IN THE MATTER OF	*	BEFORE THE
MARK V. SIVIERI, M.D.	*	MARYLAND STATE
Respondent	*	BOARD OF PHYSICIANS
License Number: D61704		Case Number: 2011-0164

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

The Maryland State Board of Physicians (the "Board") hereby charges Mark V. Sivieri, M.D. (the "Respondent") (D.O.B. 08/28/1973), License Number D61704, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-401 *et seq.* (2009 Repl.Vol. & 2011 Supp.).

The pertinent provisions of the Act under H.O. § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* 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[.]

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:

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 Maryland on May 12, 2004.

2. The Respondent is board-certified in family medicine.

3. At all times relevant to the events stated herein, the Respondent maintained an office for the practice of medicine in Columbia, Maryland.

ALLEGATIONS OF FACT[1]

4. On or about August 26, 2010, the Board received a complaint from an orthopedic surgeon alleging that the Respondent, in the capacity of a patient's primary care physician, was prescribing an excessive quantity of Fioricet with codeine, a Schedule III Controlled Dangerous Substance ("CDS").

5. The Board thereafter initiated an investigation of the Respondent's practice, which included referral of patient records to a peer review organization and the Respondent's written summary of his care.

6. A summary of the peer reviewers' findings are set forth below. These summaries are not intended as and do not represent a complete description of the evidence with respect to the Respondent's conduct in this matter.

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the Board's charges. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

Patient-Specific Allegations

Patient 1[2]

7. Patient 1, a male born in 1950 , was first seen by the Respondent in 2004 (he had been seen by other physicians in the practice since 1989). Patient 1 presented with a history of chronic headaches and sinus problems. His medications included Fioricet, a combination of butalbital, acetaminophen and caffeine,[3] that had been prescribed by other physicians prior to seeing the Respondent.

8. When Patient 1 first saw the Respondent in 2004, Patient 1 reported that he had "tried everything" to treat his chronic headaches and was currently taking Zyrtec and Fiorinal.[4] The Respondent prescribed Fiorinal with codeine and advised Patient 1 to return in two to three months.

9. Patient 1 returned to the Respondent in February 2005. At that visit the Respondent obtained a more detailed history of Patient 1's headaches and use of Fiorinal. The Respondent discussed the addictive potential of Fiorinal and advised him to decrease his usage. The Respondent prescribed Fiorinal with codeine (#90) with one refill and advised Patient 1 to return in three or four months.

10. Patient 1 returned in June 2005 and informed the Respondent that he was taking four to five Fiorinals with codeine every day. The Respondent discontinued

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[2] Patient numbers correspond to the peer review reports. Patient names are confidential. They will be provided to the Respondent upon request.
[3] Fioricet (without codeine) is not a CDS.
[4] Fiorinal is a Schedule III CDS.

Fiorinal and started Fioricet with codeine (#90 with three refills), advising Patient 1 to decrease his usage.

11. In December 2005, Patient 1 reported to the Respondent that he was taking four to five Fioricets a day and that he was afraid to change the amount he was taking. The Respondent provided him with a refill of Fioricet and discussed alternative treatments for pain management.

12. In October 2008, Patient 1 reported to the Respondent that his headaches worsened whenever he tried to change the amount of Fioricet he took. On that visit, the Respondent noted that Patient 1's GGT level[5] was elevated and documented that it was secondary to "?? Tylenol."

13. Over the next two years, the Respondent documented that Patient 1 reported he was taking "a lot" of Fioricets and in one instance was "popping them." Patient 1's GGT level continued to remain elevated which the Respondent noted was possibly related to "Tylenol."[6]

14. From January 2010 through September 2010, the Respondent prescribed Fioricets to Patient 1 at a level of twelve tablets a day.

15. The Respondent failed to meet the standard of quality care in this aspect of his treatment of Patient 1 because he failed to address Patient 1's increased use of Fioricet and change him to a less toxic medication. As early as October 2008, the Respondent noted Patient 1's elevated liver function tests and noted that it could be due to "Tylenol" yet did not address that Patient 1 was receiving large doses of acetaminophen form the Fioricets he was taking. The Respondent

[5] An elevated GGT level indicates possible liver damage.
[6] Tylenol, a non-CDS, is a brand name for acetaminophen.

failed to address the risk of acetaminophen inherent to Patient 1's high usage of Fioricet.

16. In addition, the Respondent failed to refer Patient 1 to a neurologist or pain management center notwithstanding Patient 1's long-standing history of chronic headaches.

Patient 2

17. Patient 2, a female born in 1943, had been a patient of the Respondent for over 17 years. She is medically complex with multiple medical and psychiatric issues including chronic migraines, polyarthralgia, chronic diarrhea, gastrointestinal issues and elevated antinuclear antibodies. Her psychiatric issues include depression and insomnia.

18. To treat Patient 2's chronic insomnia, the Respondent had prescribed Ambien (zolpidem tartrate, a Schedule IV CDS), a sleep agent, to her since at least 2005. Until 2010, the Respondent prescribed the standard recommended dose of 10 mg (one tablet) before bedtime.

19. The Respondent documented the status of Patient 2's insomnia at almost every visit. For example, on September 25, 2009, the Respondent documented that it was a "severe, severe situation – on high dose Ambien, add in alprazolam[7] [Xanax] 2 mg, 2 tabs PO Q HS" [orally every night at bedtime]. Similarly, on December 16, 2009, he documented that it was a "severe situation" and that Patient 2 had "been off Ambien since 11/30/09."

20. In 2010, the Respondent prescribed significantly larger dosages of Ambien to Patient 2. On April 15, 2010, the Respondent documented that Patient 2 was

[7] Xanax is a Schedule IV CDS.

taking "3 Ambien + 4 mg Xanax," and that he had "again discussed high dose Ambien & side effects."

