and reduce pain medications when osteomyelitis is resolved (GS0997), but the reduction never occurs and actually he increased the pain medication.

The Respondent states in an addendum to his 9/27/2017 office note that he plans on prescribing Narcan at the next visit (GS1000), but he never prescribes it despite having the patient on high dose opioids. The Respondent notes that the patient is on high dose opioids since the 1990's, and believed maintaining the patient on high dose opioids is necessary for his functioning, and notes the risk of using benzodiazepines concomitantly with opioids. The Respondent believes the benefits outweigh the risk, and notes the patient is aware of the risk and agrees to use the medication combination. The Respondent stated the patient is under palliative care for his pain management (GS0992). The definition of palliative care according to the World Health Organization (WHO), "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual". The patient had osteomyelitis that was being treated successfully as an out-patient and he notes the wound "has healed" (GS0989 and GS0985). The patient was able to work (GS0983).

The Respondent uses an anxiety assessment tool that notes the patient has minimal anxiety (GS1005-6), yet he continued to prescribe the benzodiazepine chronically. Reassessment of the need for current regimen and possibly the use of other anxiolytic medications that do not create a risk with a patient on chronic opioid therapy. It is the Respondent's responsibility to shield the patient from these risks, especially when the patient lacks the insight regarding the dangers of using benzodiazepines with opioids. The Respondent did not explain how he made assessment that the benefit outweighed the risk of using benzodiazepine along with high dose opioids, he just continued a medication that he inherited the patient on. The Respondent noted that the patient showed no risk of addiction or diversion (GS0992), and he had the patient complete an Opioid Risk Tool (ORT) and this was scored incorrectly as a three and noted to be minimal risk, but the actual score is seven, which would indicate moderate risk (GS1004). The Respondent did not routinely check the PDMP.

4) **A. Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016?**

Yes.

B. Provide specific examples and note the page number where this can be found:

The Respondent documented the pain treatment contracts (GS0965-71), new patient visit (GS1001), progress notes (GS0975-99), drug tests (GS1021-38), brief pain inventory (GS1009-17), ORT (GS1004), and general anxiety scale (GAD 7 [GS1005-6]).

Chart #4:- Patient - JT

1) **Provide a synopsis of the care provided by the Respondent:**

The patient is a 41 year old male. The Respondent was treating this patent for chronic thoracic pain presumably due to DDD of the Thoracic spine, Lumbar DDD, lumbar extruded disc, lumbar radiculopathy and ulnar neuropathy and spasms. He also was treating the patient for panic attacks using Klonopin 1mg, daily. He prescribed high dose opioid regimen in the form of Methadone 20mg, TID, and Oxycodone 30mg, QID. This was eventually tapered to Methadone 10mg, TID, and Oxycodone 30mg, QID. He also prescribed non-opioid adjuvants at different times including Naproxen and Cyclobenzaprine.

2) **Provide the components of the Standard of Quality Care required in treating this patient.**

   a. **Establish a proper diagnosis for pain etiology, and treatment Plan.**

   b. **Obtain and review medical records from previous and current treating medical providers relevant to the patient's pain management treatment.**

   c. **Use of Opioid Risk Assessment Screening Tools.**

   d. **Prior to initiating Opioid therapy, discuss the risk and benefits of treatment using Prescription Opioids, including establishing realistic expectations and possibly termination of therapy. After initiating opioid therapy, documentation of routine re-assessments to determine efficacy of treatment, appropriate need to continue therapy, reasons to adjust therapy or discontinue therapy. Assess substance abuse history.**

   e. **Discuss the current standard being applied for treatment with opioids in non-cancer pain of less than 90 mg equivalent of oral Morphine daily (90 MME/day) starting around mid-late 2016.**

   f. **Prescribe naloxone for prevention of unintentional opioid overdose in patients who are on high dose opioids.**

   g. **Check Prescription Drug Monitoring Program (PDMP), starting in 2014 when it became available in Maryland.**

   h. **Discuss and sign Opioid and Pain Management Treatment Contract.**

   i. **Perform Random Drug Testing.**

3) **A. Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016?**

No.

