**BEFORE THE DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE**

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| **IN RE: DILIPKUMAR J. JOSHI** | | **10-45-15** |
| | | **10-65-15** |
| | **Case Nos:** | **10-114-15** |
| | | **10-118-15** |
| **LICENSE NO.: C1-0005796** | | **10-123-15** |

## ORDER

**WHEREAS**, the Board of Medical Licensure and Discipline has reviewed this matter; and

**WHEREAS**, the Board of Medical Licensure and Discipline approves the Consent Agreement of the parties and intends to enter it as an Order of the Board;

**IT IS HEREBY ORDERED** this __4___ day of ___April_____, 2017

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| **IN RE: DILIPKUMAR J. JOSHI** | | **10-45-15** |
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## CONSENT AGREEMENT

A written Complaint was filed with the Delaware Board of Medical Licensure and Discipline ("Board" alleging that Dilipkumar J. Joshi ("Respondent"), a licensed physician, engaged in conduct that constitutes grounds for discipline pursuant to Delaware's *Medical Practice Act* (24 *Del. C.* Ch. 17).

The State of Delaware, by the undersigned Deputy Attorney General, and Respondent submit this Consent Agreement for approval by the Board as a means of resolving the pending administrative prosecution against Respondent pursuant to 24 *Del. C.* Ch. 17 and 29 *Del. C.* Ch. 101.

**IT IS UNDERSTOOD AND AGREED THAT:**

1. Respondent is a licensed medical doctor in the State of Delaware. His license, number C1-0005796, was issued in 1999 and expires on March 31, 2017. His license is currently active.

2. Respondent is a practicing psychiatrist with offices in Newark, Delaware and Dover, Delaware. Respondent also practices at Rockford Center, a private psychiatric facility, Gaudenzia, an addiction treatment and recovery facility, and Claymont Comprehensive Treatment Center, a drug treatment facility.

**Case no. 10-45-15**

3. In May of 2014, Respondent began treating Patient W.H., and treatment

continued through 2015. Respondent's treatment of W.H. included prescribing a controlled substance, Amphetamine/Dextroamphetamine ("Adderall"), for the treatment of Attention Deficit Disorder ("ADD"). During Respondent's treatment of W.H., Respondent:

a. Failed to contact any past treatment providers or review past treatment records and relied on W.H.'s self-reported medical history and self-reported ADD diagnosis prior to prescribing Adderall;

b. Failed to adequately update informed consent documentation for medications subsequent to the initial intake evaluation date;

c. Failed to discuss or document such discussion of alternative treatment options or concurrent therapeutic counseling with W.H.;

d. Failed to check the Prescription Monitoring Program ("PMP") report for W.H.;

e. Failed to document diagnoses associated with treatment with antidepressant medications;

f. Failed to adequately maintain a prescribing routine to avoid providing additional monthly supplies of controlled substances to W.H. before previous prescriptions had finished;

g. Failed to consistently document Respondent's clinical rationale for medication dose adjustments or medication changes; and

h. Failed to order urine/serum medication level screening or utilize other controls for evaluating prescription compliance or abuse.

4. Between at least May of 2014 and September of 2014, W.H. continued to see his prior practitioner and received prescriptions for Adderall from that practitioner in addition to those he was receiving from Respondent.

5. After Respondent discovered that W.H. was receiving prescriptions from another practitioner, Respondent failed to consult with the other practitioner and failed to conduct any screenings or evaluations to assess W.H.'s potential for drug abuse or diversion. Respondent confronted W.H., but did not document such confrontation in his notes. W.H. thereafter stopped receiving prescriptions from the other practitioner.

6. In March of 2015, Respondent billed W.H.'s insurance for two separate office visits, but was unable to produce treatment notes for those dates of service.

7. Respondent violated 24 *Del. C.* §§ 1731(b)(3) and (b)(17) in that he engaged in unethical conduct as defined by Board Regulation 8.1.13, in failing to adequately maintain and properly document patient records.

8. Respondent violated 24 *Del. C.* § 1731(b)(11) in that he engaged in misconduct, incompetence, gross negligence or a pattern of negligence in the practice of medicine.

**Case no. 10-65-15**

9. On October 9, 2014, Respondent began treating Patient M.S., and treatment continued through December 9, 2014. Respondent's treatment of M.S. included prescribing a controlled substance, Adderall, for Attention Deficit Hyperactivity Disorder ("ADHD").

