

IN THE MATTER OF

* BEFORE THE

BRUCE RIND, M.D.

* STATE BOARD OF PHYSICIAN

Respondent

* QUALITY ASSURANCE

License Number: D37186

* Case Number: 98-0507

* * * * *

CONSENT ORDER

PROCEDURAL BACKGROUND

The State of Maryland Board of Physician Quality Assurance (the "Board"), on December 15, 1999, voted to charge Bruce Rind, M.D. (the "Respondent") (D.O.B. January 16, 1951), License Number D37186, under the Maryland Medical Practice Act (the "Act"), MD. CODE ANN., HEALTH OCC. ("H.O.") § 14-404 (1999 Supp.).

The pertinent provisions of the Act provide the following:

Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

- (3) Is guilty of immoral or unprofessional conduct in the practice of medicine;
- (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;
- (23) Wilfully submits false statements to collect fees for which services are not provided; and
- (40) Fails to keep adequate medical records as determined by appropriate peer review.

The Board also charged that Respondent violated the following statutory and

regulatory provisions which, in pertinent part, state:

Md. Code Ann., Health Occ. § 14-506 (Supp. 1999) :

(b) *Registration required* - Unless licensed under Title 1A of this article¹, a physician shall be registered by the Board before the physician may perform acupuncture in this State.

(g) *Reprimand, probation, suspension and revocation* - Subject to the hearing provisions of § 14-405 of this title, the Board, on the affirmative vote of a majority of its full authorized membership, may reprimand or place a physician who performs acupuncture on probation or suspend or revoke the registration of a physician for:

(1) Any conduct prohibited under the provisions of this section or prohibited under any regulation adopted pursuant to the provisions of this section[;].

The Code of Maryland Regulations adopted pursuant to § 14-506 specify in pertinent part:

MD. Regs. Code ("COMAR") tit.10 § 32.15.03 - Unprofessional conduct in the practice of medicine includes the failure of a physician to:

A. Comply with the statute and regulations governing physicians who perform acupuncture, and includes representing oneself as a registered acupuncturist without having met all the previous requirements; and

B. Be registered by the Board, or to have met all the requirements of Health Occupations Article, §§ 1A-101-1A-502²

On September 28, 2000, Respondent was subsequently notified of the Board's charges by certified mail to Respondent's counsel, Alan Dumoff, Esquire.

On November 1, 2000, Respondent, his attorney Alan Dumoff, Esquire, and Janet

¹Title 1A of the Health Occupations Article is the Maryland Acupuncture Act.

²§§ 1A-101-1A-502 is the Maryland Acupuncture Act.

Klein Brown, Administrative Prosecutor, appeared before the Case Resolution Conference Committee (the "CRC") of the Board. As a result of negotiations with the Office of the Attorney General, Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law and Order, with the terms and conditions set forth below.

FINDINGS OF FACT

I. Background

1. At all times relevant to these Charges, Respondent was and is a physician licensed to practice medicine in Maryland. The Respondent was originally issued a license to practice medicine in Maryland on or about August 10, 1988, being issued license number D37186. Respondent also has active licenses to practice medicine in Virginia and Washington, D.C.

2. At all times relevant hereto, Respondent has maintained an office for the practice of medicine in Rockville, Maryland.³ Respondent's self-designated specialty is anesthesiology, having been Board certified by the American Board of Anesthesiology in January 1988.

3. On or about January 12, 1998, the Board received correspondence from Blue Cross Blue Shield of the National Capital Area ("BC/BS"), informing the Board that upon reviewing ten (10) medical records and related claims in 1994, BC/BS determined that the services were "outside the standard of good medical practice" because the services rendered were considered by BC/BS to be related to the "treatment of environmental

³Respondent's solo practice is called "Center for Holistic Medicine."

Illness," a non-covered service. BC/BS referred the cases to the Board for its review.