B. Provide specific examples and note the page number where this can be found:

In review of the Respondent's summary of care, he reported initially starting the patient on Tramadol, Gabapentin and Naproxen. The Respondent changed medication to Methadone 10mg, QID, and Oxycodone 30mg, QID, and this was further increased within a 3 month period to Methadone 20mg, TID, along with Oxycodone 30mg, QID, after reviewing the patient's past medical records. The Respondent on 1/17/2018, documented on the progress note that the patient has been on pain medications for 21 years, off and on and that the Respondent did not start the patient on his pain medication (GS1096). Later, the Respondent documented that he is decreasing the patient's pain medications for non-medical reasons (GS1085). Again the standard of care for the safe treatment of chronic non-cancer pain with chronic opioid therapy is 90MME/day. The Respondent prescribed at much higher doses at the beginning of his care for this patient and even with the reduction to Methadone 10mg, TID, and Oxycodone 30mg, QID, (GS1083) this patient remains at 420MME/day.

The Respondent again noted, the patient is on high dose opioids and states that the dose is medically necessary and safe since the patient is tolerant and is less likely to develop serious side effects (GS1109) for function. This along with chronically prescribing a benzodiazepine and while noting the risk, justifying the benefit over the risk (GS1104). The Respondent notes that the patient had side effects to selective serotonin reuptake inhibitor (SSRI) medications used for anxiety (GS1105). Recommended referral to a psychiatrist if the patient truly suffers from panic attacks, are standard of care.

It was noted, the patient had right sided extruded disc on his lumbar magnetic resonance imaging (MRI) at L4-5 and L5-S1 (GS1044) and lower extremity weakness (GS1144), a reasonably treatment option would be to refer the patient to a spine specialist. Again the Respondent was prescribing Methadone to treat chronic pain, but does not check a 12 lead EKG to evaluate the risk of prolonged QTc, which can be associated with a fatal arrhythmia. At times in the progress notes the Respondent suggested, that Klonopin is being used to treat muscle spasms, and Flexeril which is a traditional antispasmodic agent is used when the symptoms are severe (GS1103). The contradiction is that a number of drug tests came back negative for Klonopin and positive for the marijuana metabolite tetrahydrocannabinol (THC) (GS1247, GS1220, GS1251, and GS1225). The Respondent addressed this by noting the patient uses Klonopin as needed (PRN), but he continues to prescribe it as if the patient is using it daily. The Respondent never addressed the presence of an illicit drug (THC), in multiple drug tests.

Contrary to the Respondents documentation that he reviewed an MRI of the thoracic spine (GS1044), an MRI of the thoracic spine was documented in the records, and in fact he notes that the patient's insurance company was a barrier to obtaining an MRI of the thoracic spine (GS1113).

4) **A. Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016?**

Yes.

B. Provide specific examples and note the page number where this can be found:

Treatment contracts (GS1067-72, GS1077-9), progress notes (GS1082-135), drug tests (GS1200, GS1225, GS1234, GS1247, and GS1251), brief pain inventory (GS1176-1204), ORT (GS1210) although this was scored incorrectly, GAD-7 anxiety screening (GS1166-74), PDMP/ Chesapeake Regional Information for Patients (CRISP) checks (GS1082, and GS1217), Narcan prescription (GS1212), medication list (GS1213-6), and past medical records (GS1264-6).

Chart #5:- Patient – MA

1) **Provide a synopsis of the care provided by the Respondent:**

   The patient is a 33 year old male. The Respondent started treating this patient on 8/2/2017, for chronic neck and upper extremity pain with a history of one cervical spine surgery, and chronic lower back and lower extremity pain with a history of three lumbar surgeries and diabetic neuropathy pain.

2) **Provide the components of the Standard of Quality Care required in treating this patient.**

   a. **Establish a proper diagnosis for pain etiology, and treatment Plan.**

   b. **Obtain and review medical records from previous and current treating medical providers relevant to the patient's pain management treatment.**

   c. **Use of Opioid Risk Assessment Screening Tools.**

   d. **Prior to initiating Opioid therapy, discuss the risk and benefits of treatment using Prescription Opioids, including establishing realistic expectations and possibly termination of therapy. After initiating opioid therapy, documentation of routine re-assessments to determine efficacy of treatment, appropriate need to continue therapy, reasons to adjust therapy or discontinue therapy. Assess substance abuse history.**

   e. **Discuss the current standard being applied for treatment with opioids in non-cancer pain of less than 90 mg equivalent of oral Morphine daily (90 MME/day) starting around mid-late 2016.**

   f. **Prescribe naloxone for prevention of unintentional opioid overdose in patients who are on high dose opioids.**

   g. **Check Prescription Drug Monitoring Program (PDMP), starting in 2014 when it became available in Maryland.**

   h. **Discuss and sign Opioid and Pain Management Treatment Contract.**

   i. **Perform Random Drug Testing.**

3) **A. Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016?**

   No.

