STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE

In re:	)	CONSENT AGREEMENT
C. Thomas Folkemer, M.D.	)	
Complaint No. CR11-060	)	

This document is a Consent Agreement regarding disciplinary action concerning and conditions imposed upon the license of C. Thomas Folkemer, M.D. to practice medicine in the State of Maine. The parties to this Consent Agreement are: C. Thomas Folkemer, M.D. ("Dr. Folkemer"), the State of Maine Board of Licensure in Medicine ("the Board") and the State of Maine Office of the Attorney General ("the Attorney General"). This Consent Agreement is entered into pursuant to pursuant to 10 M.R.S.A. § 8003(5)(B) and 32 M.R.S.A. § 3282-A.

FACTUAL BACKGROUND

1. On October 1, 2009, the Board received an application from C. Thomas Folkemer, M.D. to practice medicine in the State of Maine. Dr. Folkemer's medical specialty is Internal Medicine.

2. On his application for licensure, Dr. Folkemer answered "yes" to the following question:

> Have you EVER had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, probation with or without monitoring?

3. Dr. Folkemer explained that his medical license in Maryland was not restricted; however, in 1998 the Maryland Medical Board had placed his license on probation for three (3) years as a result of substandard medical record keeping. Dr. Folkemer further explained that as

part of the probation, he completed fifty (50) hours of continuing medical education and had his medical charts reviewed.

4. A review of the documentation of the Maryland Board of Physician Quality Assurance (Maryland Board) revealed the following:

a. On May 27, 1998, Dr. Folkemer entered into a Corrective Action Agreement with the Maryland Board following a complaint investigation regarding Dr. Folkemer's failure to meet the standard of care with regard to: his assessment of a patient who subsequently died of a pulmonary embolism; and his delivery of quality medical and surgical care as a result of a review of the medical charts of eight (8) of eleven (11) patients by the Medical and Chirurgical Faculty of Maryland. In the Corrective Action Agreement, Dr. Folkemer agreed to: allow the Maryland Board to monitor his medical practice for two (2) years; enroll in and successfully complete within nine (9) months a medical record keeping course approved by the Maryland Board; and enroll in and successfully complete within twelve (12) months a Board-approved internal medicine course of at least eighty (80) hours or two weeks.

b. On February 23, 2000, Dr. Folkemer entered into a Consent Order with the Maryland Board for violating the Corrective Action Agreement in the following ways: failing to cooperate at all times with the Maryland Board's monitoring of his medical practice; failing to enroll in and successfully complete a medical record keeping course within nine (9) months; and failing to enroll in and successfully complete a Board-approved internal medicine course of at least eighty (80) hours within twelve (12) months. In addition, the Consent Order concluded that as a matter of law that Dr.

Folkemer failed to meet appropriate standards for the delivery of quality medical and surgical care. As a result of the foregoing violations, Dr. Folkemer agreed to the suspension of his Maryland medical license, which was stayed, and a license probation of three (3) years with the following conditions: immediate compliance with the Corrective Action Agreement; successful completion of fifty (50) hours of continuing medical education approved by the Maryland Board with eighteen (18) months; chart review by a Board designee.

c. On February 24, 2003, the Maryland Board terminated Dr. Folkemer's probation as it had concluded as a matter of law that he had complied with the conditions and terms of the probationary period.

5. On March 10, 2010, the Maine Board of Licensure in Medicine issued Dr. Folkemer a license to practice medicine in the State of Maine.

6. On November 18, 2010, Dr. Folkemer entered into a Consent Order with the Maryland Board based upon Dr. Folkemer's: failure to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in [Maryland]; and failure to keep adequate medical records as determined by appropriate peer review. As a result, Dr. Folkemer agreed to the suspension of his medical license for one (1) year, with all but ninety (90) days suspended, and a license probation of three (3) years with conditions. A copy of that Consent Order is attached to and incorporated into this Consent Agreement for Licensure as "Exhibit A."

7. On March 15, 2011, the Maine Board of Licensure in Medicine initiated a

complaint against Dr. Folkemer's Maine medical license, pursuant to 32 M.R.S. § 3282-A, based upon the Consent Order Dr. Folkemer entered into with the Maryland Board, which included a ninety (90) day license suspension and a three (3) year license probation. The Board docketed the complaint as CR11-060.

8. On April 14, 2011, the Board received a response from Dr. Folkemer to Complaint CR11-060.

9. On May 10, 2011, the Board reviewed Complaint CR11-060 and voted to schedule the matter for an adjudicatory hearing. In addition, the Board authorized its assigned legal counsel to negotiate this Consent Agreement with Dr. Folkemer in order to resolve Complaint CR11-060 without hearing.

10. This Consent Agreement has been negotiated by and between Dr. Folkemer and legal counsel for the Board in order to resolve this matter without further proceedings. Absent Dr. Folkemer's acceptance of this Consent Agreement by signing it, dating it, having it notarized, and returning it the Maine Board of Licensure in Medicine, 137 State House Station, Augusta, Maine 04333-0137 on or before July 25, 2011, the Board will conduct further investigations and proceedings.

11. By signing this Consent Agreement, Dr. Folkemer waives any and all objections to, and hereby consents to allow the Board's legal counsel to present this proposed Consent Agreement to the Board for possible ratification. Dr. Folkemer also forever waives any arguments of bias or otherwise against any of the Board members in the event that the Board fails to ratify this proposed Consent Agreement.

COVENANTS

12. Dr. Folkemer admits that his recent discipline by the Maryland Board of Physicians, together with the facts and circumstances underlying that discipline, constitutes unprofessional conduct and grounds for the Maine Board to impose discipline upon his Maine medical license pursuant to 32 M.R.S.A. § 3282-A(2)(F). In the interest of resolving this complaint expeditiously and continuing his full cooperation with the Board, Dr. Folkemer agrees to enter into this Consent Agreement.

13. As discipline for the conduct admitted in paragraph 12 above, Dr. Folkemer agrees to:

a. Within six (6) months of the date the Board executes this Consent Order, Dr. Folkemer shall successfully complete a Board-approved course in medical recordkeeping. Dr. Folkemer shall enroll in this required course within three (3) months of the date of the execution of this Consent Agreement. Dr. Folkemer shall submit written documentation to the Board regarding the particular course he proposes to fulfill this condition. The Board reserves the right to require the Dr. Folkemer to provide further information regarding the course he proposes, and further reserves the right to reject his proposed course and require submission of an alternative proposal. The Board will approve a course only if it deems the curriculum and the duration of the course adequate to satisfy its concerns. Dr. Folkemer shall be responsible for submitting written documentation to the Board of his successful completion of this course. Dr. Folkemer understands and agrees that he may not use this coursework to fulfill any requirements mandated for licensure renewal. Dr. Folkemer shall be solely responsible for furnishing the Board with adequate written verification that he has completed the course according

to the terms set forth herein.