4. Based on the complaint, the Board initiated an investigation of the matter.

5. The Board subpoenaed records, including Quality Assurance records from Kaiser Permanente and from Private HealthCare Systems ("PHCS"). Respondent was terminated from PHCS in March 1998 because certain laboratory testing was not considered by PHCS to be appropriate or acceptable in the general medical community and the medical necessity of intravenous therapy has not been substantiated.

6. On or about February 5, 1999, the Board requested the Medical and Chirurgical Faculty of Maryland ("Med Chi"), or an appropriate component society, to conduct a practice review of Respondent's medical practice.

7. Thereafter, the Montgomery County Medical Society ("MCMS") Peer Review Committee conducted a peer review. Two Board certified physicians, one in anesthesiology and one in internal medicine, reviewed thirteen (13)⁴ randomly selected medical records of Respondent's patients, the 1998 letter from BC/BS, and a July 10, 1998 letter of response written by Respondent's attorney on Respondent's behalf, and determined that the standard of quality care was not met and the medical records documentation was not adequate in twelve (12)⁵ of the thirteen (13) cases.

8. On November 19, 1999, the Board received the report of the MCMS Peer Review Committee. The Peer Reviewers noted that there were multiple deficiencies in

⁴Fourteen (14) records were sent to Med Chi, but only thirteen (13) were reviewed

⁵The "conclusion" of the Peer Review Report states the Respondent breached the standard of care in eleven of the charts reviewed; however, the text of the report cites that the standard was not met in twelve of the cases.

caring for the patients reviewed which included the following:

- a. Not obtaining informed consent on a number of patients who were given non-conditional (sic) treatments. (i.e. intravenous vitamin and colchicine therapy and prolotherapy);
- b. Billing for comprehensive visits when, in fact, the Respondent's documentation included limited information with respect to symptoms and physical findings;
- c. Inappropriate follow up with respect to diagnostic evaluation for patients presenting with significant clinical conditions;
- d. Identifying complex medical diagnoses without supporting history, physical examination and/or laboratory testing; and
- e. Respondent performed acupuncture on two of the patients who were reviewed.

II. **Patient Specific Allegations Regarding Failure to Deliver Quality Medical Care, Inadequate Medical Records and False Statements to Collect a Fee**

Patient 1⁶

9. Patient 1, then a 59 year old male (d.o.b. 5/2/36), was treated by Respondent on numerous occasions between January 4, 1995 and December 13, 1995 for myofascial pain following a motor vehicle accident and for supra-nuclear palsy.

10. Respondent saw Patient 1 on an initial office visit of January 4, 1995. Respondent noted blank facial expression and restricted range of motion of the neck. Respondent's initial assessment was incomplete in that he did not note that Patient 1 had been in an automobile accident, failed to document subjective complaints and a plan of treatment. Respondent's physical examination was limited to an assessment of reflexes

⁶Patient names are confidential and are not used in the Consent Order. Respondent is aware of the identity of each of the patients, having been provided a Confidential Patient Identification List enumerating each of the patients and their names.

and a neurological examination.

11. Respondent charged Patient 1 \$200 for an "office consult, detailed", CPT⁷ Code 99244. In 1995, CPT Code 99244 referred to an:

[O]ffice consultation for a new or established patient, which requires these three key components; a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.

CPT Code 1995.

12. Respondent did not document a comprehensive history; comprehensive examination; and assessment of moderate complexity to support coding and charging for performance of a detailed office consultation.

13. On January 4, 1995, Respondent diagnosed "supranuclear palsy secondary to heavy metal toxicity from fillings" without objective laboratory data of mercury levels. Respondent alleges that the diagnosis of supranuclear palsy was by history from Patient 1 and that he intended to "rule out" the diagnosis of "secondary to heavy metal toxicity" by a diagnostic trial of chelation therapy.

14. On June 26, 1995, Patient 1 presented with "mild hemoptysis" (coughing up blood). Respondent alleges that Patient 1's symptoms were vague. Respondent's treatment plan was "will observe." Respondent did not follow-up and obtain a chest x-ray or refer Patient 1 to his primary care physician for further assessment. On Respondent's office billing form, Respondent only noted a diagnosis of "Mercury Toxicity." Respondent saw Patient 1 for a return visit on June 30, 1995 but did not document any progress note.