10. During Respondent's treatment of M.S., Respondent:

a. Failed to request or review past treatment records prior to prescribing Adderall;

b. Failed to appropriately and adequately coordinate care with M.S.'s known medical providers, including to document contact with the referring psychologist to verify the reported ADHD diagnosis;

c. Failed to discuss or document a treatment plan, treatment options or therapeutic counseling with M.S.;

11. Respondent mistakenly billed M.S.'s insurance for an office visit on December 4, 2014 that did not occur.

12. Respondent violated 24 *Del. C.* §§ 1731(b)(3) and (b)(17) in that he engaged in unethical conduct in a bill being released for an office visit that did not occur and as defined by Board Regulation 8.1.13, in that he failed to adequately maintain and properly document patient records.

13. Respondent violated 24 *Del. C.* § 1731(b)(11) in that he engaged in misconduct, incompetence, gross negligence or a pattern of negligence in the practice of medicine.

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14. On February 12, 2010, Respondent began treating Patient R.H, and treatment continued through October of 2015. Respondent's treatment of R.H. included prescribing controlled substances, Suboxone, Methadone, Tramadol, and alprazolam ("Xanax"), for the treatment of opioid dependence and anxiety.

15. In July of 2010, R.H. reported that she had been prescribed Ritalin (Methylphenidate) in the past and that she believed she needed it again. Based on this self-report and without any documented assessment or verification of this past diagnosis, Respondent diagnosed R.H. with ADD and prescribed Adderall to R.H.

16. Starting in at least May of 2011, Respondent prescribed Methadone for maintenance treatment for R.H. as an individual practitioner not affiliated with a detoxification or maintenance treatment program in violation of Federal Regulations for the Registration of Manufacturers, Distributors and Dispensers of Controlled Substances. *See* 21 CFR 1301.23; 1306.07(a).

17. During Respondent's treatment of R.H., Respondent:

a. Failed to contact any past or present treatment providers or review past

treatment records, and relied on R.H,'s self-reported diagnoses prior to prescribing controlled substances.

b. Failed to adequately document R.H.'s informed consent for medications;

c. Failed to consistently document Respondent's clinical rationale for prescriptions, medication changes or medication dose adjustments;

d. Failed to check the PMP report for R.H.;

e. Failed to adequately maintain a prescribing routine to avoid providing additional monthly supplies of Adderall to R.H. before previous prescriptions had finished; and

f. Failed to order urine/serum medication level screening or utilize other controls for evaluating prescription compliance or abuse.

18. Respondent violated 24 *Del. C.* §§ 1731(b)(3) and (b)(17) in that he engaged in unethical conduct in prescribing Methadone outside of an approved treatment program, and as defined by Board Regulation 8.1.13, in that he failed to adequately maintain and properly document patient records.

19. Respondent violated 24 *Del. C.* § 1731(b)(11) in that he engaged in misconduct, incompetence, gross negligence or a pattern of negligence in the practice of medicine.

**Case no. 10-118-15**

20. On January 15, 2013, Respondent began treating Patient V.K, and treatment continued through October 2015. Respondent's treatment of V.K. included prescribing controlled substances, lisdexamfetamine ("Vyanase"), clonazepam ("Klonopin") and Adderall, for the treatment of depression, anxiety and ADD.

21. During Respondent's treatment of V.K., Respondent:

a. Failed to contact any past treatment providers or review past treatment

records, and relied on V.K.'s medical history reporting and self-reported diagnoses prior to prescribing controlled substances;

b. Failed to document V.K.'s informed consent for the majority of the medications he prescribed;

c. Failed to document any discussions of the overall treatment plan, treatment options or therapeutic counseling with V.K.;

d. Failed to check the PMP report for V.K.;

e. Failed to conduct a comprehensive evaluation of V.K's self-reported withdrawal symptoms and ADD;

f. Failed to adequately document Respondent's rationale for prescriptions, medication dose adjustments or medication changes; and

g. Failed to order urine/serum medication level screening or utilize other controls for evaluating prescription compliance or abuse.

22. When V.K began treatment with Respondent, V.K. was on a methadone maintenance program with another practitioner. In March of 2014, Respondent prescribed V.K. a 15-day supply of Suboxone to prevent patient-reported methadone withdrawal symptoms, despite his knowledge that V.K. was on a methadone maintenance program. Respondent was not treating V.K. for opiate addiction or dependence. Respondent failed to coordinate with the other practitioner or obtain prior treatment records for V.K., check the PMP or conduct any kind of urinalysis screening on V.K. prior to prescribing Suboxone.

23. Between February 25, 2013 and October 13, 2014, Respondent billed for service provided to V.K. performed by an employee in his office, D.D. There are no records or progress notes in V.K.'s treatment records documenting these services.