b. Within one (1) year of the date of the execution of this Consent Agreement, Dr. Folkemer shall successfully complete a course of significant duration in the following subject areas: (a) appropriate prescribing practices involving opioid medications and benzodiazepines; and (b) appropriate pain management practices. Dr. Folkemer shall enroll in this coursework within six (6) months of the date of the execution of this Consent Agreement. Dr. Folkemer shall submit written documentation to the Board regarding the particular courses he proposes to satisfy written documentation. The Board reserves the right to require Dr. Folkemer to provide further information regarding the courses he proposes, and further reserves the right to reject any proposed course and require submission of alternative proposals. The Board will approve a course only if it deems the curriculum and the duration of the course adequate to satisfy its concerns. Dr. Folkemer shall be responsible for submitting written documentation to the Board of his successful completion of this coursework. Dr. Folkemer understands and agrees that he may not use any continuing medical education credits earned through this condition to fulfill any requirements mandated for licensure renewal. Dr. Folkemer shall be solely responsible for furnishing the Board with adequate written verification that he has completed this coursework according to the terms set forth herein.

c. A three (3) year license probation commencing upon his active practice of medicine in the State of Maine. In complying with this provision, Dr. Folkemer shall notify the Board in writing within 24 hours of his active practice of medicine in Maine. Specific conditions of the probation shall include:

(i). Dr. Folkemer shall provide the Board in writing with a list of all offices, clinics and hospitals where he practices medicine in the State of Maine;

(ii). Dr. Folkemer shall not practice pain management medicine and shall not dispense or prescribe any opiates or benzodiazepine medications to any patient or individual for longer than three (3) days and only in an emergency situation.

(iii). Dr. Folkemer shall keep and maintain adequate medical records that are legible and complete.

(iv). Dr. Folkemer's practice shall be supervised by a Board-approved supervisor (the "Supervisor") subject to the following terms:

(1) Prior to Dr. Folkemer's active practice of medicine in the State of Maine, Dr. Folkemer must have a Supervisor pre-approved by the Board who is board-certified in internal medicine. The Supervisor shall be an agent of the Board pursuant to Title 24 M.R.S.A. § 2511.

(2) Dr. Folkemer shall submit the name and professional credentials of a board-certified specialist in internal medicine for purposes of obtaining Board approval to serve as Supervisor for his practice for the entire three (3) year period of probation. The Board shall retain the sole discretion to approve or deny any Supervisor proposed by Dr. Folkemer. Dr. Folkemer shall provide the Supervisor with a copy of this Consent Agreement and any other documents the Board deems relevant in this case. Dr. Folkemer understands and agrees that the Board may at its sole discretion terminate any Supervisor and require that another Supervisor be designated.

(3) Dr. Folkemer shall ensure that the Supervisor notifies the Board, in writing, within ten (10) days of the Board's approval of his/her acceptance of his/her supervisory role.

(4) The Supervisor shall meet with Dr. Folkemer at Dr. Folkemer's office and shall hold face-to-face meetings with him on a monthly basis, at which time the Supervisor shall choose a random sample of medical record charts of at least ten (10) active patient medical cases/charts/records to review. The Supervisor shall review the charts to determine Dr. Folkemer's compliance with prescribing quality of care and

recordkeeping standards. In addition, the Supervisor shall discuss the cases with Dr. Folkemer to evaluate Dr. Folkemer's understanding of the conditions he is treating and his compliance with quality of care and recordkeeping standards.

(5) The Supervisor shall submit quarterly written reports to the Board on or before the following dates: October 1st, January 1st, April 1st, July 1st. The written reports shall include but not be limited to the number and types of cases he/she reviewed, medical issues he/she discussed with Dr. Folkemer, and his/her assessment of Dr. Folkemer's understanding of the conditions he is treating and his compliance with qualify of care and recordkeeping standards. In addition to the quarterly reporting requirement, the Supervisor shall immediately inform the Board if Dr. Folkemer is unable to meet the applicable standards of medical care and record-keeping. Dr. Folkemer shall promptly execute/obtain any and all necessary release forms and/or waivers of confidentiality to allow the Board, Board Investigator, or an Assistant Attorney General to: (i) obtain copies of any medical or treatment records of concern to the Supervisor; and (ii) contact/communicate with the Supervisor.

(6) Dr. Folkemer shall have sole responsibility for ensuring that the Supervisor submits the required quarterly reports in a timely manner. To ensure such timely reporting, Dr. Folkemer agrees to pay a FINE of Five Thousand Dollars and Zero Cents ($5,000.00). However, payment of the fine is suspended so long as Dr. Folkemer complies with all of the terms and conditions of this Consent Agreement, including all of the reporting requirements. Dr. Folkemer agrees that, in the event that he fails to meet any of the reporting or other time requirements set out in this Consent Agreement (without having requested an extension prior to the due date and having that request granted by the Board), the Board may, in its sole discretion, summarily and without an adjudicatory hearing, "activate" any or all of the amount of the suspended fine. The Board shall notify Dr. Folkemer in writing of the activation of all or a portion of the suspended fine. Dr. Folkemer agrees and understands that he must pay the amount of the fine "activated" by the Board within 30 days of receiving notice that the fine was activated. Payment shall be by cashier's check or money order made out to "Treasurer, State of Maine" and be remitted to the Maine Board of Licensure in Medicine. In addition, the parties agree and understand that the Board's decision not to "activate" all or a portion of the suspended fine for one instance of noncompliance with a reporting or other time requirement does not constitute a waiver of the Board's right to "activate" all or a portion of the fine regarding a subsequent instance of non-compliance. If Dr. Folkemer fails to pay an "activated" fine within the 30 days as provided by this section, the Board

may "activate" all or a portion of the remaining portion of the "suspended" fine. Any decision by the Board pursuant to this section does not require an adjudicatory hearing and is non-appealable.

(7) The Board has sole discretion and authority for implementing any changes in the supervision and retains all authority to approve any changes in the supervision.

(8) In the event that the Supervisor discontinues supervising Dr. Folkemer for any reason, Dr. Folkemer shall immediately notify the Board. Dr. Folkemer shall be solely responsible for submitting a replacement candidate to serve as his Supervisor under the terms specified above.

(9) Dr. Folkemer shall be responsible for all costs associated with supervision of his practice and his compliance with the terms and conditions of this Consent Agreement and his probation.

(v). The Board reserves the right to conduct a peer review by an appropriate peer review entity, or a chart review by a Board designee, to be determined at the discretion of the Board.

(vi). Dr. Folkemer shall practice according to applicable standards of care and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of medicine.

(vii). Dr. Folkemer agrees to provide a copy of this Consent Agreement to: (1) any prospective employer, employer or contractor or partnership involved in his practice of medicine in the State of Maine; (2) any State medical board or other licensing authority in any location or jurisdiction where he may seek to practice or where he may make application for licensure, so long as this agreement remains in effect; and (3) his Supervisor approved by the Board.

(viii). Dr. Folkemer agrees to bear all costs associated with his

compliance with the terms and conditions of this Consent Agreement.

14. Dr. Folkemer agrees that any failure by him to comply with any of the terms or conditions of this Consent Agreement shall constitute unprofessional conduct pursuant to 32 M.R.S. § 3282-A(2)(F), and may subject him to disciplinary action as the Board may deem appropriate.

15. Pursuant to 10 M.R.S. § 8003(5)(B) the Board and Dr. Folkemer agree that, in addition to any other disciplinary action available to it by law, the Board has the authority, following hearing, to impose discipline, including modifying, suspending, or revoking his Maine medical license in the event that he fails to comply with any of the terms or conditions of this Consent Agreement.

16. This Consent Agreement may only be modified in writing by all of the parties hereto.

17. Dr. Folkemer waives any further hearings before the Board or appeal to the Courts regarding all terms and conditions of this Consent Agreement.