⁷The CPT code, or "Physicians' Current Procedural Terminology," published by the American Medical Association, is a listing of descriptive terms and identifying codes for reporting medical services performed by physicians.

including any follow-up of the hemoptysis. Respondent alleges that the coughing up blood did not reoccur.

15. Respondent saw Patient 1 on six (6) occasions between October 3, 1995 and December 13, 1995 for intravenous (IV) vitamin therapy without documenting Patient 1's progress, other than a brief note on October 18, 1995.

16. Respondent did not inform Patient 1 of the non-conventional nature of, and side effects and risks of, IV vitamin therapy, did not inform Patient 1 of conventional treatment options, and did not obtain Patient 1's informed consent to treatment with IV vitamin therapy. Respondent obtained Patient 1's written consent for oxidative (hydrogen peroxide) therapy, chelation therapy, and bee venom therapy; however, Respondent, did not inform Patient 1 of conventional treatment options. Respondent alleges that Patient 1 had knowledge of and had availed himself of conventional neurological treatment options.

Patient 2^a

Patient 3

17. Patient 3, then a 51 year old male (d.o.b.1/21/43), initially presented to Respondent on August 23, 1994 with complaints of possible right ankle sprain six weeks previously. Respondent examined the ankle and assessed "lat(eral) ankle ligament laxity." Respondent treated Patient 3 with prolotherapy⁹.

18. Respondent did not inform Patient 3 of the non-conventional and

^aThere are no charges in regard to Patient 2.

⁹Prolotherapy is the injection of an irritating solution in the joints, tendons and ligaments, intended to stimulate additional ligament and fibrous tissue growth.

experimental nature of, and side effects and risks of, prolotherapy, did not inform Patient 3 of conventional treatment options, and did not obtain Patient 3's informed consent to treatment with prolotherapy.

19. Respondent charged Patient 3 \$200 for a "level 5" office visit, CPT Code 99205, "Comprehensive/Complex New Office Visit." In 1994, CPT Code 99205 referred to an:

[O]ffice or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination and medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

CPT Code 1994.

20. Respondent did not document a comprehensive history; subjective complaints, including amount and description of pain; comprehensive physical examination, including notation of limitations, tenderness, swelling, discoloration; and assessment of high complexity to support coding and charging for performance of a comprehensive/complex examination.

21. On December 19, 1997, Patient 3 presented with a left ankle injury that he had sustained one month before. Respondent noted edema and severe sprain and diagnosed "medial/lat(eral) ligament sprained." Respondent treated Patient 3 with bee venom therapy¹⁰. Respondent charged Patient 3 for a "level 4" office visit, CPT code 99214, "Detailed Established Office Visit." In 1997, Code 99214 referred to an:

[O]ffice or other outpatient visit for the evaluation and management of an

¹⁰Bee venom therapy, a form of apitherapy, is the injection of bee venom in certain points, spots or locations in the body.

established patient, which requires at least two of these three key components: a detailed history, a detailed examination; medical decision making of moderate complexity. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

CPT Code 1997.

22. Respondent did not document Patient 3's subjective complaints, including the presence of pain, did not document an examination including the color of the skin and the location of any tenderness, and did not document an assessment of moderate complexity to support coding and charging for performance of a detailed examination of an established patient.

Patient 4

23. Patient 4, then a 46 year old female (d.o.b. 9/18/49), was seen by Respondent from December 1995 through June 1998 for problems primarily centered around myofascial pain.

24. On October 24, 1997, Respondent saw Patient 4 and noted "right frontal maxillary sinusitis." On October 24, 1997, Respondent treated Patient 4 with acupuncture to sinuses.

25. On June 18, 1998, Respondent saw Patient 4 and noted "right inner ear slightly full." On June 18, 1998, Respondent treated Patient 4 with acupuncture for right ear drainage.