B. Provide specific examples and note the page number where this can be found:

The Respondent rapidly escalated the patient's opioid regimen over the course of 6-7 months. He was treated initially with MS Contin 30mg, BID, Oxycodone 15mg, QID PRN, Lyrica 150mg, TID, and Cymbalta. By 9/27/2017, Oxycodone was increased to 20mg, QID in response to inadequate pain control (GS1360). By 10/18/2017 the Respondent doubled the MS Contin dose to 60mg, BID, and continued the higher dose of Oxycodone 20mg, QID, in response to inadequate pain control (GS1360 and GS1344). On 12/6/2017, Oxycodone was increased to 30mg, QID, and MS Contin 60mg, BID, was also prescribed (GS1360). On 1/24/2018, MS Contin was increased to 100mg, BID, and Oxycodone 30mg, QID, was also prescribed (GS1360). When this was not effective (GS1337) MS Contin was discontinued and Methadone10mg, 4 tabs, daily, was started along with Oxycodone 30mg, QID. On 2/21/2018, (GS1360 and GS1336). On 3/21/2018, Methadone was increased to 10mg, 6 tabs, daily, and Oxycodone 30mg, was increased from 4 tabs, daily, to 5 tabs, daily (GS1360 and GS1334). On 4/182018, the Respondent informed the patient that he would have to cut back on his pain medication over the next six months, so he could meet the standard of care and keeps his medical license (GS1332). Between 5/16/2018 through 7/6/2018 the Respondent weaned Methadone from 6 tabs/day to 2 tabs/day (GS1360 and GS1325-6) and eventually discontinued (GS1323-4) in favor of Exalgo 8mg, daily, along with Oxycodone 30mg. The general rule is to start low and titrate slowly. Also the standard of care for safe treatment of chronic non-cancer pain is to maintain the opioid regimen at 90MME/day. The Respondent started the patient at 150MME, daily, and escalated to >800MME/day; Methadone 60 mg, daily, along with Oxycodone 150 mg, daily (GS1360). The final regimen of Exalgo 8mg, daily, and Oxycodone 30mg, QID, on 9/5/2018 (GS1321) was 212 MME/day which is still higher than 90MME/day.

The trend for escalating the opioid regimen was at times in response to the patient informing the Respondent that he had to double his pain medication to achieve adequate pain control (GS1347). The patient had run out and also used his sister's valium (GS1348). This should have been a red flag, but the Respondent did not caution the patient or counsel the patient against the dangers and risk of such actions. He just noted that he did not believe the patient was addicted and then proceeded to increase the pain medication dose (GS1348). The Respondent did state he would monitor the patient closely, but then only one drug test was in the chart (GS1374-5). In the same progress note, the Respondent states that he will consider using Valium for muscle spasms, despite the fact that there is a risk of using Benzodiazepines and opioids (GS1348). This is an example of poor clinical judgement. The Respondent did not check a 12 lead EKG prior to starting Methadone.

4) **A. Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016?**

Yes.

B. Provide specific examples and note the page number where this can be found :

Treatment Contract (GS1310-GS1315). Medication list (GS1356-GS1358). Brief Pain Inventory (GS1367-GS1369). ORT (GS1371). Radiology Records (GS1377-GS1382).

PDMP (GS1360-GS1362). Drug test (GS1374-GS1375). New Patient visit office notes (GS1353). Progress notes (GS1321-GS1352).