18. The Board and the Attorney General may communicate and cooperate regarding Dr. Folkemer's medical practice or any other matter relating to this Consent Agreement.

19. This Consent Agreement is a public record within the meaning of 1 M.R.S. § 402 and will be available for inspection and copying by the public pursuant to 1 M.R.S. § 408.

20. This Consent Agreement constitutes adverse licensing action that is reportable to the National Practitioner Data Bank (NPDB), the Healthcare Integrity and Protection Data Bank (HIPDB), and the Federation of State Medical Boards (FSMB).

21. Dr. Folkemer acknowledges that he had the opportunity to consult with legal counsel regarding this Consent Agreement, and that he chose to represent himself. Dr. Folkemer agrees and understands that, by executing this document, he is waiving any right to a hearing regarding his application for licensure, any challenge to the jurisdiction of the Board, or to present evidence and witnesses on his behalf.

22. Nothing in this Consent Agreement shall be construed to affect any right or interest of any person not a party hereto.

I, C. THOMAS FOLKEMER, M.D., HAVE READ AND UNDERSTAND THE FOREGOING CONSENT AGREEMENT AND AGREE WITH ITS CONTENTS AND TERMS. I FURTHER UNDERSTAND THAT BY SIGNING THIS DOCUMENT, I WAIVE CERTAIN RIGHTS, INCLUDING A RIGHT TO A HEARING BEFORE THE BOARD. I HAVE HAD AN OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL REGARDING THIS DOCUMENT. I SIGN IT VOLUNTARILY, WITHOUT ANY THREAT OR PROMISE. I UNDERSTAND THAT THIS CONSENT AGREEMENT FOR CONDITIONAL LICENSURE CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND, VERBAL, WRITTEN OR OTHERWISE.

DATED: 7/18/11

C. Thomas Folkemer, MD
C. THOMAS FOLKEMER, M.D.

STATE OF Maine

Kennebec, S.S.

Personally appeared before me the above–named C. Thomas Folkemer, M.D., and swore to the truth of the foregoing based upon his own personal knowledge, or upon information and belief, and so far as upon information and belief, he believes it to be true.

DATED: 7/18/2011

Jean M Greenwood
NOTARY PUBLIC/ATTORNEY

MY COMMISSION ENDS: 9/25/2014

STATE OF MAINE

BOARD OF LICENSURE IN MEDICINE

DATED: 7/19/11

GARY R. HATFIELD, M.D., Chairman

STATE OF MAINE OFFICE
OF THE ATTORNEY GENERAL

DATED: 7/21/11

DENNIS E. SMITH
Assistant Attorney General

Effective Date: 7/21/11

IN THE MATTER OF	*	**BEFORE THE**
C. THOMAS FOLKEMER, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D14751	*	**Case Number: 2008-0868**

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

CONSENT ORDER

PROCEDURAL BACKGROUND

On June 2, 2010, the Maryland State Board of Physicians (the "Board") charged C. Thomas Folkemer, M.D. (the "Respondent") (D.O.B. 06/09/45), License Number D14751, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2000, 2005 and 2009 Repl. Vols.).

Specifically, the Board voted to charge the Respondent with violating the following provisions of the Act under H.O. § 14-404, which provide the following:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; [and]
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review.

On October 6, 2010, a Case Resolution Conference was convened in this matter. Based on negotiations occurring as a result of this Case Resolution Conference, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order, and Consent.

FINDINGS OF FACT

The Board finds the following:

BACKGROUND FINDINGS

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on February 5, 1973, under License Number D14751.

2. The Respondent practices general medicine and maintains a medical office at the following location: 4231 Postal Court, Suite 102, Pasadena, Maryland 21122.

3. The Respondent maintains hospital privileges at the Mercy Medical Center, located in Baltimore, Maryland; and the Baltimore Washington Medical Center, located in Glen Burnie, Maryland.

4. On or about July 28, 1999, the Board (then known as the State Board of Physician Quality Assurance) issued disciplinary charges in which it alleged that the Respondent violated the terms and conditions of a Corrective Action Agreement, dated May 27, 1998; and failed to meet appropriate standards for the delivery of quality medical and surgical care, in violation of H.O. § 14-404(a)(22).

5. The Respondent resolved those charges by entering into a public Consent Order with the Board, dated February 23, 2000. The Board found as a matter of law that the Respondent violated the terms and conditions of the Corrective Action Agreement, dated May 27, 1998; and failed to meet appropriate standards for the delivery of quality medical and surgical care, in violation of H.O. § 14-404(a)(22).

6. Pursuant to the terms of the Consent Order, the Board suspended the Respondent's medical license, which it immediately stayed, and placed him on probation for three years, subject to a series of probationary conditions, including compliance with all provisions of the previously imposed Corrective Action Agreement; successful completion of 50 hours of continuing medical education; and peer review.

7. On or about February 24, 2003, the Board issued an Order in which it terminated the Respondent's probation without further conditions.

CURRENT ALLEGATIONS

8. The Board initiated an investigation of the Respondent based on a complaint from the father (the "Complainant")[1] of a patient ("Patient A") the Respondent was treating. The Complainant expressed concern about the Respondent's prescribing practices, and in particular his practice of prescribing Xanax, a benzodiazepine and Schedule IV controlled dangerous substance ("CDS"), and other drugs with abuse potential to his daughter, Patient A, despite knowing that she was also taking Methadone. Methadone is a synthetic opioid and Schedule II CDS.

9. The Complainant stated that over the years, the Respondent has been known to prescribe Methadone to patients along with Xanax, which he described as a "deadly combination." The Complainant stated,

> "[m]any people on Methadone take Xanax to boost the Methadone, and it makes a close Heroin like high with this combination. These are all very well known facts and every Methadone clinic in Md. has a problem with many patients and abuse of benzodiazepines."

[1] To ensure confidentiality, the names of any individuals who are referred to in this Consent Order are not identified. The Respondent is aware of the identity of all individuals who are referenced herein.

10. The Complainant stated that after observing that Patient A was "constantly high on this combination," he warned the Respondent about prescribing these medications to her. The Complainant stated that despite this warning,

> "he [the Respondent] continues to this day to write her the Xanax. She walks around in a stupor. A lot of times not knowing what she is doing. Others just go there and then sell the pills. How can a doctor do this kind of behavior when he is a doctor and knows better???"

11. Based on this complaint, the Board requested that Maximus Federal Services, Inc. ("Maximus") perform a review of the Respondent's practice. Maximus conducted a practice review and submitted its findings to the Board in or around December 2009. This review concluded that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care and failed to keep adequate medical records.