Patient 5

26. Patient 5, then a 46 year old female (d.o.b. 1/14/52), was seen by Respondent from April 1998 to July 1998.

27. Patient 5 presented with low back pain and sciatica which Respondent

treated with prolotherapy and bee venom therapy. Respondent also administered IV colchicine therapy¹¹ and IV vitamins to Patient 5. Respondent did not inform Patient 5 of the non-conventional and experimental nature of, and side effects and risks of, IV colchicine therapy and IV vitamins, did not inform Patient 5 of conventional treatment options, and did not obtain Patient 5's informed consent to treatment with IV colchicine therapy and IV vitamins.

28. On May 11, 1998, Patient 5 presented with severe lower back pain. Respondent noted some low back muscle tightness. Respondent performed acupuncture on Patient 5's right and left back.

Patient 6

29. Patient 6, then a 45 year old female (d.o.b. 8/22/49), was seen by Respondent from January 1994 through November 1994. Patient 6 initially presented on January 14, 1994 with hip pain, disturbance in sight, lack of energy.

30. On January 14, 1994, Respondent charged Patient 6 \$200 for a "Comprehensive/Complex Established Patient Office Visit, CPT Code 99215. In 1994, CPT Code 99215 referred to an:

[Office] or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity.

CPT Code 1994.

31. Patient 6 completed a Medical History Questionnaire but Respondent did not comment on the history, mention any pertinent points in the history and did not mention

¹¹Colchicine is an oral medication used to treat gout.

Patient 6's presenting complaint. Respondent identified trigger points in the right gluteal and performed dry needle technique. Respondent performed an eye examination and referred Patient 6 to an ophthalmologist. Respondent did not render a diagnosis.

32. Respondent did not document his findings in regard to a comprehensive history; subjective complaint; comprehensive physical examination; and an assessment of high complexity to support coding and charging for performance of a comprehensive/complex office visit.

33. On May 6, 1994, Respondent rendered a diagnosis on Patient 6 of nutritional anemia and Vitamin B12/Folic Acid Deficiency. Respondent did not obtain a vitamin B12 level. Patient 6's hemoglobin and hematocrit on May 7, 1994 were normal. Respondent gave Patient 6 vitamin B12 shots periodically, beginning in May 1994. Respondent alleges that he rendered the diagnosis of nutritional anemia and Vitamin B12/Folic Acid Deficiency based on clinical presentation and a plan for a diagnostic trial of Vitamin B12.

34. On May 6, 1994, Respondent charged Patient 6 \$130 for a "Comprehensive/Complex Established Patient Office Visit CPT Code 99215."¹² Respondent did not document an office visit on May 6, 1994 in Patient 6's progress notes.

35. Respondent saw Patient 6 approximately monthly from June through November 1994 for IM vitamin therapy. Respondent did not document Patient 6's progress in the medical record, other than a note on May 26, 1994.

36. Respondent did not inform Patient 6 of the non-conventional nature of, and

¹²See paragraph 30 for a description of CPT Code 99215 in 1994.

risks and side effects of, IM vitamin therapy, did not inform Patient 6 of conventional treatment options, and did not obtain Patient 6's informed consent to treatment with IM vitamins.

Patient 7

37. Patient 7, then a 55 year old male (d.o.b. 10/12/42), initially presented to Respondent on May 27, 1998 with right knee pain. Respondent treated Patient 7 with prolotherapy and honey bee venom therapy.

38. Respondent charged Patient 7 \$215 for a "level 5" office visit, CPT Code 99205, "Comprehensive/Complex New Office Visit." CPT Code 99205. In 1998, CPT Code 99205 referred to an:

(O)ffice or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity.

CPT Code 1998.

39. Patient 7 completed a Medical History Questionnaire but Respondent did not comment on the pertinent points in the history, did not document a description of symptoms, physical examination, diagnosis or treatment plan to support coding and charging for performance of a comprehensive/complex examination.