Chart #6:- Patient - SGJ

1) **Provide a synopsis of the care provided by the Respondent:**

The patient is a 44 year old female patient. The Respondent treated this patient for chronic multifactorial pain; including abdominal pain from adhesions following multiple abdominal surgeries including: bariatric surgery, lower back pain and lumbosacral radiculopathy associated with failed back surgery syndrome, bilateral foot pain, neuropathy, and rib fracture after a fall. The Respondent treated the patient on high dose opioids, citing her inability to absorb the medications due to her abdominal pathology following her surgeries and tolerance to the medication. She was prescribed Fentanyl patch 100 micrograms per hour (mcg/hour) and another Fentanyl patch 50mcg/hour for a total of 150mcg/hour to be changed every 48 hours along with Oxycodone 30mg, ten tablets per day. Additionally, her non-opioid regimen consisted of Neurontin 800mg, QID, and Tizanidine 2mg, QID.

2) **Provide the components of the Standard of Quality Care required in treating this patient.**

   a. **Establish a proper diagnosis for pain etiology, and treatment Plan.**

   b. **Obtain and review medical records from previous and current treating medical providers relevant to the patient's pain management treatment.**

   c. **Use of Opioid Risk Assessment Screening Tools.**

   d. **Prior to initiating Opioid therapy, discuss the risk and benefits of treatment using Prescription Opioids, including establishing realistic expectations and possibly termination of therapy. After initiating opioid therapy, documentation of routine re-assessments to determine efficacy of treatment, appropriate need to continue therapy, reasons to adjust therapy or discontinue therapy. Assess substance abuse history.**

   e. **Discuss the current standard being applied for treatment with opioids in non-cancer pain of less than 90 mg equivalent of oral Morphine daily (90 MME/day) starting around mid-late 2016.**

   f. **Prescribe naloxone for prevention of unintentional opioid overdose in patients who are on high dose opioids.**

   g. **Check Prescription Drug Monitoring Program (PDMP), starting in 2014 when it became available in Maryland.**

   h. **Discuss and sign Opioid and Pain Management Treatment Contract.**

   i. **Perform Random Drug Testing.**

3) **A. Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016?**

No.

B. Provide specific examples and note the page number where this can be found:

The Respondent prescribed one of the highest opioid regimens I have seen in a non-cancer patient from the combination of Fentanyl 100mcg/hour/Fentanyl 50mcg/hour changing the patches every 48 hours and Oxycodone 30mg, dispensing 300 tablets per month, using about ten tablets per day (GS1453 and GS1411). The Fentanyl conversion ratio of 2.4, daily, on 150mcg/hours of Fentanyl patches equates to 720MME/day with an additional ten tablets per day of Oxycodone 30mg, with a conversion ratio of 1.5, which equals 300mg/day of Oxycodone equating to 450MME/day this totals to 1170 MME/day (see attached work sheet). This patient was clearly too complex for the Respondent to manage her pain and he should have referred her to a pain management specialist early in the treatment course. On his 8/22/17, office note, the Respondent documents that the high dose opioids for this patient's condition had been validated by a pain management specialist in the past and that specialist referred her to him because his office had changed the rules and could no longer prescribe the necessary dose to control the patient's pain (GS1431). Late in the treatment course, the Respondent did refer the patient to a reputable pain management specialist, to take over her pain management and evaluate for an intra-thecal pain pump (GS1407), unfortunately he reported the patient never made the appointment (GS1383-4).

When the Respondent decreased the patient's Oxycodone 30mg, monthly quantity by only 15 tablets from 300 tablets per month to 285 tablets per month or a reduction from 10 tablets per day to 9.5 tablets per day, he documented that the patient could barely get out of bed, walk or function (GS1432). This reduction represents less than 2% reduction in her overall opioid regimen. Despite the high dose opioids being prescribed, the Respondent did not prescribe Narcan for the patient for almost an entire year from the 2016 review date (GS1435). The Respondent documented that the Podiatrist, "felt the pain medication regimen was fine" (GS1429). A Podiatrist would not likely be qualified to give such an opinion regarding such a high dose of opioid use, or why it would be relevant to document this opinion.

The Respondent constantly justified the high dose opioids by referencing the patient's inability to adequately absorb the pain medications (GS1437), but this would only apply to medication taken orally. The Fentanyl patches would not be affected by this issue, pain medications absorbed via buccal cavity and suppository would also not be affected by this issue. However the best option if the patient needed such a high dose of opioids (higher than the 150 mcg/hour Fentanyl equal to 720MME/day) would be a pain pump and this should have been recognized early in her treatment course. The Respondent did refer the patient for an intra-thecal pain pump evaluation (GS1402), but did not ensure the patient follow through with this plan, and just accepted the patient's excuse for not making the appointment and never insisted that the patient reschedule the appointment (GS1383-4).

