IN THE MATTER OF	*	**BEFORE THE**
REGINALD BIGGS, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D54306	*	**Case Number: 2217-0001A**

* * * * * * * * * * * * * *

CONSENT ORDER

PROCEDURAL BACKGROUND

On September 14, 2017, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **REGINALD BIGGS, M.D.** (the "Respondent"), License Number D54306, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") §§ 14-101 *et seq.* (2014 Repl. Vol.).

Specifically, Panel A charged the Respondent with violating the following provision of the Act under Health Occ. II § 14-404:

> (a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a 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[.]

On December 6, 2017, the Respondent appeared before Panel A, sitting as a Disciplinary Committee for Case Resolution. As a result of negotiations occurring before Panel A, the Respondent agreed to enter into the following Consent Order,

consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

FINDINGS OF FACT

Panel A makes the following Findings of Fact:

I. Licensing Information

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on January 12, 1999, under License Number D54306. The Respondent's license is currently active and is scheduled for renewal on September 30, 2018.

2. The Respondent is not board-certified in any medical specialty. The Respondent's self-designated specialty is psychiatry.

3. At all times relevant to these charges, the Respondent maintained a medical office at 3731 Branch Avenue, B-309, Temple Hills, Maryland 20748.

II. The Complaint

4. On or about June 15, 2016, the Board received a complaint from a registered nurse (the "Complainant")[1] from an alcohol and drug treatment center who reported that a patient reported to him that the Respondent was engaging in "vast overprescribing" of multiple stimulants, benzodiazepines, Suboxone and muscle relaxants. The Complainant stated that the patient reported entering the Respondent's office and requesting medications including Xanax, Klonopin, Suboxone and increased Adderall, which the Respondent prescribed. The Complainant also stated that the

[1] For confidentiality reasons, the names of complainants, health care facilities, patients or other individuals will not be disclosed in this document. The Respondent is aware of the identity of all individuals and entities referenced herein.

patient reported referring other drug users to the Respondent's clinic to obtain stimulants and benzodiazepines.

5. Based on the complaint, the Board initiated an investigation of the Respondent.

III. Investigation Findings

6. Pursuant to its investigation, the Board obtained five patient records from the Respondent and submitted them to two physicians who are board-certified in psychiatry and neurology for a practice review. The patients whose charts were reviewed were adult females who had diagnoses including depression, anxiety/panic disorder, and in two instances, a history of substance abuse disorders. The Respondent treated the patients with a variety of psychotropic medications, including antidepressants, various benzodiazepines (Schedule IV controlled dangerous substances ("CDS")) and stimulants (Schedule II CDS). The reviewers determined that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care in four of the five cases they reviewed ("Patients A through D").

7. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. II § 14-404(a)(22), with respect to Patients A through D. Deficiencies include but are not limited to:

(a) failing to perform or document adequate mental status examinations (*see, e.g.*, Patients A, B, C, D);

(b) failing to attempt an adequate trial of anti-depressant medications or failing to utilize alternative anti-depressant medications prior to prescribing

short-acting benzodiazepines and/or other scheduled medications (*see, e.g.*, Patients A, C, D);

(c) failing to document or adequately address difficulties with prior anti-depressant use (*see, e.g.*, Patient A);

(d) inappropriately prescribing benzodiazepines, including prescribing escalating dosages of benzodiazepines, concomitant prescribing of multiple benzodiazepines, prescribing inappropriately high dosages of benzodiazepines in conjunction with stimulants, and/or prescribing benzodiazepines on a long-term basis (*see, e.g.*, Patients A, B, C, D);

(e) failing to document or address long-term benzodiazepine use with patients (*see, e.g.*, Patients A, B, D);

(f) failing to adequately document or address patient histories of drug/alcohol use in conjunction with benzodiazepine prescribing (*see, e.g.*, Patients A, B);

(g) failing to adequately document or address patient histories of alcohol or substance abuse issues (*see, e.g.*, Patients A, B, D);

(h) failing to adequately document or develop information in order to establish a diagnosis (*see, e.g.*, Patients A, C, D);

(i) failing to adequately document or develop signs, symptoms, duration and severity of symptoms which led to diagnoses (*see, e.g.*, Patients A, C, D);

(j) failing to document methadone or Suboxone amounts prescribed or possible medication interactions (*see, e.g.*, Patient B);

(k) mismanaging suspected attention deficit hyperactivity disorder (*see, e.g.*, Patient C); and

(l) failing to document an adequate rationale for Lithium prescribing and/or failing to document Lithium levels or other blood tests associated with this prescribing (*see, e.g.*, Patient D).