Patient 8

40. Patient 8, then a 47 year old female (d.o.b. 4/8/51), was seen by Respondent on May 7, 1998 with complaint of a 2 to 3 month history of right wrist pain. Patient 8 completed a Medical History Questionnaire. Respondent examined Patient 8's right upper extremity and ordered laboratory work. Respondent treated Patient 8 with

trigger point injections.

41. On May 7, 1998, Respondent charged Patient 8 \$215 for a "level 5" office visit, CPT Code 99205, "Comprehensive/Complex New Office Visit."¹³ Respondent obtained a limited history and documented a limited examination and ordered some laboratory work but did not document an assessment of the right wrist pain to support coding and charging for performance of a comprehensive/complex examination.

Patient 9

42. Patient 9, then a 31 year old female (d.o.b. 3/10/67), presented to Respondent on June 29, 1998 with a lesion on her upper lip. Respondent noted a 3mm. diameter papule and made an assessment that the lesion appeared "more viral than neoplastic." Respondent reviewed treatment options of either applying an herbal preparation or biopsying the lesion. Patient 9 opted for the herbal preparation.

43. On June 29, 1998, Respondent charged Patient 9 \$215 for a "level 5" office visit, CPT Code 99205, Comprehensive/Complex New office Visit."¹⁴ Patient 9 completed a Medical History Questionnaire but Respondent did not comment on the pertinent points of the history. Respondent noted the subjective complaint of a bump on the upper lip, noted a history which was limited to the bump and conducted an examination which was limited to the bump. Respondent did not document a comprehensive history; a comprehensive examination and an assessment of high complexity to support coding and charging for performance of a comprehensive/complex examination.

¹³See paragraph 38 for a description of CPT Code 99205 in 1998.

¹⁴See paragraph 38 for a description of CPT Code 99205 in 1998.

44. Patient 9 returned for an office visit on August 14, 1998. Respondent noted that the lesion fell off twice but returned, smaller in size. Respondent charged Patient 9 \$130 for a "level 5" office visit, CPT Code 99215, "Comprehensive/Complex Established Office Visit". In 1998, CPT Code 99215 referred to an:

[Office] or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity.

CPT Code 1998.

45. Respondent did not document a comprehensive history; a comprehensive examination and an assessment of high complexity to support coding and charging for performance of a comprehensive/complex office visit.

46. Respondent noted in the medical record that he offered Patient 9 bee venom therapy. Patient 9 signed a consent form for Honey Bee Venom Therapy; however, Respondent did not inform Patient 9 of conventional treatment options.

Patient 10

47. Patient 10, then a 48 year old female (d.o.b. 9/24/49), presented to Respondent on June 26, 1998, with a 17 year history of rheumatoid arthritis.

48. On June 26, 1998, Respondent charged Patient 10 \$215 for a "level 5" office visit, CPT Code 99205, "Comprehensive/Complex New Office Visit."¹⁵ Patient 10 completed a Medical History Questionnaire. Respondent performed an examination which focused on Patient 10's arthritis. Respondent did not comment on the pertinent points in the medical history. Respondent did not document a comprehensive history; a

¹⁵See paragraph 38 for a description of CPT Code 99205 in 1998 .

comprehensive examination; and an assessment of high complexity to support coding and charging for performance of a comprehensive/complex examination.

49. On June 29, 1999, Respondent gave Patient 10 IV treatments. Respondent did not document the substances or the amount in the intravenous solution.

50. Respondent did not inform Patient 10 of the non-conventional nature of, and side effects and risks of, the IV vitamin treatment, did not inform Patient 10 of conventional treatment options, and did not obtain Patient 10's informed consent to IV vitamin therapy.

Patient 11

51. Patient 11, then a 66 year old female (d.o.b. 2/8/32), presented to Respondent on January 28, 1998 with a complaint of knee pain. Respondent treated Patient 11 with prolotherapy and bee venom therapy. Respondent obtained Patient 11's written consent for honey bee venom therapy; however, Respondent, did not inform Patient 11 of conventional treatment options.