From July 2016 through July 2018 only 3 drug tests were completed (GS1620-34), this is entirely too few for any patient on high dose opioids.

4) **A. Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016?**

Yes.

B. Provide specific examples and note the page number where this can be found:

Pain treatment contract (GS1397-1401), PDMP (GS1555-61), progress notes (GS1406-57), brief pain inventory (GS1570-1600), ORT (GS1601) but it was scored incorrectly, and drug tests (GS1620-34).

Chart #7:- Patient - AD

1) **Provide a synopsis of the care provided by the Respondent:**

The patient is a 44 year old female. The Respondent treated this patient for multifactorial chronic pain including cervical degenerative disc disease, cervical stenosis, cervical disc herniation, lumbar disc herniation, lumbar stenosis, peripheral neuropathy, recurrent pancreatitis, migraine headaches, carpal tunnel syndrome and nephrocalcinosis with renal stones. He treated the patient with high dose opioids including Methadone and Oxycodone. The Respondent also treated the patient for anxiety using Diazepam.

2) **Provide the components of the Standard of Quality Care required in treating this patient.**

a. **Establish a proper diagnosis for pain etiology, and treatment plan.**

b. **Obtain and review medical records from previous and current treating medical providers relevant to the patient's pain management treatment.**

c. **Use of Opioid Risk Assessment Screening Tools.**

d. **Prior to initiating Opioid therapy, discuss the risk and benefits of treatment using Prescription Opioids, including establishing realistic expectations and possibly termination of therapy. After initiating opioid therapy, documentation of routine re-assessments to determine efficacy of treatment, appropriate need to continue therapy, reasons to adjust therapy or discontinue therapy. Assess substance abuse history.**

e. **Discuss the current standard being applied for treatment with opioids in non-cancer pain of less than 90 mg equivalent of oral Morphine daily (90 MME/day) starting around mid-late 2016.**

f. **Prescribe naloxone for prevention of unintentional opioid overdose in patients who are on high dose opioids.**

g. **Check Prescription Drug Monitoring Program (PDMP), starting in 2014 when it became available in Maryland.**

h. **Discuss and sign Opioid and Pain Management Treatment Contract.**

i. **Perform Random Drug Testing.**

3) **A. Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016?**

No.

B. Provide specific examples and note the page number where this can be found:

The Respondent treated the patient with high dose opioids this included; Methadone 10mg, QID, and the Oxycodone was increased to 30mg, QID (GS0100) which equates to 500MME/day. The Respondent also treated the patient for anxiety using Diazepam 10mg, BID. The standard of care for safe treatment using chronic opioids in chronic non-cancer pain is equal to or less than 90MME/day. The Respondent was treating this patient at greater than five times that quantity and repeatedly documents that he has reviewed the high dose opioid regimen and feels that it is medically necessary and safe (GS1717-23).

The Respondent referred the patient to an orthopedic spine surgeon and noted that after the evaluation, he did alter her pain regimen, he offered the same opinion after the patient saw the orthopedic specialist who performed her hip replacement surgery (GS2729 and GS1723). It is neither relevant nor appropriate for either of these specialists to alter the patient's pain regimen since they were not evaluating the patient for management of their pain management and it reveals the poor insight the Respondent has regarding his role in treating the patient with chronic opioid therapy.

Additionally the patient was treating anxiety with Diazepam 10mg, BID (GS0100), which when used concomitantly with prescription opioids poses a significant risk for respiratory depression. The Respondent acknowledges this risk but states the benefits outweigh the risk (GS1715). Despite chronic use of Methadone, the Respondent never ordered a 12 lead EKG to evaluate the risk of prolonged QTc.

4) **A. Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016?**

Yes.

B. Provide specific examples and note the page number where this can be found:

Treatment contract (GS1686-9), progress notes (GS1702-35), brief pain inventory (GS1800-8), GAD-7 anxiety scale (GS1810-13), PDMP (GS1816-26), medication list (GS1828-31), drug tests (GS1834-48), and past medical records (GS1850-97).

