BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

ROHIT MALHOTRA, M.D.

Holder of License No. 33419
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-14-1374A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND AND PROBATION

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 7, 2017. Physician, M.D. ("Respondent"), appeared before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 33419 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-14-1374A after receiving a complaint regarding Respondent's care and treatment of patients RL and SM, alleging inappropriate prescribing of controlled substances.

Patient RL

4. On October 29, 2013, RL was transported to the Emergency Room ("ER") via emergency medical services ("EMS"). RL made suicidal statements while intoxicated by alcohol. RL also complained of chronic low back pain stating that he was pending a third spine surgery, and complained of more recent abdominal pain. A urine drug test was negative for any narcotics, and was positive for alcohol. The Controlled Substances Prescription Monitoring Program ("CSPMP") report for RL documents that in the previous
twelve months, RL had been dispensed 55 controlled substance prescriptions written by 15 prescribers.

5. On October 30, 2013, Respondent prescribed RL oxycodone and oxymorphone. Respondent continued to treat RL periodically through January 20, 2014. Care was briefly re-established between August 6, 2014 and August 29, 2014. In his response to the Board, Respondent stated that he discharged RL from his practice on September 17, 2014 due to non-compliance with treatment recommendations.

6. A Medical Consultant ("MC") who reviewed Respondent’s electronic medical records ("EMR") for RL reported that it was extremely difficult to follow Respondent’s notes for RL or identify a chronology, with many undated notes, and multiple visits documented on the same page.

7. During his treatment of RL, Respondent prescribed high doses of opioid medication, including oxymorphone, oxycodone, and Percocet as well as Soma.

Patient SM

8. Patient SM established care with Respondent on January 29, 2014 and continued through October 6, 2014. Respondent wrote and dispensed prescriptions for Percocet and Soma on SM’s initial visit. The CSPMP report for SM indicates that on the same date of his initial visit, SM obtained prescriptions for Vicodin and Soma from another provider from a different medical office.

9. Respondent’s records indicate that SM had a past medical history of wrist, femur and ankle fractures, as well as complaints of chronic low back pain from bulging discs. During the course of Respondent’s treatment of SM, he prescribed Soma as well as Percocet or Norco.

10. A note dated February 25, 2014 states that SM had a medical marijuana card so he did not have to take narcotic medications for most of the year.
11. On April 15, 2014, Respondent's note indicates a referral to pain management was submitted. A note dated May 13, 2014 states that SM did not complete the pain management referral.

**Deviations from the Standards of Care for Patients RL and SM**

12. The standard of care requires a physician to maintain adequate and legible medical records such that another physician can take over care at any time. Respondent deviated from the standard of care for Patients RL and SM by failing to maintain adequate and legible medical records to allow another physician to assume the patients' care at any time.

13. The standard of care prior to prescribing long term opioid medications for chronic non-malignant pain requires appropriate evaluation of the pain problem, physical examination, diagnostic work up, medical records review and identification of an objective pain generator. Respondent deviated from the standard of care by prescribing opioids to RL and SM, and Soma to SM, in the absence of appropriate evaluation, physical examination, diagnostic work up, medical records review, or objective diagnoses to support this treatment.

14. The standard of care prior to introduction, continuation and/or escalation of long term opioids for chronic pain requires close monitoring for patient non-compliance and/or aberrant drug seeking. Respondent deviated from the standard of care by failing to perform a CSPMP review at the time RL initiated care. Respondent also deviated from the standard of care by failing to perform CSPMP review at the time SM initiated care, and by failing to adequately monitor, investigate and/or counsel SM regarding potential non-compliance.

15. The standard of care requires that the chronic pain management treatment plan be individualized, and include consideration of non-opioid approaches. With regard to RL, Respondent deviated from the standard of care by relying solely on high dose opioids.
in the absence of a coordinated multidisciplinary treatment plan, and without consideration of non-opioid medications or other alternative treatments.

16. The standard of care for ongoing opioid prescribing requires reassessment to identify objective clinical evidence of a pain generator warranting continued opioid management. With regard to RL, Respondent deviated from the standard of care by failing to perform any reassessment to identify objective clinical evidence of a pain generator warranting continued high dose opioid management.

17. The standard of care prior to prescribing long term opioids for chronic pain requires the physician to educate the patient on safe use and establish, either verbally or in writing, informed consent and the elements of a standard opioid treating agreement. With regard to RL and SM, Respondent deviated from the standard of care by failing to document any patient education or review of the elements of a standard opioid treating agreement prior to initiating, continuing and re-establishing high dose opioids for chronic pain.