24. D.D. is not licensed to work as a counselor in Delaware, and Respondent failed to

verify D.D.'s licensure status before contracting with D.D. Upon learning that D.D. did not maintain a Delaware license, D.D.'s relationship with Respondent's practice was terminated.

25. Respondent violated 24 *Del. C.* §§ 1731(b)(3) and (b)(17) in that he engaged in unethical conduct in failing to verify D.D.'s licensure status and ensure appropriate documentation by D.D. and as defined by Board Regulation 8.1.13., in failing to adequately maintain and properly document patient records.

26. Respondent violated 24 *Del. C.* § 1731(b)(11) as he engaged in misconduct, incompetence, gross negligence or a pattern of negligence in the practice of medicine.

**Case no. 10-123-15**

27. At all times relevant to this case, Respondent was working at the Rockford Center ("Rockford") as a contracted psychiatrist.

28. On or about September 21, 2015, Patient H.T. was admitted to Rockford for emotional stress and suicidal ideation.

29. On September 21, 2015, Respondent performed an initial intake and evaluation of H.T. and ordered medications for the treatment of H.T. Respondent did not assess H.T. again until she was discharged four days later after her health improved, but Respondent was available if called upon. H.T. remained at Rockford until September 25, 2015, when she was discharged in an improved state of health.

30. Respondent failed to meet with, assess or evaluate H.T. until the day of her discharge, but documented on her treatment records that he had seen her on September 22, 2015 and September 24, 2015.

31. A bill was submitted to Rockford for his treatment of H.T. for September 22, 23 and 24, despite the fact that he did not see H.T. on those dates. Rockford was repaid after the error was discovered.

32. Respondent did not arrange for any other physician to treat H.T. on the days that he did not meet with or render treatment to H.T.

33. Respondent violated 24 *Del. C.* § 1731(b)(1) in that he generated a false document in connection with the practice of medicine.

34. Respondent violated 24 *Del. C.* § 1731(b)(11) as he engaged in misconduct, incompetence, gross negligence or a pattern of negligence in the practice of medicine.

35. Respondent violated 24 *Del. C.* §§ 1731(b)(3) and (b)(17) in that he engaged in unethical conduct as defined by Board Regulation 8.1.13, in that he failed to adequately maintain and document patient records.

36. Respondent admits that the allegations set forth in paragraphs one through 35 above are true and correct.

37. Respondent avers the following in mitigation. Regarding the treatment of H.T., Respondent was covering patients for other contracted psychiatrists and felt overwhelmed with the patient load. In working to complete documentation, Respondent mistakenly documented H.T.'s treatment records to reflect that he had seen her on dates that he had not seen her. Due to mistaken documentation, a bill was submitted to Rockford for those dates of services. Rockford was repaid after the error was discovered.

38. D.D.'s relationship with Respondent's practice was terminated when Respondent discovered that D.D. did not maintain a Delaware license.

39. Respondent has taken several actions to improve documentation and to tighten controls to prevent the possibility of medication abuse or diversion, or both, including the following:

a. Adopted a practice policy regarding checking the PMP report when circumstances are presented that lead to Respondent having a reasonable

belief that the patient may be seeking a controlled substance, in whole or in part, for any reason other than the treatment of an existing medical condition;

b. Adopted a practice policy regarding the use of urine medication screening to determine compliance with medication treatment, based upon current medical literature;

c. Adopted a practice policy to request all treatment records from physicians that have previously diagnosed a patient and to contact prior treating physician(s) if the patient requests such direct contact, if there is a doubt about the patient's medical history, or if there is a clinical reason to contact such physician(s) or both;

d. Adopted a practice policy regarding the issuance of prescriptions with the appropriate earliest date the prescription may be filled by a pharmacy written on the prescription; and

e. Revised his documentation format and practices to better assure the capturing of all pertinent clinical data at each encounter, as well as to more clearly express the treatment plan, including modification to that plan (e.g., increases or decreases in medication dosage).

40. Respondent certifies that he has transferred his private practice patients in need of drug addiction treatment with approved controlled substances, including buprenorphine (e.g., Suboxone and Subutex), to other federally qualified physicians for continuation of treatment and that he has no intention of treating patients with drug addiction utilizing such medications in his private practice.