Chart #8:- Patient - EF

1) **Provide a synopsis of the care provided by the Respondent:**

The patient is a 50 year old female. The Respondent treated the patient for multifactorial pain; including failed back surgery syndrome, osteoarthritis of the knees, neck pain, migraine headaches and a left foot fracture using Methadone and Oxycodone.

2) **Provide the components of the Standard of Quality Care required in treating this patient.**

   a. **Establish a proper diagnosis for pain etiology, and treatment Plan.**

   b. **Obtain and review medical records from previous and current treating medical providers relevant to the patient's pain management treatment.**

   c. **Use of Opioid Risk Assessment Screening Tools.**

d. **Prior to initiating Opioid therapy, discuss the risk and benefits of treatment using Prescription Opioids, including establishing realistic expectations and possibly termination of therapy. After initiating opioid therapy, documentation of routine re-assessments to determine efficacy of treatment, appropriate need to continue therapy, reasons to adjust therapy or discontinue therapy. Assess substance abuse history.**

e. **Discuss the current standard being applied for treatment with opioids in non-cancer pain of less than 90 mg equivalent of oral Morphine daily (90 MME/day) starting around mid-late 2016.**

f. **Prescribe naloxone for prevention of unintentional opioid overdose in patients who are on high dose opioids.**

g. **Check Prescription Drug Monitoring Program (PDMP), starting in 2014 when it became available in Maryland.**

h. **Discuss and sign Opioid and Pain Management Treatment Contract.**

i. **Perform Random Drug Testing.**

3) **A. Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016?**

No.

B. Provide specific examples and note the page number where this can be found:

The Respondent treated the patient on high dose prescription opioids including Methadone 10mg, using 11-12 tablets daily, and Oxycodone 30mg using between 4-5 tablets, daily. The standard of care for safe treatment using chronic opioids in chronic non-cancer pain is equal to or less than 90MME/day. The last regimen reviewed per the PDMP was Methadone 10mg, using 11 tablets, daily and Oxycodone 30mg, 4 tablets daily (GS2007). This equates to 1500MME/day by 7/2018. This is an improvement from 7/2016 when the pain regimen was Methadone 10mg, 480 tablets per month, or 16 tablets daily, along with Oxycodone 30mg, 150 tablets per month, or 5 tablets daily, with a total of 2145MME/day (GS2009). The Respondent again notes that the regimen is safe and medically necessary (GS1936-9). Despite the taper, this is a high dose and high risk opioid regimen. Additionally, the Respondent does not have a 12 lead EKG to evaluate the risk of prolonged QTc, which could lead to a fatal arrhythmia, while using Methadone. The Respondent did not frequently drug test this patient, one test was documented for the timeline of this review. The Respondent stated, there is no sign of diversion, however, given the quantity of pain medication being prescribed monthly, this would be hard to decipher.

4) **A. Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016?**

Yes.

B. Provide specific examples and note the page number where this can be found:

Pain treatment contract (GS1915-18), PDMP (GS2007-11), progress notes (GS1934-63), brief pain inventory (GS2028-41), medication list (GS2045-8), drug tests (GS2051-2), and past medical records (GS2067-93).

Chart #9:- Patient - PB

1) **Provide a synopsis of the care provided by the Respondent:**

The patient is a 62 year old female. The Respondent treated the patient for chronic multifactorial pain including: rheumatoid arthritis, neck pain and upper extremity pain, lower back pain associated with lumbar degenerative disc disease and a history of multiple lumbar surgeries and fibromyalgia. The Respondent used Oxycodone to treat the pain. He also treated the patient for anxiety using Klonopin.

2) **Provide the components of the Standard of Quality Care required in treating this patient.**

   a. **Establish a proper diagnosis for pain etiology, and treatment Plan.**

   b. **Obtain and review medical records from previous and current treating medical providers relevant to the patient's pain management treatment.**

   c. **Use of Opioid Risk Assessment Screening Tools.**

   d. **Prior to initiating Opioid therapy, discuss the risk and benefits of treatment using Prescription Opioids, including establishing realistic expectations and possibly termination of therapy. After initiating opioid therapy, documentation of routine re-assessments to determine efficacy of treatment, appropriate need to continue therapy, reasons to adjust therapy or discontinue therapy. Assess substance abuse history.**

   e. **Discuss the current standard being applied for treatment with opioids in non-cancer pain of less than 90 mg equivalent of oral Morphine daily (90 MME/day) starting around mid-late 2016.**

   f. **Prescribe naloxone for prevention of unintentional opioid overdose in patients who are on high dose opioids.**

   g. **Check Prescription Drug Monitoring Program (PDMP), starting in 2014 when it became available in Maryland.**

   h. **Discuss and sign Opioid and Pain Management Treatment Contract.**

   i. **Perform Random Drug Testing.**

3) **A. Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016?**

No.