GENERAL FINDINGS

12. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40). Throughout the cases reviewed, the Respondent prescribed opioid medications, including Methadone, OxyContin, and hydrocodone, to patients over extended periods of time in an inappropriate manner. The Respondent failed to establish or document establishing a comprehensive treatment plan when utilizing these medications. The Respondent failed to establish or document establishing a comprehensive treatment plan to address his patients' chronic pain complaints or drug dependency/addiction issues. The Respondent failed to appropriately evaluate or document his evaluation of his patients' chronic pain

complaints and use/misuse of CDS. The Respondent typically did not attempt a trial of non-narcotic medications or attempt other treatment modalities prior to prescribing potent opioid medications. The Respondent prescribed potent narcotic medications without performing or documenting performing appropriate neurological examinations or obtaining diagnostic findings to establish an objective basis to support such prescribing. The Respondent sometimes prescribed potent narcotic medications upon patient request, and without verifying his patients' prior use of such medications. The Respondent failed to obtain consultants' reports or recommendations when treating patients with chronic pain complaints, or failed to follow up on or address his patients' non-compliance with his referrals for consultations/diagnostic studies. In at least one instance where the Respondent did obtain a specialty consultation, the Respondent prescribed narcotic medications contrary to the consultant's advice, without documenting his rationale for disregarding it. The Respondent failed to establish or document establishing appropriate therapeutic goals for patients to whom he prescribed opioid medications. The Respondent failed to establish pain contracts with patients to whom he prescribed opioid medications, or failed to document the specifics of those contracts, if they existed. The Respondent failed to undertake appropriate age-related preventative care measures with respect to the patients whose charts were reviewed. In addition, the Respondent's medical recordkeeping failed to meet quality medical standards and was otherwise inadequate. The Respondent's medical recordkeeping was cursory and frequently illegible. The Respondent failed to take or document taking adequate histories or follow-up histories and failed to perform or document performing appropriate physical examinations. The Respondent failed to record adequate

documentation when treating patients with chronic pain or drug dependency/addiction issues. Examples of these deficiencies are set forth *infra*.

PATIENT-SPECIFIC FINDINGS

Patient A

13. The Respondent provided medical records for Patient A that involved office visits from 2003 to 2008. In a letter to the Board, dated December 19, 2008, however, the Respondent stated that Patient A "has been followed for 25 years in our practice." Patient A reportedly had a medical history that included intravenous ("IV") narcotics abuse, chronic back pain, anxiety, depression and seizures. Patient A had at least one live birth and one miscarriage that occurred during the time period reflected in the Respondent's records.

14. The Respondent's first entry for Patient A, who was then 22 years old, was for an office visit, dated December 10, 2002. Patient A reportedly failed to appear for this visit.

15. Patient A returned for follow-up visits beginning in January 2003 and continuing until 2008. Throughout these visits, the Respondent noted that Patient A was an IV drug abuser. The Respondent also diagnosed her with depression, anxiety and back pain.

16. During the treatment period referenced in the records, the Respondent prescribed Methadone for Patient A or noted that she was receiving it from other sources, such as a Methadone program. Throughout the treatment period, the Respondent consistently prescribed various benzodiazepines for Patient A, including

Xanax and Valium. At times, the Respondent prescribed oral contraceptives for Patient A.

17. The Respondent's office records are cursory and frequently illegible. The Respondent failed to take or record taking a comprehensive history or document his thought processes in his office notes. The Respondent's physical examination findings are cursory and difficult to read or are illegible. The Respondent did not document his treatment plans with respect to Patient A's drug dependence and depression.

18. The Respondent noted that at one point (*e.g.*, office note, August 19, 2003), Patient A was using IV Heroin and was giving away her Methadone. In a subsequent office note, dated September 15, 2003, however, the Respondent gave Patient A an additional prescription for Methadone, and a prescription with two refills for 100 pills of Valium (10 mg). The Respondent noted that Patient A was scheduled to enter a drug rehabilitation program, but later notes do not indicate whether Patient A entered the program. In subsequent visits, the Respondent occasionally prescribed Methadone for Patient A.

19. In 2005, the Respondent noted that Patient A had had a seizure and that he recommended that she see a neurologist. In subsequent entries, the Respondent did not note that he discussed any recommendations based on this consultation, if it occurred. The Respondent noted that Patient A had additional seizures in 2006. The Respondent prescribed an anti-seizure medication, Dilantin, for Patient A. Patient A's chart does not contain the results of any laboratory measurements of Dilantin levels, if the Respondent ordered them. In addition, the Respondent's chart does not contain laboratory results for any other laboratory testing.

20. In 2007, the Respondent saw Patient A, who was 11 weeks pregnant at the time, and prescribed Xanax for her. The Respondent did not note that he counseled Patient A about taking a benzodiazepine while pregnant or potential side effects to her fetus. In January 2008, Patient A delivered by Cesarean section and returned to see the Respondent for an additional prescription for Xanax.

21. The Respondent also noted that Patient A had chronic back pain. The Respondent's office notes do not document that the Respondent consistently performed any diagnostic tests when assessing or diagnosing Patient A with this condition.

22. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient A, for reasons including but not limited to the following:

a. the Respondent failed to establish or document establishing a comprehensive treatment plan to address Patient A's medical conditions, including drug dependency/drug addiction and seizure disorder;

b. the Respondent failed to take or document an appropriate history or follow-up histories;

c. the Respondent failed to perform or document performing appropriate physical examinations of Patient A;

d. the Respondent's office records are cursory and frequently illegible;

e. the Respondent prescribed oral contraceptives for Patient A but did not perform or document performing gynecologic examinations or take periodic Pap smears;

f. the Respondent inappropriately prescribed benzodiazepines and other medications for Patient A, who had a history of IV drug abuse and depression;

g. the Respondent failed to adequately address and treat or document his attempts to treat Patient A's seizure disorder;

h. the Respondent prescribed large doses of benzodiazepines for Patient A without notifying or documenting that he notified Patient A's obstetrician;

i. the Respondent failed to refer Patient A for counseling for her drug dependence and psychological issues;

j. the Respondent failed to appropriately assess and treat or document his assessment and treatment of Patient A's anxiety;

k. the Respondent failed to appropriately assess and treat or document his assessment and treatment of Patient A's chronic back pain;

l. the Respondent failed to impose appropriate safeguards to minimize Patient A's abuse and diversion of CDS; and

m. the Respondent failed to communicate with or document his communications with consultants regarding Patient A's medical conditions.

Patient B

23. The Respondent provided medical records for Patient B that involved office visits from May 2007 until November 2008. Patient B, then a man in his mid-40s, had a medical history that included chronic back pain, depression and chronic obstructive pulmonary disease ("COPD").

24. The Respondent's office notes typically consist of a chief complaint of "renew RX's"; a brief, two-line examination; and typically, a diagnosis of chronic back pain and COPD. Over the course of these visits, the Respondent prescribed various combinations of the following medications: Xanax; Percocet, a narcotic analgesic and Schedule II CDS; OxyContin, a long-acting narcotic analgesic and Schedule II CDS; and Duragesic (fentanyl) transdermal patches, a narcotic analgesic and Schedule II

CDS. The Respondent also prescribed various medications to treat Patient B's COPD, including Advair, Singulair and a Proventil inhaler. The Respondent's office notes do not contain any diagnostic studies or other testing to assess Patient B's back condition. On November 20, 2008, the Respondent performed a Department of Transportation physical examination.

25. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient B, for reasons including but not limited to the following:

a. the Respondent failed to establish or document establishing a comprehensive treatment plan to address Patient B's chronic back pain;

b. the Respondent failed to take or document taking an appropriate medical history or follow-up histories;

c. the Respondent failed to perform or document performing appropriate physical examinations to assess Patient B's various medical conditions;

d. the Respondent failed to assess or document a full assessment of Patient B's musculoskeletal complaints/chronic back pain;

e. the Respondent failed to order appropriate diagnostic studies to assess Patient B's complaints of back pain;

f. the Respondent's office notes do not contain the results of any diagnostic testing performed to assess Patient B's back pain;

g. the Respondent failed to refer or document referring Patient B for specialty consultation for his back pain;

h. the Respondent prescribed narcotic analgesics for Patient B in an inappropriate manner;

i. the Respondent failed to refer or document referring Patient B to a pain management specialist;

j. the Respondent's office records are cursory and frequently illegible; and

k. the Respondent failed to appropriately evaluate Patient B's COPD, or refer Patient B for smoking cessation.