52. Respondent did not inform Patient 11 of the non-conventional and experimental nature of, and side effects and risks of, prolotherapy, did not inform Patient 11 of conventional treatment options, and did not obtain Patient 11's informed consent for prolotherapy.

Patient 12

53. Patient 12, then a 45 year old male (d.o.b. 1/24/53), was seen by Respondent on multiple occasions between February 16, 1998 and December 1998 for low back pain and sacroiliac instability.

54. On February 16, 1998 Respondent charged Patient 12 \$215 for a "level 5"

office visit, CPT Code 99205, "Comprehensive/Complex New Office Visit."¹⁶ Patient 12 completed a Medical History Questionnaire. Respondent performed a review of systems and a limited examination. Respondent did not reference the pertinent points of the medical history and did not perform an adequate examination of Patient 12's back, the area of the presenting complaint. Respondent did not document a comprehensive history; comprehensive physical examination and an assessment of high complexity to support coding and charging for performance of a comprehensive/complex office visit.

55. Respondent prescribed prolotherapy, intravenous vitamins and colchicine. Respondent obtained Patient 12's written informed consent for prolotherapy but did not inform Patient 12 of conventional treatment options.

56. Respondent did not inform Patient 12 of the non-conventional and experimental nature of, and side effects and risks of, IV vitamins and IV colchicine, did not inform Patient 12 of conventional treatment options, and did not obtain Patient 12's informed consent to treatment with IV vitamins and IV colchicine.

57. On October 8, 1998, Respondent noted in the medical record, "right SI rib pain also systemic yeast." Respondent made a diagnosis of systemic yeast based solely on patient report. Respondent prescribed 31 tablets of Diflucan, a potent antifungal. The record does not demonstrate that Respondent obtained a history or performed an examination to support the diagnosis of a yeast related illness. Respondent alleges that he obtained a full history and performed a full examination, but did not document the history or the examination.

¹⁶See paragraph 38 for a description of CPT Code 99205 in 1998.

Patient 13

58. Patient 13, then a 56 year old female (d.o.b. 4/10/41), initially presented to Respondent on February 25, 1998, with a complaint of pain in the right foot for one year.

59. On February 25, 1998, Respondent charged Patient 13 \$215 for a "level 5" office visit, CPT Code 99205, "Comprehensive/Complex New Office Visit."¹⁷ Patient 13 completed a Medical History Questionnaire. Respondent noted "pain at Rt foot" and noted that lumbar x-rays were unremarkable. Respondent's physical examination consisted of "Rt leg short." Respondent did not comment on the pertinent points in the medical history and did not document a comprehensive history; comprehensive physical examination and an assessment of high complexity to support coding and charging for performance of a comprehensive/complex office visit.

60. Respondent saw Patient 13 for 5 additional visits through June 1998, during which time Respondent performed prolotherapy and osteopathic manipulation. Respondent did not inform Patient 13 of the non-conventional and experimental nature of, and side effects and risks of, prolotherapy, did not inform Patient 13 of conventional treatment options, and did not obtain Patient 13's informed consent to prolotherapy.

Patients 1, 3, and 6 through 13

61. Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to keep adequate medical records of Patients 1, 3, and 6 through 13, including but not limited, in that he:

- a. failed to document patients' symptoms, physical findings, diagnoses and treatment plans;

¹⁷See paragraph 38 for a description of CPT Code 99205 in 1998.

- b. failed to document patients' progress;
- c. failed to document follow-up of mild hemoptysis;
- d. diagnosed supranuclear palsy secondary to heavy metal toxicity from dental fillings without objective laboratory data of mercury levels or other proper documentation of the basis for the diagnosis;
- e. diagnosed anemia in a patient with normal blood counts and diagnosed vitamin B12/Folic Acid Deficiency without obtaining a vitamin B12 level or serum methylmalonic acid level;
- f. rendered a diagnosis of systemic yeast based on inadequate documentation of patient history and examination;
- g. failed to document the substances and amounts used in intravenous therapy;
- h. failed to obtain patients' informed consent to treatment with IV vitamin therapy, colchicine therapy, and prolotherapy; and
- i. Failed to inform patients of conventional treatment options to alternative treatments.