21. Notwithstanding the Respondent's documented concern regarding Patient 2's insomnia and her use of Ambien, on May 23, 2010, he prescribed 270 tablets of Ambien to Patient 2 with instructions for her to take three tablets at bedtime.

22. Pharmacy surveys reveal that in March 2010, the Respondent prescribed a total of 360 tablets of Ambien (from two different pharmacies) to Patient 2; for the three month period from April 2010 through June 2010, the Respondent prescribed to Patient 2,660 tablets of Ambien.

23. On January 6, 2011, the Respondent documented that he had had an "extensive discussion" with Patient 2 on that date. The Respondent further documented: "I do not want to refill her zolpidem at 3 [tablets] PO QHS. She is taking only 1 now anyway. Last fill 6/22/10 and had 3 mos supply and asking for refill now."

24. The Respondent failed to meet the standard of quality care in this aspect of his treatment of Patient 2 because although he had advised Patient 2 not to take so many Ambien and had discussed on multiple occasions its addictive potential, he failed to restrict her supply of Ambien until 2011.

Patient 8

25. Patient 8, a female born in 1965, initially presented to the Respondent in May 2005. Her past medical history included: depression; low back pain; irritable bowel syndrome ("IBS"), anxiety and insomnia. The Respondent noted that Patient 8 had been in psychiatric therapy "for years" and had been under the care of a gastroenterologist.

26. On November 7, 2005, the Respondent started Vicodin (#30), a Schedule III CDS, noting that Patient 8 had complained that her lower back was still "killing" her.

27. In his summary of care, the Respondent stated that he had chosen Vicodin for "its efficacy for pain control and also its constipating side effects, which could be beneficial in this patient with chronic diarrhea."

28. On October 6, 2007, the Respondent discontinued Vicodin and prescribed OxyContin[8] 40 mg for Patient 8's uncontrolled abdominal and back pain. In his summary of care, the Respondent once again noted that he had chosen OxyContin for its constipating effects.

29. In October 2008, the Respondent doubled Patient 8's dosage of OxyContin from 40 mg to 80 mg. twice a day.

30. In March 2008, the Respondent discussed with Patient 8 weaning off OxyContin, but continued to prescribe OxyContin 80 mg twice a day.

31. On April 5, 2009, Patient 8 reported to the Respondent in a telephone conversation that she had been unable to wean off OxyContin and had taken some Vicodin that was left over from an old prescription.

32. On May 2, 2009, Patient 8 complained of "all over pain." The Respondent began Vicodin ES (extra strength; contains a higher dosage of hydrocodone) and continued Patient 8's OxyContin 80 mg.

33. On June 24, 2010, Patient 8 called the Respondent and once again requested his help her as she was experiencing withdrawal symptoms and was unable to afford to refill her prescription for OxyContin.

[8] A Schedule II CDS.

34. The Respondent advised Patient 8 to "use benzos BID [twice a day], wean off Vicodin but use as bridge."

35. On July 16, 2010, the Respondent saw Patient 8 and noted that she was in a "severe situation." He noted that she was not taking OxyContin but was still on Vicodin. He further noted, "consider short vs. long term disability."

36. In a letter dated November 19, 2010, to Patient 8's insurance company, the Respondent stated in pertinent part: "[a]t the date of disability, [Patient 8's] condition was significantly destabilized by increased pain and mental instability as well as insomnia. This necessitated the continuation and some increase in the use of benzos and opiates." He also noted that Patient 8 had previously stopped treatment with a psychiatrist because of that physician's concerns regarding Patient 8's prescription drug use. The Respondent further stated that he had had an "extended telephone consultation" with Patient 8 in mid-September 2010 and that she had also undergone a psychiatric consultation at that time. The Respondent concluded: "[s]he stabilized quickly with an adjustment of her regimen and return *(sic)* to work without restrictions thereafter."

37. The Respondent saw Patient 8 several more times but did not prescribe narcotics or benzodiazepines to her in 2011 or 2012 although she continued to complain of the same symptoms she had in the past.

38. The Respondent failed to meet the standard of quality care prior to 2011 because he continued to prescribe escalating dosages of benzodiazepines and narcotics to Patient 8 in the absence of a clear etiology of her symptoms and without any

evidence that the drugs had a significant impact on her symptoms, with the exception of her diarrhea.

39. Throughout the records that were reviewed, the Respondent failed to maintain adequate medical records because he typically failed to note the dosage and quantity of medication prescribed by the Respondent in the patients' notes. The Respondent kept copies of prescriptions; however, they are generally maintained in a separate section of the patient's files.

40. The Respondent's conduct, in whole or in part, constitutes failure to meet the standard of quality care, in violation of H.O. § 14-404(a)(22) and failure to maintain adequate medical records, in violation of H.O. § 14-404(a)(40).

41. If, after a hearing, the Board finds that there are grounds for action under H.O. § 14-404(a)(22), the Board may impose disciplinary sanctions against the Respondent's license in accordance with the Board's regulations under Md. Regs. Code tit. 10, § 32.01.10 (2013), including revocation, suspension, or reprimand and may place the Respondent on probation, and/or may impose a monetary fine.

NOTICE OF CASE RESOLUTION CONFERENCE

A Case Resolution Conference has been scheduled for **Wednesday, May 1, 2013, at 10:00 a.m.** at the offices of the Board, 4201 Patterson Avenue, Baltimore, Maryland, 21215. The nature and purpose of the Case Resolution Conference are described in the attached letter to the Respondent. If this case is not resolved at the Case Resolution Conference, a pre-hearing conference and hearing will be scheduled

before an Administrative Law Judge at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland 21031.

DOUGLAS F. GANSLER
ATTORNEY GENERAL

3-6-2013
Date

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