Patient C

26. Patient C, then a 47-year old woman, first saw the Respondent on June 27, 2002, after becoming injured in a motor vehicle accident, after which she reportedly began having knee pain. Patient C apparently underwent some physical therapy. The Respondent may have referred Patient C for an orthopedic consultation, but there are no consultants' reports in Patient C's chart. Patient C was also morbidly obese. Patient C saw the Respondent from 2002 until 2008. Patient C's conditions included knee and chronic back pain, obesity and hypertension.

27. During her initial visit, the Respondent referred Patient C for a computed tomography ("CT") study of her knee. The Respondent's office notes do not contain a CT report or documentation of any radiographic findings. The Respondent's chart does not contain any reports from consultants to whom the Respondent referred Patient C.

28. During the treatment period, the Respondent prescribed various narcotic analgesic pain medications, including Lortab, a Schedule II CDS, and Duragesic patches. The Respondent also prescribed Lidoderm patches. Lidoderm patches contain a local anesthetic, lidocaine. In 2007, the Respondent discontinued Lortab and began prescribing Methadone, a Schedule II CDS, which he continued into 2008.

29. The Respondent also diagnosed Patient C with lymphedema and prescribed a diuretic, Lasix. The Respondent also placed Patient C on anti-hypertensive medications. The Respondent recommended that Patient C undergo

specialty consultations with an orthopedist and a vascular surgeon. The Respondent's chart does not contain any consultants' reports or findings, or document whether Patient C complied with these recommendations.

30. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient C, for reasons including but not limited to the following:

a. the Respondent failed to establish or document establishing a comprehensive treatment plan to evaluate Patient C's knee and back complaints;

b. the Respondent prescribed narcotic analgesics for Patient C in an inappropriate manner;

c. the Respondent failed to assess or document a full assessment of Patient C's chronic musculoskeletal/knee/back complaints;

d. the Respondent failed to obtain diagnostic studies to evaluate Patient C's knee/back complaints, or document the reason why these studies were not obtained;

e. the Respondent did not address or document that he addressed Patient C's non-compliance with his recommendations for consultations/diagnostic studies;

f. the Respondent failed to obtain laboratory testing after placing Patient C on diuretic therapy;

g. the Respondent failed to establish or document establishing a comprehensive treatment plan with respect to Patient C's morbid obesity;

h. the Respondent failed to take or document taking an appropriate medical history or follow up histories;

i. the Respondent failed to perform or document performing appropriate physical examinations to assess Patient C's medical conditions; and

j. the Respondent's office records are cursory and frequently illegible.

Patient D

31. The Respondent's office notes for Patient D, then a 46-year old man, begin in or around April 1996, and continue into 2009. The Respondent's office notes do not contain a comprehensive history of Patient D's medical conditions. The Respondent apparently referred Patient D for an orthopedic consultation in 2000. The consultant's report states that Patient D had an anterior cervical spine fusion in 1996 and a posterior cervical spinal decompression in 1998. Patient D reportedly had chronic low back pain/sciatica. The consultant ordered lumbar myelography with CT scanning, after which he recommended a laminectomy at L5.

32. Thereafter, the Respondent treated Patient D for chronic pain and hyperlipidemia. The Respondent began prescribing various narcotic analgesics for Patient D, including Tylenol # 3, an analgesic containing codeine, and OxyContin; and on occasion, Lidoderm patches. In addition, the Respondent also prescribed benzodiazepines including Valium. The Respondent continued to prescribe these medications until 2007, when he discontinued prescribing OxyContin and began prescribing Methadone and Percocet, a Schedule II CDS. The Respondent's notes state that he tried to taper Patient D off of narcotic analgesics.

33. In 2007, the Respondent recommended that Patient D see an orthopedist. The Respondent's office notes do not contain any consultants' reports or findings, or whether Patient D acted on this recommendation. The Respondent noted in January 2008 that Patient D was scheduled for a pain management consultation. The

Respondent continued to prescribe Methadone and Percocet to Patient D after this referral.

34. The Respondent ordered laboratory studies in 2007 and 2008. Laboratory studies taken in 2008 indicate that Patient D had abnormal kidney function test findings.

35. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient D, for reasons including but not limited to the following:

a. the Respondent failed to establish or document establishing a comprehensive treatment plan to address Patient D's musculoskeletal complaints/chronic back pain;

b. the Respondent failed to take or document taking an adequate history or follow-up histories of Patient D's musculoskeletal complaints/chronic back pain;

c. the Respondent failed to perform or document performing appropriate physical examinations of Patient D;

d. the Respondent's office records are cursory and frequently illegible;

e. the Respondent prescribed narcotic analgesics for Patient D on a long-term basis in an inappropriate manner;

f. the Respondent failed to refer Patient D to a pain management specialist in a timely manner, or follow up or document following up on such a referral, if one was made;

g. the Respondent failed to appropriately assess and treat Patient D's hyperlipidemia;

h. the Respondent failed to order timely laboratory tests when evaluating Patient D's hyperlipidemia; and

i. the Respondent failed to address Patient D's abnormal kidney function test results found in 2008 and/or failed to document that he addressed them with him.

Patient E

36. The Respondent's office notes for Patient E, then a 44-year old man, begin in 2004 and continue into 2009. The Respondent did not document a comprehensive history of Patient E's medical conditions. According to consultants' reports, Patient E had a history of chronic back pain, arthritis, left knee replacement, fusion of his left knee, ankle surgery, COPD and hydrocele. Patient E also underwent surgical repair of his right rotator cuff.

37. During the treatment period reviewed, the Respondent diagnosed Patient E with various conditions, including chronic pain, COPD and depression, and treated him with various narcotic analgesic medications including Duragesic patches and OxyContin. The Respondent also prescribed other medications, including benzodiazepines, muscle relaxants, anti-depressants, and medications to treat COPD. During the treatment period, the Respondent periodically ordered laboratory studies and referred Patient E for specialty consultation (*e.g.*, colonoscopy). No laboratory findings are contained in Patient E's chart, however. Patient E's chart does contain an orthopedic consultation report from 2005 and a pulmonary consultation report from 2009.

38. On March 6, 2007, the Respondent performed a pre-operative examination of Patient E. The Respondent's note for this examination fails to specify for which procedure Patient E was being cleared. The Respondent failed to review

standard laboratory parameters, such as a complete blood count, chest x-ray and EKG, before clearing Patient E for surgery.

39. Patient E had a pulmonary embolism ("PE") on September 21, 2007. The Respondent saw Patient E for a follow-up office visit on September 24, 2007. The Respondent's office note for that date states that Patient E would be maintained on anti-coagulants until March 2008, and should obtain weekly monitoring levels (INRs) during this period. The Respondent's office chart for Patient E contains only two laboratory INR results, however, performed in October 2007. No further INR monitoring levels are contained in Patient E's chart.