62. Respondent wilfully submitted false statements to collect fees for services

which were not provided in regard to Patients 1, 3, 6-10, 12, 13 in that he:

- a. charged patients for comprehensive/complex office visits without obtaining or documenting comprehensive histories, performing comprehensive/complex examinations and making assessments of high complexity; and
- b. charged patients for detailed office visits without obtaining or documenting detailed histories, performing detailed examinations and making assessments of moderate to high severity.

III. **Immoral and Unprofessional Conduct and Performing Acupuncture without Registration and Representing Self as a Registered Acupuncturist**

63. On October 24, 1997, Respondent performed acupuncture on Patient 4.

(See paragraph 24 above.)

64. On June 18, 1998, Respondent performed acupuncture on Patient 4. (See paragraph 25 above.)

65. On May 11, 1998, Respondent performed acupuncture on Patient 5. (See paragraph 28 above.)

66. In correspondence of October 1997 to Private HealthCare Systems ("PHCS"), Respondent used office letterhead which states "acupuncture" as one of his areas of practice.

67. On a fax cover sheet sent on July 23, 1996 in regard to Patient 4, Respondent used office letterhead which states "acupuncture" as one of his areas of practice.

68. In office literature describing his practice, Respondent stated he has "MD and acupuncture licenses."

69. Respondent is not certified by the Board to practice acupuncture.

70. Respondent is not licensed under Title 1A of the Health Occupations Article to practice acupuncture.

71. Respondent is guilty of unprofessional conduct in the practice of medicine and engaged in prohibited conduct in that he:

- a. failed to be registered by the Board to perform acupuncture; and
- b. represented himself as an acupuncturist without being registered by the Board to perform acupuncture.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that the Respondent committed prohibited acts under the Act, Health Occupations Article §§ 14-404(a)(3), (22).

(23), and (40); §14-506(b) and (g)(1); and COMAR tit. 10 § 32.15.03A and B. Accordingly, the Board concludes as a matter of law that the Respondent is guilty of unprofessional conduct in the practice of medicine; failing 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; wilfully submitting false statements to collect fees for which services are not provided; failing to keep adequate medical records as determined by appropriate peer review; representing himself as a registered acupuncturist without having been registered by the Board and performing acupuncture without being registered by the Board.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 25th day of DECEMBER, 2000, by a majority of the full authorized membership of the Board considering this case:

ORDERED that Respondent be **REPRIMANDED**, and it is further

ORDERED that Respondent be placed on **PROBATION** for **EIGHTEEN (18) MONTHS** from the date of this Consent Order, subject to the following conditions of probation:

1. Respondent shall pay a monetary penalty payable to the Board of \$8,000.00 in four equal installments with initial payment due on January 31, 2001, and subsequent payments due on June 30, 2001, January 31, 2002, and May 20, 2002.

2. **Within sixty (60) days** from the date of this Order, Respondent shall enroll in a Board-approved course in medical records documentation and successfully complete

the course within **twelve (12) months** from the date of this Order.

3. **Within sixty (60) days** from the date of this Order, Respondent shall enroll in a Board-approved review course in family practice or internal medicine and successfully complete the course **within twelve (12) months** from the date of this Order.

4. **Within sixty (60) days** from the date of this Order, Respondent shall enroll in a Board-approved CPT Code course and successfully complete the course **within twelve (12) months** from the date of this Order;

5. **Within thirty (30) days** of the date of this Order, Respondent shall meet **monthly** with a Board-approved mentor physician who specializes in family practice or internal medicine. Respondent shall meet with the mentor who will conduct a random chart review of Respondent's medical records in regard to quality of medical care, accuracy of billing and quality of documentation. The mentor shall also review the documentation of informed consent to alternative treatment and whether Respondent is practicing acupuncture without being registered.

