IN THE MATTER OF

ROBERT B. KROOPNICK, M.D.

Respondent

License Number: D14753

BEFORE THE

MARYLAND STATE

BOARD OF PHYSICIANS

Case Number: 2013-0643

CONSENT ORDER


Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. § 14-404:

(a) In general. -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a licensee 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 June 11, 2014, a conference was held before Disciplinary Panel A of the Board sitting as the Disciplinary Committee for Case Resolution. As a result of negotiations, the Respondent agreed to enter into this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.
FINDINGS OF FACT

The Board makes the following Findings of Fact:

BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in the State of Maryland on February 5, 1973. The Respondent's license is current through September 30, 2014.

2. At the times relevant hereto, the Respondent was board-certified in internal medicine and maintained an office for the practice of medicine in Pikesville, Maryland.

3. The Board initiated an investigation of the Respondent after receiving an anonymous complaint on or about March 5, 2013, alleging inappropriate prescribing of pain medications.

4. In furtherance of its investigation, the Board submitted patient medical records it obtained from the Respondent for a formal peer review. A summary of the Board's investigative findings from the peer review is set forth below.

GENERAL FINDINGS

5. The Respondent failed to meet quality medical and record keeping standards, in violation of Health Occ. § 14-404(a)(22) and (40), with respect to his treatment of Patients A through E\(^1\), for reasons including:

   a. Failing to perform or document comprehensive evaluations of patients to include: obtaining medical history, performing physical

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\(^1\) To ensure confidentiality, the names of individuals, hospitals and healthcare facilities involved in this case are not disclosed in this document.
examinations, performing pain assessments, and assessing past substance misuse or abuse;

b. Failing to implement written opioid pain care agreements with patients;

c. Failing to devise or document a clear treatment plan for patients;

d. Failing to order routine urine drug screens to monitor patient compliance;

e. Failing to document all patient office visits;

f. Failing to document all medications prescribed to patients;

g. Failing to keep legible progress notes of patient visits; and

h. Failing to document his communications with patients' other healthcare providers.

PATIENT-SPECIFIC FINDINGS

Patient A

6. Patient A, a female born in the 1950s, initially presented to the Respondent sometime in 2009 for pain management and general primary care. Patient A had a history of chronic pain of her back, right groin and right lower extremities stemming from a work-related slip and fall in 2003. The Respondent's records of Patient A contained records from her previous care providers, which indicated a history of analgesic abuse/dependence and psychiatric hospitalization for depression/anxiety.

7. From around June 15, 2009, to August 2, 2011, Patient A was seeing a pain specialist ("Physician A") at a pain management facility ("Facility A"), at the same
time she saw the Respondent. In a progress note, dated June 15, 2009, Physician A stated, "This patient presents with a five-year history of chronic pain complaints which apparently do not appear to be clearly delineated and have been managed primarily with high dose narcotic medications in the past." Under "Recommendation/Treatment Plan," Physician A stated, "I do not believe that narcotic medication is a long-term solution for her pain complaints."

8. On or about August 2, 2011, Facility A discharged Patient A from further treatment, stating it received validated information that Patient A was receiving narcotic pain medications from another provider, while receiving pain medications from Facility A.

9. From around January 2012 to August 2013, the Respondent saw Patient A on a monthly basis, during which he prescribed to her on a combination of medications that included OxyContin,\(^2\) oxycodone,\(^3\) Ambien CR\(^4\) and Carisoprodol.\(^5\)

10. The Respondent's progress notes of Patient A from January 2012 to August 2013 consisted of templates with preprinted checkboxes. The handwritten notes the Respondent made were largely illegible. The medications listed in the progress notes lacked any information as to the dosages or the quantities prescribed.

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\(^2\) OxyContin, a brand name for oxycodone, is a Schedule II opioid pain medication used to treat moderate to severe pain.

\(^3\) Oxycodone is a Schedule II opioid pain medication used to treat moderate to severe pain.

\(^4\) Ambien, a brand name for zolpidem tartrate, is a Schedule IV CDS indicated for the short-term treatment of insomnia.

\(^5\) Carisoprodol is a Schedule IV muscle relaxant is used to relax muscles and relieve pain.
11. During the time period the Respondent treated Patient A, he failed to implement a written opioid pain care agreement with Patient A and ordered a urine drug screen only once, which occurred on or about August 7, 2013.

12. In his care of Patient A, the Respondent failed to meet quality medical and record keeping standards, in violation of Health Occ. § 14-404(a)(22) and (40), for reasons as set forth in the general findings above.

Patient B

13. Patient B, a male born in the 1950s, had been a patient of the Respondent's for "many years," according to his written summary of care to the Board. Patient B was morbidly obese and had a history of severe osteoarthritis with diffuse degeneration of the cervical spine and cervical cord syndrome caused by his being struck in the head by a beam in 2004 for which he underwent posterior laminectomy and fusion.

14. From around the late 1990s to August 6, 2013, when he was discharged from practice, Patient B saw the Respondent on a regular basis for chronic pain and primary care issues. Beginning in or around the mid-2000, the Respondent maintained Patient B on a combination of medications that included OxyContin 80 mg (four times daily), oxycodone 30 mg (four times daily) and Adderall 30 mg\(^6\) (three times daily).