40. In 2008, the Respondent referred Patient E for pain management. After this referral, the Respondent continued to prescribe narcotic analgesics for Patient E, including OxyContin 40 mg, Duragesic patches and benzodiazepines.

41. In 2009, Patient E was admitted for hospitalization. The consultant who evaluated Patient E made a tentative diagnosis of pneumonia. The Respondent performed a follow-up evaluation of Patient E on March 11, 2009. The Respondent's note for that date states that Patient E was hospitalized for a TIA (transient ischemic attack) and "now feels well."

42. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient E, for reasons including but not limited to the following:

a. the Respondent failed to establish or document establishing a comprehensive treatment plan to address Patient E's medical conditions, particularly in light of Patient E's TIA;

b. the Respondent failed to take or document taking an adequate history or follow-up histories of Patient E;

c. the Respondent failed to perform or document performing appropriate physical examinations of Patient E;

d. the Respondent failed to follow up on his referrals of Patient E for consultations and laboratory studies;

e. the Respondent's office records are cursory and frequently illegible;

f. the Respondent failed to appropriately evaluate and treat, or document his evaluation and treatment of, Patient E's anti-coagulation status;

g. the Respondent failed to appropriately monitor Patient E's anti-coagulation status after his discharge for PE, or document his discussions regarding Patient E's compliance with obtaining monitoring;

h. the Respondent did not order routine laboratory studies in a timely manner to assess Patient E;

i. the Respondent failed to appropriately assess and manage or document his assessment and management of Patient E's chronic pain condition; and

j. the Respondent failed to perform or document performing an adequate pre-operative physical examination.

Patient F

43. Patient F, then a 34-year old woman, first saw the Respondent on March 15, 2002. The Respondent listed Patient F's chief complaint as "new pt—need Rx for OxyContin." Patient F self-reported neck and low back pain and was legally blind. The Respondent took a very minimal history, performed a brief physical examination and wrote Patient F a prescription for 100 tablets of 40 mg of OxyContin.

44. Patient F then returned for monthly follow-up visits, during which time the Respondent gave her additional prescriptions for OxyContin. The Respondent referred

Patient F for a neurology consultation in September 2002. In her consultation reports, the neurologist stated that Patient F's MRIs were "negative," her EMG and nerve conduction studies were "normal," and she had no significant CT scan findings. The neurologist stated that she was "not impressed with any focal neurological deficits," and recommended against narcotics ("No narcotics").

45. Patient F's chart also contains a lumbar spine CT report, taken on August 15, 2003, which was unremarkable; and a report for a head CT for "headaches," which was "normal."

46. The Respondent continued to follow Patient F into 2009. On a monthly basis during the treatment period, the Respondent regularly prescribed OxyContin, Darvocet, an analgesic, and muscle relaxants. The Respondent also provided primary care to Patient F.

47. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient F, for reasons including but not limited to the following:

a. the Respondent failed to establish or document establishing a comprehensive treatment plan to address Patient F's complaints of chronic pain;

b. the Respondent failed to take or document taking an adequate history or follow-up histories of Patient F;

c. the Respondent failed to perform or document performing appropriate physical examinations of Patient F;

d. the Respondent's office records are cursory and frequently illegible;

e. the Respondent prescribed narcotic analgesics for Patient F on a long term basis in an inappropriate manner;

f. the Respondent prescribed significant quantities of potent narcotic analgesics for Patient F in the absence of objective pathologic findings;

g. the Respondent failed to establish sufficient objective physical examination findings to justify prescribing long-term opioid therapy;

h. the Respondent disregarded the recommendations of the consultant neurologist to whom he referred Patient F, or failed to document his rationale for disregarding the consultant's recommendations; and

i. the Respondent failed to order timely laboratory studies to evaluate Patient F.

Patient G

48. Patient G, then a 44-year old woman, initially saw the Respondent in 2007 with complaints of "serious pain on back, hips, neck, legs." On a patient history form, Patient G reported that she underwent back surgery in 1995 and 1996 and was taking "Oxycotten 40mg" and Percocet. The Respondent performed a minimal physical examination that included a positive bilateral straight leg raising test. The Respondent did not obtain Patient G's prior medical records. The Respondent diagnosed Patient G with back lumbosacral pain, arthritis and anxiety, and prescribed Methadone and a muscle relaxant, Soma.

49. The Respondent saw Patient G on three additional visits in 2007-08. In a note for a visit, dated November 5, 2007, the Respondent stated that he planned to refer Patient G for an orthopedic consultation. The Respondent's office records do not contain any reports from consultants, however, or discuss whether or not Patient G complied with his recommendation. The Respondent's office records do not contain

any radiographic test findings. On these office visits, the Respondent continued to prescribe Methadone for Patient G.

50. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient G, for reasons including but not limited to the following:

a. the Respondent failed to establish or document establishing a comprehensive treatment plan to address Patient G's musculoskeletal complaints/chronic back pain;

b. the Respondent failed to order diagnostic testing to evaluate Patient G's musculoskeletal/chronic pain complaints, or failed to obtain the results of such testing, if it was performed;

c. the Respondent prescribed potent narcotic analgesics for Patient G under inappropriate circumstances;

d. the Respondent prescribed potent narcotic analgesics for Patient G in the absence of positive radiographic findings;

e. the Respondent failed to establish sufficient pathological findings to justify prescribing potent narcotics to Patient G;

f. the Respondent failed to take or document taking an adequate history or follow-up histories of Patient G;

g. the Respondent failed to perform or document performing appropriate physical examinations of Patient G;

h. the Respondent's office records are cursory and frequently illegible;

i. the Respondent failed to obtain Patient G's prior medical records when assessing her for complaints of chronic pain; and

j. the Respondent failed to verify Patient G's claim that she was previously prescribed narcotic analgesics or obtain her prior medical records for this purpose.

Patient H

51. Patient H, then a 37-year old man, initially saw the Respondent on December 1, 2006. Patient H had been shot in the head by police, leading to right eye blindness and chronic pain. The Respondent examined Patient H and referred him to the Wilmer Eye Clinic for an ophthalmologic consultation. The Respondent diagnosed Patient H with traumatic blindness and a skin rash. The Respondent prescribed Percocet and an anti-depressant, Trazadone.

52. Patient H returned for follow-up on January 7, 2007. The Respondent discontinued prescribing Percocet and instead, prescribed Methadone. The Respondent continued the Trazadone and added a second anti-depressant, Wellbutrin. The Respondent noted a plan that included a "contract for pain." No written contract is contained in the Respondent's office record, however.

53. Patient H returned for monthly visits until the end of 2008. During these visits, the Respondent, over time, began prescribing increasing amounts of Methadone. In addition, the Respondent prescribed various psychotropic medications and also prescribed benzodiazepines.

54. The Respondent periodically noted his plan to refer Patient H for psychiatric and pain consultations. The Respondent's records do not contain any reports from consultants, however.

55. In two occasions in 2008, the Respondent's staff noted that Patient H telephoned the office to report that he lost his Methadone and requested new prescriptions.

56. In his letter to the Board, dated December 19, 2008, the Respondent stated, "[w]hen he has his eye removed, the pain should decrease and will reduce his pain medications."

57. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient H, for reasons including but not limited to the following:

a. the Respondent failed to establish or document establishing a comprehensive treatment plan to address Patient H's complaints of chronic pain;

b. the Respondent failed to take or document taking an adequate history or follow-up histories of Patient H;

c. the Respondent failed to perform or document performing appropriate physical examinations of Patient H;

d. the Respondent's office records are cursory and frequently illegible;

e. the Respondent's office records do not contain any reports from consultants, or address Patient H's non-compliance with his referrals to consultants;

f. the Respondent failed to establish adequate justification for maintaining Patient H on potent narcotics;

g. the Respondent failed to establish a pain contract; and

h. the Respondent's office records do not contain a "contract for pain," or reference the contents of the contract, if one existed.

Patient I

58. The Respondent provided medical records for Patient I involving office visits from 2004 to 2008. In a letter to the Board, dated December 19, 2008, however, the Respondent stated, "[t]his patient has been followed for many years."

59. Patient I, a woman born in 1945, had a medical history that included hypertension, hypothyroidism, gastro esophageal reflux disease ("GERD"), arthritis and stress. During the treatment period reviewed, the Respondent also treated Patient I for upper respiratory infections/sinusitis.

60. During the treatment period, the Respondent prescribed various medications, including blood pressure medications, thyroid medications, Darvocet, and Xanax. On one occasion, a mammogram order was mailed to Patient I. The Respondent did not document any attempts to prescribe other medications for Patient I's anxiety other than benzodiazepines.

61. The Respondent's office records do not contain any laboratory testing results.

62. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient I, for reasons including but not limited to the following:

a. the Respondent failed to provide appropriate preventative care to Patient I;

b. the Respondent failed to order timely laboratory studies to evaluate Patient I's medical conditions, including hypothyroidism;

c. the Respondent did not perform or document performing annual breast examinations;

d. the Respondent did not provide Patient I with annual mammogram orders;

e. the Respondent failed to take or document taking an adequate history or follow-up histories of Patient I;

f. the Respondent failed to perform or document performing appropriate physical examinations of Patient I;

g. the Respondent's medical records are cursory and frequently illegible;

h. the Respondent inappropriately treated Patient I's anxiety;

i. the Respondent prescribed benzodiazepines for Patient I under inappropriate circumstances; and

j. the Respondent did not document his attempts to provide other anti-anxiety medications to Patient I in lieu of benzodiazepines.

Patient J

63. The Respondent provided medical records for Patient J for office visits from 2003 to 2007. In a letter to the Board, dated December 19, 2008, however, the Respondent stated that he began seeing Patient J in 2001. The Respondent further stated, "[h]e received Methadone for chronic back pain, but has difficulty with over using the medication."

64. The Respondent's notes state that Patient J, a male born in 1953, was Methadone dependent. The Respondent saw Patient J on a monthly basis during which time he refilled Patient J's Methadone prescriptions. The Respondent also prescribed other medications in addition to Methadone, including benzodiazepines. The Respondent diagnosed Patient J with chronic pain, anxiety and at times, cellulitis. The Respondent's chart also notes that Patient J was diagnosed with Hepatitis C.

65. In a note dated November 27, 2006, the Respondent ordered laboratory studies. The Respondent's office records do not contain any laboratory findings, however, or document any discussion with Patient J about whether he obtained these studies.

66. Office notes state that in June and July 2007, Patient J was hospitalized. In July 2007, Patient J was reportedly hospitalized after a drug overdose. In subsequent visits, the Respondent continued to prescribe Methadone and benzodiazepines for Patient J. The Respondent's office notes also report that Patient J's sister contacted him and expressed concern that her brother was addicted to drugs. The Respondent subsequently arranged for Patient J's sister to dispense his medications to him.

67. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient J, for reasons including but not limited to the following:

a. the Respondent failed to establish or document establishing a comprehensive treatment plan to address Patient J's chronic pain/drug addiction;

b. the Respondent failed to take or document taking an adequate history or follow-up histories of Patient J;

c. the Respondent failed to perform or document performing appropriate physical examinations of Patient J;

d. the Respondent's office records are cursory and frequently illegible;

e. the Respondent prescribed Methadone and other habituating medications for Patient J under inappropriate circumstances;

f. the Respondent did not establish a diagnosis to justify prescribing Methadone and benzodiazepines for Patient J;

g. the Respondent failed to appropriately address or document addressing Patient J's drug addiction with him;

h. the Respondent failed to obtain timely laboratory testing to evaluate Patient J, or failed to follow up or document following up on Patient J's non-compliance with his recommendations for such testing;

i. the Respondent failed to follow up on or document that he followed up on Patient J's reported Hepatitis C diagnosis; and

j. the Respondent failed to obtain consultants' reports, if such consultations took place.

Patient K

68. Patient K, then a 26-year old woman, initially saw the Respondent on October 19, 2001. The Respondent's office note for this date states that Patient K had been taking narcotics for two and one-half years and wanted to get into the pain clinic at St. Agnes Hospital. The Respondent performed a straight leg raising test that was positive bilaterally. The Respondent diagnosed Patient K with chronic back pain and wrote prescriptions for 300 tablets of 20 mg OxyContin and 60 tablets of Percocet. He also prescribed a tricyclic anti-depressant, Elavil; Lidoderm patches; physical therapy; and referred Patient K for a CT of her lumbosacral spine.

69. Patient K returned on November 13, 2001, with a new complaint, a swollen left ankle. The Respondent diagnosed Patient K with chronic back pain, drug dependence and depression. The Respondent provided additional prescriptions for an additional 300 tablets of 20 mg OxyContin, Percocet and Lidoderm patches. The Respondent dated these prescriptions for November 19, 2001.

70. Thereafter, the Respondent saw Patient K on a frequent basis until 2008. The Respondent initially prescribed OxyContin to Patient K, but then switched to prescribing Methadone in 2004. The Respondent continued prescribing Methadone to Patient K until 2008.

71. The Respondent's office records state that throughout the treatment period, he referred Patient K for various specialty consultations (*e.g.*, physical therapy,

psychological, neurological, neurosurgical), diagnostic studies (*e.g.*, MRI, CT, EMG), and laboratory studies. Aside from an x-ray report and bone scan of the left foot in 2007, which was negative for osteomyelitis or other acute finding, the Respondent's office records do not contain reports of any diagnostic study findings, consultation reports or laboratory studies. The Respondent's office notes do not document whether Patient K obtained these consultations or underwent these studies. The Respondent's office notes do not address why Patient K did not obtain these consultations or undergo these studies.

72. In or around February 2008, the Respondent reportedly referred Patient K for pain management to Carroll Hospital Center. The Respondent's office notes state that after this referral, he continued to prescribe Methadone for Patient K.

73. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient K, for reasons including but not limited to the following:

a. the Respondent inappropriately prescribed narcotics to Patient K over the course of several years without determining objective radiographic findings to support such prescribing;

b. the Respondent failed to establish or document establishing a comprehensive treatment plan to address Patient K's chronic pain complaints/drug addiction;

c. the Respondent prescribed long-term narcotic medications for Patient K in an inappropriate manner;

d. the Respondent failed to take or document taking an adequate history or follow-up histories of Patient K;

e. the Respondent failed to perform or document performing appropriate physical examinations of Patient K;

f. the Respondent's office notes are brief and often illegible;

g. the Respondent inappropriately prescribed Methadone and other habituating medications for Patient K over several years without establishing sufficient medical justification;

h. the Respondent failed to obtain diagnostic studies or consultants' reports, if such studies/consultations took place; and

i. the Respondent failed to address or document addressing Patient K's non-compliance with obtaining consultations/studies.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records as determined by appropriate peer review, in violation of H.O. § 14-404(a)(40).