B. Provide specific examples and note the page number where this can be found:

The Respondent prescribed Oxycodone and Klonopin concomitantly and notes that he recognizes the risk, but he feels the benefits outweigh the risk (GS2115). The patient ran out of Klonopin early, because she used more than prescribed. The Respondent gave an additional prescription of Xanax, and permitted the patient to pay out of pocket for this prescription (GS2115). The Respondent explained this in his summary of care response by noting the patient was dealing with multiple stressors (GS2096). This would be considered a red flag. Additionally the patient had a failed drug test on 12/18/2017, which was inconsistent for morphine and buprenorphine (GS2213). The Respondent did not document the inconsistent result in the 1/16/2018 progress note (GS2116). He did attempt

to justify the result in his summary of care response by documenting that it was determined that the patient received these medications when she was having surgery (GS2096). However, the two ophthalmology surgeries noted in the records were on 6/9/2017 (GS2227) and 10/10/2017(GS2225) so they were not in proximity of the drug test date. The PDMP did not show any of these two medications being prescribed for the patient (GS2174). Given the drug test inconsistency, the Respondent did not subsequently order enough random drug tests.

The Respondent also documented that he referred the patient to a Rheumatologist for treatment of her Rheumatoid arthritis and the patient never went (GS2114). It is the Respondent's responsibility to ensure treatment compliance and there certainly could be benefits from the involvement of a Rheumatologist in this patient's care and adding disease modifying anti-rheumatic drugs (DMARDs), which could potentially reduce her opioid load. The Respondent did not place the patient on any medication to treat her Fibromyalgia syndrome, and there are effective non-opioids that could be used and also this could potentially reduce the patient's opioid load.

4) **A. Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016?**

Yes.

B. Provide specific examples and note the page number where this can be found:

Treatment contract (GS2104-7), progress notes (GS2113-32), PDMP (GS2173-80), brief pain inventory (GS2184-94), GAD-7 anxiety screen (GS2197-200), medication list (GS2204-9), drug tests (GS2212-19), and past medical records (GS2221-31).

Chart #10:- Patient – KS

1) **Provide a synopsis of the care provided by the Respondent:**

The patient is a 30 year old female. The Respondent treated this patient for lumbar DDD, cervical degenerative disc disease, carpal tunnel syndrome, stenosis, and trigeminal neuralgia. The patient was prescribed a number of different opioids and non-opioids for her pain control between 12/20/17 and 8/18/18. The opioids include Oxycodone, Methadone and Morphine Sulfate ER. The non-opioids include Gabapentin, Naproxen, Cyclobenzaprine and Prednisone.

2) **Provide the components of the Standard of Quality Care required in treating this patient.**

   a. **Establish a proper diagnosis for pain etiology, and treatment Plan.**

   b. **Obtain and review medical records from previous and current treating medical providers relevant to the patient's pain management treatment.**

   c. **Use of Opioid Risk Assessment Screening Tools.**

   d. **Prior to initiating Opioid therapy, discuss the risk and benefits of treatment using Prescription Opioids, including establishing realistic expectations and possibly termination of therapy. After initiating opioid therapy, documentation of routine re-assessments to**

determine efficacy of treatment, appropriate need to continue therapy, reasons to adjust therapy or discontinue therapy. Assess substance abuse history.

e. **Discuss the current standard being applied for treatment with opioids in non-cancer pain of less than 90 mg equivalent of oral Morphine daily (90 MME/day) starting around mid-late 2016.**

f. **Prescribe naloxone for prevention of unintentional opioid overdose in patients who are on high dose opioids.**

g. **Check Prescription Drug Monitoring Program (PDMP), starting in 2014 when it became available in Maryland.**

h. **Discuss and sign Opioid and Pain Management Treatment Contract.**

i. **Perform Random Drug Testing.**

3) **A. Does the Respondent meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, including but not limited to the Respondent's overall prescribing of CDS after July 11, 2016?**

No.