41. The State and Respondent agree that the appropriate disciplinary sanctions are as

follows:

a. Respondent's license shall be placed on probation for five (5) years with the following conditions:

b. Within 60 days of the Board's Order, Respondent shall complete nine (9) hours of continuing education, of which three hours shall be in documentation practices and six (6) hours shall be in safe prescribing practices. The nine hours shall be in addition to the continuing education hours required for license renewal;

c. Respondent shall engage, at his own expense, the services of an independent auditing company, subject to approval by the Board. The company shall make an initial review of Respondent's private practice within 90 days of the Board's approval/order and make quarterly reports to the Board thereafter during the term of his probation. The Board may, in its discretion, appoint one of its professional members to approve and/or accept Respondent's proposed auditor, self-evaluations, educational requirements or audit reports, or to otherwise oversee Respondent's probationary conditions;

d. During the term of probation, Respondent shall disclose this Consent Agreement to other Delaware treatment providers that he is contracted to work with or provide medical services to;

e. During the period of probation, Respondent understands and agrees that an investigator from the Division of Professional Regulation may appear at his private practice to perform random inspections and to ensure compliance with Delaware law;

f. After two years of probation, Respondent may petition the Board to lift the remaining term of probation upon submission of evidence, satisfactory to the Board in its sole discretion, of improved documentation and patient monitoring;

g. Respondent shall pay a civil monetary fine within 90 days of the date of this Order in the amount of $2500.00 payable to the State of Delaware and mailed to the Division of Professional Regulation, Delaware Board of Medical Licensure and Discipline, Cannon Building, Suite 203, 861 Silver Lake Boulevard, Dover, Delaware 19904; and

h. The Board reserves jurisdiction, in connection with any further hearing for removal from probation or violation of any of the terms and conditions of probation, to determine whether any additional conditions or restrictions on Respondent's license to practice medicine are necessary to protect the public.

43. In addition to the above, Respondent has agreed to no longer accept private patients for the purpose of treating addiction with controlled substances.

44. In the concurrent case before the Delaware Secretary of State (case no. 38-03-16) stemming from the same conduct, the parties have submitted a Consent Agreement for approval with a proposal that Respondent's CSR be placed on probation for 5 years with the understanding that Respondent may petition for removal from probation after 2 years.

45. The parties to this Consent Agreement are the State of Delaware and Respondent. The parties agree and acknowledge that nothing contained in this Consent Agreement shall affect any rights or interests of any person not a party to this Consent Agreement.

46. Respondent acknowledges that he is waiving his rights under 24 *Del. C.* Ch. 17 and 29 *Del. C.* Ch. 101 to a hearing before the Board prior to the imposition of disciplinary sanctions.

47. Respondent hereby acknowledges and agrees that he has carefully read and understands this Consent Agreement, and is entering into this Consent Agreement freely, knowingly, voluntarily, and after having received or having been afforded the opportunity to receive the advice of counsel.

48. Respondent acknowledges that this Consent Agreement is a public record within the meaning of 29 *Del. C.* § 10002 and will be available for public inspection and copying as provided for by 29 *Del. C.* § 10003.

49. The parties acknowledge and agree that this Consent Agreement is subject to approval by the Board.

50. The parties acknowledge and agree that if the Board does not accept this Consent Agreement, it shall have no force or effect, except as follows:

a. Neither Respondent, nor anyone on his behalf, will in any way or in any forum challenge the ability of the Board or any of its members to conduct an evidentiary hearing relating to the allegations in the subject Complaint;

b. The Consent Agreement, or conduct or statements made in negotiating the Consent Agreement, will be inadmissible at any administrative, civil or criminal legal proceeding; and

c. No provision contained in the Consent Agreement shall constitute or have the effect of an admission by Respondent as to any fact alleged in the Complaint in this matter or in this Consent Agreement.

51. If the Board accepts the Consent Agreement and enters it as an Order, the Consent

Agreement shall be admissible as evidence at any future proceedings before the Board.

52. Respondent acknowledges and agrees that the Board will report this Consent Agreement to the licensing authority of any other state in which he is licensed to practice.

53. The parties acknowledge and agree that this Consent Agreement, along with any exhibits, addendums, or amendments hereto, encompasses the entire agreement of the parties and supersedes all previous understandings and agreements between the parties, whether oral or written. There are no other terms, obligations, covenants, representations, statements or conditions, or otherwise, of any kind whatsoever concerning this agreement.

54. This Consent Agreement, and any disciplinary sanctions contained herein, shall be effective upon acceptance by the Board and entry of the Board's Order.

Dilipkumar Joshi, M.D.
Respondent

Dated: 2/24/17

Zoe Plerhoples (I.D. No. 5415)
Deputy Attorney General

Dated: 3/6/17

Devashree Brittingham
Executive Director
Delaware Board of Medical Licensure and Discipline

Dated: 3.30.2017