Respondent shall ensure that the mentor submits monthly reports to the Board. After the initial **six (6) months**, the Board will evaluate whether mentoring should continue at the same frequency. The frequency of the meetings may be increased or decreased as recommended by the mentor and approved by the CRC.

6. **Within sixty (60) days** of the date of the Order, Respondent shall submit for Board approval, consent to treatment forms for all non-conventional medicine therapy which he provides, including consent forms for prolotherapy, IV vitamin therapy, IV Colchicine therapy, IM vitamin therapy, which include a provision describing conventional

treatment options;

7. Respondent shall cease and desist from performing acupuncture unless registered by the Board to perform acupuncture;

8. After completion of **one (1) year** of probation, Respondent shall undergo a chart review by a Board designee, to be determined at the discretion of the Board, after which the Board may recommend a peer review by an appropriate peer review society; or peer review , with additional chart or peer review at the Board's discretion. The reviews shall focus on quality of medical care, medical records documentation, accuracy of billing, informed consent, and practice of acupuncture without registration.

9. Respondent shall be responsible for all costs necessary to comply with the terms of this Order.

10. Respondent shall be on probation for the full **eighteen (18) months**; there shall be no early termination of probation and be it further

ORDERED that Respondent shall not engage in the practices as described in the Findings of Fact; and it is further

ORDERED that Respondent will comply with and practice within all statutes and regulations governing the practice of medicine in the State of Maryland; and it is further

ORDERED that any violation of any of the terms of this Order shall constitute unprofessional conduct;

AND BE IT FURTHER ORDERED that if Respondent has satisfactorily complied with all conditions of probation, and there are no outstanding complaints regarding Respondent's practice, Respondent may petition the Board for termination of probation

without further conditions or restrictions after the **eighteen (18) month** period of probation imposed under this Consent Order; and be it further

ORDERED that if the Board has probable cause to believe that Respondent presents a danger to the public health, safety or welfare, the Board, **WITHOUT PRIOR NOTICE AND AN OPPORTUNITY FOR A HEARING, MAY SUMMARILY SUSPEND THE RESPONDENT'S CERTIFICATION/LICENSE**, provided that Respondent is given notice of the Board's action and an opportunity for a hearing within thirty (30) days after requesting same in accordance with MD. CODE ANN., STATE GOV'T § 10-226(c) (1999 Repl. Vol.); and be it further

ORDERED that if Respondent violates any of the terms of Respondent's probation, or fails to comply with the terms of this probation, the Board, after notice and a hearing, and a determination of violation, may impose any other disciplinary sanctions it deems appropriate, said violation of probation being proved by a preponderance of evidence.

ORDERED that this Consent Order is a public document pursuant to MD. CODE ANN., STATE GOV'T § 10-611 et seq.

12/20/05

Date



Samir R. Neimat, M.D., Chair
Maryland State Board of Physician Quality
Assurance

CONSENT


I, Bruce Rind, M.D., acknowledge that I am represented by legal counsel, Alan Dumoff, Esquire, and I have had the opportunity to consult with counsel before entering into and signing this document. By this consent, I hereby admit the Findings of Fact and Conclusions of Law, and submit to the foregoing Consent Order consisting of twenty-five (25) pages.

I acknowledge the validity of this Consent Order as if entered 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 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 an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

11/22/00

Date



Bruce Rind, M.D., Respondent

Reviewed by:



Alan Dumoff, Esquire
Counsel for Respondent

STATE OF MARYLAND

CITY/COUNTY of STATE OF MARYLAND
COUNTY OF MONTGOMERY

I HEREBY CERTIFY that on this 22nd day of Dec, 2000, before
me, a Notary Public of the State and County aforesaid, personally appeared **Bruce Rind**,
M.D., and made oath in due form of law that the foregoing was his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.


Notary Public

My Commission Expires: 12/31/2002

S:\JANET\RIND_C~1.WPD
November 17, 2000 (8:44AM)