18. The standard of care when concurrently prescribing opioid and benzodiazepine medications requires a physician to base the decision on well-documented and reasonable medical rationale, as this combination is known to significantly increase the risk of respiratory depression, accidental overdose and death. With regard to RL, Respondent deviated from the standard of care by failing to document a rationale to warrant the risks of initiating Alprazolam in combination with high dose opioids.

19. The standard of care requires a physician to consider input volunteered by family members. Respondent deviated from the standard of care by refusing to consider information and concerns regarding SM’s history of addiction and abuse of pain medications, which was volunteered by the patient’s wife.

Patient HT
20. Patient HT, a 39 year-old female with diagnoses including bronchiectasis, low back pain, anxiety and ADHD, established care with Respondent on January 17, 2014 and continued treatment with him through May 13, 2016. Respondent provided primary care services to HT including management of chronic pain.

21. During the course of his treatment of HT, Respondent prescribed her medications including Percocet, Nuvigil, Methylphenidate and Carisoprodol. In November, 2015, HT's pain management was assumed by a pain management specialist. After the specialist assumed care, HT's opioid dose was decreased by half, and the CSPMP indicates that HT is on a regular schedule with her narcotics.

22. A MC who reviewed Respondent's records for HT found that some records were not provided for review, and that of the records reviewed, the MC had an extremely difficult time following Respondent's treatment.

Deviations from the Standard of Care for Patient HT

23. The standard of care prior to prescribing long term opioids for chronic pain requires a physician to conduct an appropriate evaluation, which includes a pain history, review of medical records, targeted physical exam, medication history including verification of current prescriptions, CSPMP review, diagnostic testing and specialist consultation as indicated. Respondent deviated from the standard of care by prescribing chronic long term Carisoprodol to HT with no medical indication.

24. The standard of care requires a physician to closely monitor the patient for non-compliance and/or aberrant drug seeking with performance of urine drug screens and a CSPMP review. Respondent deviated from the standard of care by failing to monitor early refills or address HT's aberrant behavior.

25. The standard of care requires a physician to maintain adequate and legible medical records such that another physician can take over care at any time. Respondent deviated from the standard of care by failing to maintain adequate medical records for HT.
Patients PA, KH and BM

26. Patient PA, a 68 year-old female with diagnoses including depression, renal insufficiency, sciatica, cervical spondylosis, and brachial neuritis, established care with Respondent on August 12, 2014. Respondent provided primary care and pain management for PA through May 4, 2016 with treatment including Morphine 45 mg per day and temazepam for sleep.

27. Patient KH, a 28 year-old male with diffuse joint pain from falling off a horse, established care with Respondent in July, 2012. KH was also a tobacco and marijuana user. Between August 22, 2014 and May 7, 2015, Respondent prescribed KH Oxycodone 7.5/325.

28. Patient BM, a 60 year-old female with diagnoses including COPD, low back pain and sciatica who used marijuana for glaucoma, was treated by Respondent with medications including Norco. The MC noted that he was unable to determine what occurred at each visit.

Deviation from the Standard of Care for Patients PA, KH and BM

29. The standard of care requires a physician to maintain adequate and legible medical records such that another physician can take over care at any time. Respondent deviated from the standard of care for PA, KH and BM by failing to maintain adequate medical records.

Patient RB

30. Patient RB, a 59 year-old morbidly obese male with multiple medical problems including oxygen dependent COPD, osteoarthritis and hypertension, established care with Respondent in 2013.

31. Respondent’s treatment of RB continued through June 21, 2016 with medications including Oxycodone and Morphine. During 2014, the MC noted that there was a rapid dose escalation with early refills of Oxycodone and Morphine. Along with
medications from other physicians, RB's morphine equivalent dose ("MED") was more than 260 mg.

32. Beginning January 14, 2015, RB was referred to a pain specialist who titrated RB's opioid medications down to an MED of 112 mg.

**Deviations from the Standard of Care for Patient RB**

33. The standard of care prior to prescribing long term opioids for chronic pain requires a physician to conduct an appropriate evaluation, which includes a pain history, review of medical records, targeted physical exam, medication history including verification of current prescriptions, CSPMP review, diagnostic testing and specialist consultation as indicated. Respondent deviated from the standard of care by prescribing RB large doses of opioids without frequent urine drug screens and failed to closely monitor the CSPMP.