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 18th day of November 2010, by a quorum of the Board considering this case:

ORDERED that the Respondent's license to practice medicine in the State of Maryland shall be **SUSPENDED** for a minimum period of **ONE (1) YEAR,** with all but **NINETY (90) DAYS** of said suspension **STAYED,** said suspension to commence on December 15, 2010; and it is further

ORDERED that after the conclusion of the **NINETY (90) DAY** period of **SUSPENSION** referred to above, the Board shall lift the suspension of the Respondent's medical license and place him on **PROBATION** for a minimum period of **THREE (3) YEARS**, and continuing until the Respondent successfully complies with the following terms and conditions:

1. Within six (6) months of the date the Board executes this Consent Order, the Respondent shall successfully complete a Board-approved, one-on-one tutorial in medical recordkeeping. The Respondent shall enroll in this required course within three (3) months of the date the Board executes this Consent Order. The Respondent shall submit written documentation to the Board regarding the particular course he proposes to fulfill this condition. The Board reserves the right to require the Respondent to provide further information regarding the course he proposes, and further reserves the right to reject his proposed course and require submission of an alternative proposal. The Board will approve a course only if it deems the curriculum and the duration of the course adequate to satisfy its concerns. The Respondent shall be responsible for submitting written documentation to the Board of his successful completion of this course. The Respondent understands and agrees that he may not use this coursework to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing the Board with adequate written verification that she has completed the course according to the terms set forth herein.

2. Within one (1) year of the date the Board executes this Consent Order, the Respondent shall successfully complete a course of significant duration in the following subject areas: (a) appropriate prescribing practices involving opioid medications and

benzodiazepines; and (b) appropriate pain management practices. The Respondent shall enroll in this coursework within six (6) months of the date the Board executes this Consent Order. The Respondent shall submit written documentation to the Board regarding the particular courses he proposes to satisfy this condition. The reserves the right to require the Respondent to provide further information regarding the courses he proposes, and further reserves the right to reject any proposed course and require submission of alternative proposals. The Board will approve a course only if it deems the curriculum and the duration of the course adequate to satisfy its concerns. The Respondent shall be responsible for submitting written documentation to the Board of his successful completion of this coursework. The Respondent understands and agrees that he may not use any continuing medical education credits earned through this condition to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing the Board with adequate written verification that he has completed this coursework according to the terms set forth herein.

3. The Respondent shall not practice pain management medicine and shall not dispense or prescribe any opiates or benzodiazepine medications to any patient or individual for longer than three (3) days and only in an emergency situation.

4. The Respondent shall keep and maintain adequate medical records that are legible and complete.

5. The Respondent's practice shall be supervised by a Board-approved supervisor (the "Supervisor") who is board-certified in internal medicine, subject to the following terms:

(a) Not less than forty-five (45) days prior to the date the Board lifts the suspension of the Respondent's medical license, the Respondent

shall submit the name and professional credentials of a board-certified specialist in internal medicine for purposes of obtaining Board approval to serve as Supervisor for his practice for the entire three (3) year period of probation. The Supervisor must be approved by the Board's Investigative Review Panel. The Respondent shall provide the Supervisor with a copy of the charging document, this Consent Order, any other documents the Board deems relevant in this case. The Respondent understands and agrees that the Board may terminate any Supervisor and require that another Supervisor be designated.

(b) The Respondent shall ensure that the Supervisor notifies the Board, in writing, within ten (10) days of the Board's approval of his/her acceptance of his/her supervisory role.

(c) The Supervisor shall meet with the Respondent at the Respondent's office and shall hold face-to-face meetings with him on a monthly basis, at which time the Supervisor shall choose a random sample of medical record charts of at least ten (10) active cases to review. The Supervisor shall review the charts to determine the Respondent's compliance with prescribing, quality of care and recordkeeping standards. In addition, the Supervisor shall discuss the cases with the Respondent to evaluate the Respondent's understanding of the conditions he is treating and his compliance with quality of care and recordkeeping standards.

(d) The Supervisor shall submit quarterly written reports to the Board, which shall include but not be limited to the number and types of cases he/she reviewed, medical issues he/she discussed with the Respondent, and his/her assessment of the Respondent's understanding of the conditions he is treating and his compliance with quality of care and recordkeeping standards.

(e) The Respondent shall have sole responsibility for ensuring that the Supervisor submits the required quarterly reports in a timely manner.

(f) The Board has sole authority for implementing any changes in the supervision and retains all authority to approve any changes in the supervision.

(g) In the event that the Supervisor discontinues supervising the Respondent for any reason, the Respondent shall immediately notify the Board. The Respondent shall be solely responsible for submitting a replacement candidate to serve as his Supervisor under the terms specified above.

(h) The Respondent shall be responsible for all costs associated with supervision of his practice.

6. The Board reserves the right to conduct a peer review by an appropriate peer review entity, or a chart review by a Board designee, to be determined at the discretion of the Board.

7. The Respondent shall practice according to the Maryland Medical Practice Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of medicine.

AND IT IS FURTHER ORDERED that after the conclusion of the **entire THREE (3) YEAR** period of **PROBATION**, the Respondent may file a written petition to the Board requesting termination of his probation. After consideration of his petition, the probation may be terminated through an order of the Board or designated Board committee. The Respondent may be required to appear before the Board or designated Board committee. The Board, or designated Board committee, will grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions of this Consent Order, including the expiration of the **THREE (3) YEAR** period of **PROBATION**, and if there are no outstanding complaints related to the charges before the Board; and it is further

ORDERED that if the Respondent violates any of the terms or conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before an administrative law judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing before the Board, may impose any other disciplinary sanction that the Board may have imposed, including a reprimand,

probation, suspension, revocation and/or monetary fine, said violation being proven by a preponderance of the evidence; and it is further

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

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

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't. Code Ann. §§ 10-611 *et seq.* (2009 Repl. Vol.).

11/18/10
Date

John T. Papavasiliou
Deputy Director
Maryland State Board of Physicians

CONSENT

I, C. Thomas Folkemer, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am

waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

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

10/25/10
Date

C. Thomas Folkemer, M.D.
Respondent

Read and approved:

10.28.10
Date

Thomas C. Morrow, Esquire
Counsel for Dr. Folkemer

NOTARY

STATE OF Maryland

CITY/COUNTY OF: Anne Arundel

I HEREBY CERTIFY that on this 25th day of October, 2010, before me, a Notary Public of the State and County aforesaid, personally appeared C. Thomas Folkemer, M.D., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Toni Gerber
Notary Public

My commission expires: 2/4/12

Toni Gerber
Notary Public
Anne Arundel Co., MD
My Commission Expires 2/4/12

I HEREBY ATTEST AND CERTIFY UNDER PENALTY OF PERJURY ON 2/5/2014 THAT THE FORGOING DOCUMENT IS A FULL, TRUE AND CORRECT COPY OF THE ORIGINAL ON FILE IN MY OFFICE AND IN MY LEGAL CUSTODY.

DEPUTY DIRECTOR
MARYLAND BOARD OF PHYSICIANS