8. The Board provided the Respondent with the reports from the reviewers. The Respondent submitted a response to the Board, which it received on or about June 23, 2017. The Respondent acknowledged the reviewers' criticisms of his practice and reported making changes to address some of the criticisms, including but not limited to implementing a more comprehensive intake form and requiring written provider contracts, undertaking routine substance abuse and drug testing, and curtailing seeing new patients who reported being on certain existing medication regimens (benzodiazepines and stimulants).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent violated the following provision of the Act: Health Occ. II § 14-404(a)(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.

ORDER

It is, on the affirmative vote of a majority of the quorum of Panel A, hereby:

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

ORDERED that the Respondent is placed on probation for a minimum period of **ONE (1) YEAR**,[2] to begin upon the effective date of this Consent Order, subject to the following probationary terms and conditions:

1. The Respondent shall not treat patients for chronic pain;

2. Within six (6) months, the Respondent shall successfully complete a Board disciplinary panel-approved course in the pharmacologic management of psychiatric conditions and substance abuse disorders. The panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. The Respondent must provide documentation to the panel that he has successfully completed the course;

3. Within six (6) months, the Respondent shall successfully complete a Board disciplinary panel-approved course in the appropriate medical recordkeeping. The panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. The Respondent must provide documentation to the panel that the Respondent has successfully completed the course;

4. The Respondent shall implement the following practice changes:

(a) The Respondent's patient charts shall include a section for the performance of a mental status examination. The Respondent shall perform a mental status examination on each patient office visit;

(b) The Respondent's progress notes shall include a section for assessment of current medications and the rationale for maintenance or

[2] If the Respondent's license expires while the Respondent is on probation, the probationary period and any probationary conditions will be tolled.

adjustment of medications. The Respondent shall review medications at each patient office visit and shall document his rationale for maintenance or adjustment of medications; and

(c) The Respondent shall perform complete psychiatric assessments annually for all patients.

5. The Panel will issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's CDS prescriptions. The administrative subpoenas will request a review of the Respondent's CDS prescriptions from the beginning of each quarter;

6. During the probationary period, the Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agents. An unsatisfactory chart and/or peer review will constitute a violation of probation; and

7. The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann, Health Occ. II §§ 14-101 – 14-702, and all laws, statutes, and regulations governing the practice of medicine.

AND IT IS FURTHER ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or of this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board or disciplinary panel; and it is further

ORDERED that after the appropriate hearing, if the Board or Board panel determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board or Board panel may reprimand the Respondent, place Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or Board panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and condition of this Consent Order; and it is further

ORDERED that after **ONE (1) YEAR,** the Respondent may submit a written petition to the Board or Panel A requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Panel A. The Respondent may be required to appear before the Board or Panel A to discuss his petition for termination. The Board or Panel A will grant the petition to terminate the probation if the Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of the Panel A; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* (2014).

01/05/2018
Date

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

CONSENT

I, Reginald Biggs, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact, Conclusions of Law and Order.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of Panel A 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 Disciplinary Panel B that might have followed any such hearing.

I sign this Consent Order after having had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and

terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

12/12/17
Date

Reginald Biggs, M.D.
Respondent

Read and approved:

Michael J. Halaiko, Esquire
Counsel for Dr. Biggs

NOTARY

STATE OF Maryland

CITY/COUNTY OF Prince Geo's

HARRY J. MARTIN JR. NOTARY PUBLIC PRINCE GEORGE'S COUNTY, MD

I HEREBY CERTIFY that on this 12 day of DEN, 2017, before me, a Notary Public of the foregoing State and City/County, did personally appear Reginald Biggs, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Notary Public

My commission expires: 1-27-2021