34. The standard of care requires a physician to maintain adequate and legible medical records such that another physician can take over care at any time. Respondent deviated from the standard of care by failing to maintain adequate medical records and failed to document the benefits of prescribing controlled medications to a high risk patient.

**Actual and Potential Patient Harm**

35. Actual harm occurred to RL in that RL's aberrant drug seeking and non-therapeutic use of controlled substances (defined as abuse, addiction and/or diversion) was perpetuated. Actual harm occurred to SM in that Respondent perpetuated SM's drug seeking behavior which culminated in a behavioral outburst.

36. There was the potential for patient harm in that patients HT and RB were placed on higher doses of medications than were actually required.

37. There was potential patient harm for patients HT, PA, RB, KH and BM in that another physician taking over the patients care would have a very hard time assuming the care with the poor quality and cumbersome medical records.
38. During a Formal Interview on this matter, Respondent testified that he is board certified in internal medicine, and provides primary care and internal medicine services for his patients. With regard to pain management, Respondent stated that the goal of the practice is to act as a bridge until patients could obtain treatment with a specialist. Respondent testified that in many cases, including RL, SM, and HT, he simply refilled the same combination of medications that the patient was previously prescribed.

39. Respondent also testified that his practice was victimized by hackers during a transition from one EMR to another, which corrupted his medical records and adversely affected the function of the practice’s computer system.

40. Respondent testified that he had taken an opioid prescribing course for a total of 12.75 continuing medical education (“CME”) credits and is scheduled to take a medical recordkeeping course from the UC San Diego Physician Assessment and Clinical Education (“PACE”) program in July, 2017. Respondent stated that his practice for a new patient with a chronic pain complaint is now different, and that he checks the CSPMP, attempts to obtain previous records, obtains a medication agreement and provides any opioid prescription for a short period of time, while assisting the patient to obtain a pain management specialist. Respondent noted that patients with chronic pain complaints comprise a small percentage of his overall patient population.

41. During that same Formal Interview, one Board member commented that despite the practice changes testified to by the Respondent, the case rose to the level of discipline. The Board member commented that probation was warranted in order to ensure that Respondent was more fully informed about opioid and controlled substance prescribing.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.
2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

2. Respondent is placed on Probation for a period of 2 years with the following terms and conditions:

   a. **Continuing Medical Education**

      Respondent shall within 6 months of the effective date of this Order obtain no less than 15 hours of Board staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, in-person course regarding medical recordkeeping and within 12 months of the effective date of this Order, enroll in and complete the Basics of Chronic Pain Management course offered by the Center for Personalized Education for Physicians ("CPEP"). Respondent shall notify the Board within 5 days of registering for the CPEP course and if Respondent has not completed the July, 2017 PACE course, Respondent shall within thirty days of the effective date of this Order submit his request for CME to the Board for pre-approval for a medical recordkeeping course.

      Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure.
b. **Chart Reviews**

Board staff or its agents (a Board-approved monitoring company) shall conduct periodic chart reviews for a period of one year following completion of the CPEP course. Respondent shall bear all costs associated with the chart reviews. Based upon the chart review, the Board retains jurisdiction to take additional disciplinary or remedial action. The chart reviews shall involve current patients' charts and focus on controlled substance prescribing after completion of the CPEP course.

c. **Obey all Laws**

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

d. **Tolling**

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

e. **Probation Termination**

Prior to the termination of Probation, Respondent must submit a written request to the Board for release from the terms of this Order. Respondent's request for release will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 14 days prior to the Board meeting. Respondent's request for release must provide the Board with evidence establishing that he has successfully satisfied all of the terms and conditions of this Order. The Board has the sole discretion to
determine whether all of the terms and conditions of this Order have been met or whether
to take any other action that is consistent with its statutory and regulatory authority.

3. The Board retains jurisdiction and may initiate new action against Respondent
   based upon any violation of this Order. A.R.S. § 32-1401(27)(r).

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or
review. The petition for rehearing or review must be filed with the Board’s Executive
Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
petition for rehearing or review must set forth legally sufficient reasons for granting a
rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after
date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,
the Board’s Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is
required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this 3rd day of August, 2017.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed
this 3rd day of August, 2017 to:

Rohit Malhotra, M.D.
Address of Record

ORIGINAL of the foregoing filed
this 3rd day of August, 2017 with:
Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

[Signature]
Board staff