15. The Respondent's progress notes of Patient B consisted mostly of templates with preprinted checkboxes. The handwritten notes the Respondent made were largely illegible. The medications listed in the progress notes lacked any information as to the dosages or the quantities prescribed.

\(^6\) Adderall, a brand name for amphetamine and dextroamphetamine, is a Schedule II central nervous system stimulant used to treat attention deficit hyperactivity disorder.
16. In a progress note, dated July 10, 2013, the Respondent stated thatPatient B was "Very depressed right now. Very depressed at the present time." TheRespondent 's plan of care was simply "We will go from there."

17. Despite having treated Patient B's chronic pain issues for "many years,"the Respondent failed to implement a written opioid pain care agreement with Patient B.Furthermore, Patient B was only ordered to take urine drug screens on two occasions,once on or about November 12, 2012, and the other on or about July 31, 2013. Withrespect to the November 12, 2012, urine drug screen, Patient B tested positive formarijuana metabolite, but the Respondent never discussed or document discussing theabnormal test result with Patient B in subsequent office visits.

18. In his care of Patient B, the Respondent failed to meet quality medical andrecord keeping standards, in violation of Health Occ. § 14-404(a)(22) and (40), forreasons that are set forth in the general findings above.

Patient C

19. According to his written response to the Board, the Respondent providedcare to Patient C, a male born in the 1950s, for fibromyalgia, chronic joint pain,osteoarthritis, back pain and severe diabetic neuropathy before the year 2000. Patient Crelocated at some point in time, and the Respondent did not see him for some time. The Respondent resumed care of Patient C in or around June 2009 until October 1,2012, when he discharged Patient C for non-compliance.
20. From the documentation the Respondent provided, he prescribed oxycodone 30 to 15 mg (four times daily) and alprazolam 2 mg\textsuperscript{7} (three times daily) to Patient C on a monthly basis. The Respondent's progress notes of visits by Patient C consisted of templates with preprinted checkboxes. The handwritten notes the Respondent made were largely illegible. The medications listed in the progress notes lacked any information as to the dosages or the quantities prescribed.

21. During Patient C's treatment period, the Respondent failed to implement a written opioid pain care agreement. Furthermore, the Respondent failed to order any routine urine drug screens to monitor Patient C's compliance.

22. In his care of Patient C, the Respondent failed to meet quality medical and record keeping standards, in violation of Health Occ. § 14-404(a)(22) and (40), for reasons that are set forth in the general findings above.

**Patient D**

23. Patient D, a male born in the 1960s, had been under the Respondent's care on a consistent basis since late 2001. Patient D saw the Respondent in or around 2010 after being treated at an area hospital for a fractured femur and serious injuries to the right foot as a result of a motorcycle accident. Patient D had a history of two cervical spine surgeries, repairs of a femur fracture, foot trauma and significant degenerative disease of the spine and knee.

24. In his written summary of care to the Board, the Respondent stated that he had been Patient D's "doctor for many years," that Patient D was on OxyContin 40

\textsuperscript{7} Alprazolam is a Schedule IV benzodiazepine medication used to treat anxiety disorder, panic disorder, and anxiety caused by depression.
mg twice daily and oxycodone 30 mg three times a day, and that Patient D visited his office every month.

25. The progress notes the Respondent kept of Patient D consisted of templates with preprinted checkboxes. The handwritten notes the Respondent made were largely illegible. The medications listed in the progress notes lacked any information as to the dosages or the quantities prescribed.

26. Despite having treated Patient D's chronic pain issues with opioid analgesics for "many years," the Respondent failed to implement a written opioid pain care agreement with Patient D. Furthermore, the Respondent failed to order that Patient D undergo routine or random urine drug screens to monitor his compliance.

27. In his care of Patient D, the Respondent failed to meet quality medical and record keeping standards, in violation of Health Occ. § 14-404(a)(22) and (40), for reasons that are set forth in the general findings above.

Patient E

28. Patient E, a female born in the 1950s, was a patient of the Respondent's, who had a history of Large Cell Non-Hodgkin's Lymphoma, hysterectomy complicated by a laceration of the ureter, chronic pain syndrome associated with fibromyalgia and neuropathic pain, bipolar disorder and significant anxiety. Although Patient E was under the care of a pain specialist, the Respondent stated in his written response to the Board that he regularly prescribed MS Contin 30 to 60 mg\(^8\) (twice daily), Dilaudid 8 mg\(^9\) (every

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\(^8\) MS Contin, a brand name for morphine sulfate, is a Schedule II opioid pain medication used to treat moderate to severe pain.

\(^9\) Dilaudid, a brand name for hydromorphone, is a Schedule II opioid pain medication used to treat moderate to severe pain.
six hours), Ambien 10 mg and Lorazepam 2 mg\textsuperscript{10} (four times daily) to her in coordination with her pain specialist.

29. The Respondent had been her family physician since at least April 12, 2011.

30. The Respondent’s progress notes of Patient E consisted of templates with preprinted checkboxes. There was virtually no information with respect to the Respondent’s encounter with Patient E, let alone his diagnoses and treatment plans.