B. Provide specific examples and note the page number where this can be found:

The respondent does not appear to have requested or review past records of this patient, during her new patient evaluation. There were no past records included such as, imaging studies or notes from a neurologist whom diagnosed Trigeminal Neuralgia (GS2276-7). There are no imaging reports or medical records to corroborate the diagnosis listed by the Respondent.

On 12/20/2017, the Respondent started this patient on a moderate dose opioid regimen of Oxycodone/acetaminophen 5/325mg, 60 tablets, for two weeks supply (GS2277 and GS2300). Following the trend of the Respondent's prescribing habits on the PDMP, there is a disturbing trend of the Respondent quickly escalating the dose two weeks later (on 1/3/2018) to Oxycodone 15mg, 120 tablets. Three weeks later (on 1/22/2018) increased to Oxycodone 20mg, 14 tablets. Two days later on 1/24/2018, prescribed Oxycodone 20mg, 120 tablets. Four weeks later by 2/28/2018, the Respondent increased the pain regimen to Oxycodone 30mg, 120 tablets, and Methadone 10mg, 120 tablets (GS2300).

Approximately 2 months later, the Respondent prescribed 564 tablets of prescription opioids and the Respondent went from 30MME/day to 500MME/day. These adjustments in the pain medication regimen were made without any objective evidence of significant pathology, new trauma/injuries, or new pathology findings discovered by a reasonable workup; but simply by the patient's subjective complaints. Later by May 2018, the patient was prescribed Morphine Sulfate ER 60mg, 60 tabs, monthly and Oxycodone 20mg, 150/monthly, which equates to 270MME/day.

The Respondent did not appropriately respond to drug test inconsistencies on 1/3/2018 for morphine and hydromorphone (GS2308). On 4/18/2018 the drug test was inconsistent for amphetamine (GS2304). Prior to the drug test being administered the patient informed the Respondent on 4/18/2018 that she ran out of medication and used her mother's morphine (GS2266), but this drug test was negative for morphine. The Respondent did

not respond to any of these inconsistencies and took the patient's word that she did not know how amphetamines got in her urine drug test (GS2264).

Other red flags for this patient ignored by the Respondent include early in the treatment course the patient stating she doubled the dose of pain medication she was using without discussing this with the provider (GS2270).

This patient should be considered high risk given her drug tests inconsistencies: over taking prescription opioids outside the instructions, running out of medication early, and a notation on her intake form that she smoked marijuana just three weeks prior to the initial evaluation (GS2253). Due to these findings more random drug tests should have been done.

Lastly the Respondent ordered imaging studies but the patient never complied and the Lumbar MRI was not done even after eight months (GS2255).

4) **A. Does the Respondent keep adequate medical records as determined by appropriate peer review after July 11, 2016?**

Yes.

B. Provide specific examples and note the page number where this can be found:

Treatment contract (GS2251-GS2252), New Patient visit (GS2276, GS2277), Progress note (GS2255-GS22Brief Pain Inventory (GS2284-GS2289), ORT (GS2295), Medication list (GS2297, GS2298), Drug tests (GS2300-GS2310), PDMP (GS2300, GS2301)

E. Summary

Based on my review of the 10 records:

The Respondent has several bad habits including prescribing opioids at extremely high doses out of the standard of care for safe opioid use for chronic non-cancer pain of 90MME/day. He routinely treated concomitantly with prescription opioids and benzodiazepines despite the risk, and minimized the risk.

The Respondent did not routinely offer non-opioid or non-pharmacological adjuvant treatments. He did not consistently recognize when to refer the patients to other qualified medical specialist and when referrals were made he did not enforce compliance by his patients. He did effectively order and use random drug testing, although, The Respondent did not respond appropriately to inconsistencies noted in the drug testing and red flags in patient behavior.

F. PEER REVIEWER'S STATEMENT

I have reviewed the records, as stated in this report, and am willing to testify regarding the care rendered by the Physician under review in this case. I declare under the penalties of perjury that I am not aware of any professional relationship or other conflict of interest which exists which would prevent me from rendering an objective and impartial opinion in this case.

Signature Date

[redacted]

Typed/Printed Name of Peer Reviewer