31. Also absent from the Respondent’s records of Patient E were problem lists, medication lists, copies of all prescriptions issued, correspondence with Patient E’s other physicians, or any documentation coherently reflecting the Respondent’s treatment of Patient E.

32. In his care of Patient E, the Respondent failed to meet quality medical and record keeping standards, in violation of Health Occ. § 14-404(a)(22) and (40), for reasons that are set forth in the general findings above.

**Patient F**

33. Patient F, a male born in the 1950s, was a patient of the Respondent’s, who had a history of morbid obesity, diabetes mellitus, coronary artery disease with myocardial infarction in 1993 and 1996, coronary artery bypass graft and chronic pain syndrome. The Respondent was managing Patient F’s chronic pain with regular prescriptions for oxycodone 30 mg (#120) and Percocet 10/325 mg.\textsuperscript{11}

34. The Respondent stated in his written summary of care to the Board that Patient F had been his patient for "many years," but Patient F’s records provided by the

\textsuperscript{10} Lorazepam is a Schedule IV benzodiazepine medication used to treat anxiety disorder.

\textsuperscript{11} Percocet, a brand name for oxycodone and acetaminophen, is a Schedule II opioid pain medication used to treat moderate to severe pain.
Respondent did not indicate when he started treating Patient F. The earliest documentation in Patient F's records was a letter from the Respondent, dated April 12, 2007.

35. The Respondent's progress notes of Patient F consisted of templates with preprinted checkboxes. The handwritten notes the Respondent made were largely illegible. The medications listed in the progress notes lacked any information as to the dosages or the quantities prescribed.

36. Also absent from Patient F's record were problem lists, medication lists, copies of all prescriptions issued, correspondence with Patient F's other physicians, or any documentation coherently reflecting the Respondent's treatment of Patient F.

37. In his care of Patient F, the Respondent failed to meet quality medical and record keeping standards, in violation of Health Occ. § 14-404(a)(22) and (40), for reasons that are set forth in the general findings above.

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 performed in an office in this state, in violation of Health Occ. § 14-404(a)(22); and failed to keep adequate medical records as determined by appropriate peer review, in violation of § 14-404(a)(40).
ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 15th day of July, 2014, by a majority of the quorum of Disciplinary Panel A of the Board considering this case:

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

ORDERED that the Respondent is placed on PROBATION for a minimum of ONE (1) YEAR, and until all of the following terms and conditions are fully and satisfactorily complied with:

1. Within SIX (6) MONTHS of the date the Board executes this Consent Order, the Respondent shall enroll in and successfully complete Board-approved courses in 1) the proper approach to prescribing controlled dangerous substances, and 2) medical recordkeeping (completion of the medical recordkeeping course may extend beyond the six-month period). The Respondent shall be responsible for all costs incurred in fulfilling the course requirements and shall be responsible for submitting written documentations to the Board showing that he has successfully completed the courses. The courses shall not apply toward, and shall be in addition to, the Continuing Medical Education requirements for continued medical licensure in Maryland;

2. The Respondent shall permanently not treat any new chronic pain patients, where chronic pain patients are defined as patients receiving Controlled Dangerous Substances ("CDS") for a period of longer than three months;

3. The Respondent shall initiate an opioid taper with his current opioid patients, to be completed within two months of this Consent Order, or shall transfer his opioid patients to a board-certified pain medicine specialist, for their pain management care, within two months of the execution of the Consent Order;

4. Disciplinary Panel A reserves the right to conduct a peer review by an appropriate peer review entity, or a chart review by a designee, of the Respondent's practice, to be determined at the discretion of Disciplinary Panel A;
5. The Respondent shall pay a monetary fine in the amount of **FIVE THOUSAND DOLLARS ($5,000)** by bank certified check or money order made payable to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297 **within thirty (30) days** of the execution of this Consent Order; and

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

**AND IT IS FURTHER ORDERED** that after one (1) year from the date the Consent Order goes into effect, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board, or a 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 and there are no pending complaints related to the charges; and it is further

**ORDERED** that if the Respondent violates any of the terms and conditions of this Consent Order, including an unsatisfactory chart and record review, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before the Office of Administrative Hearings if there is a genuine dispute as to the underlying facts, or an opportunity for a show cause hearing before the Board otherwise, may impose any sanction which the Board may have imposed in this case, including probationary terms and conditions, a reprimand, suspension, revocation and/or a monetary penalty; 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 this Consent Order; and it is further


July 15, 2014
Christine A. Farrelly
Acting Executive Director
Maryland State Board of Physicians

CONSENT

I, ROBERT B. KROOPNICK, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.
I sign this Consent Order, voluntarily and without reservation, after having an 
opportunity to consult with counsel, and I fully understand and comprehend the 
language, meaning and terms of this Consent Order.

Date

Robert B. Kroopnick, M.D.

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 14 day of July, 2014, before me, a Notary Public of the foregoing State and City/County personally 
appear Robert B. Kroopnick, M.D., License Number D14753, and made oath in due 
form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Notary Public

My commission expires: 11/07/2015