State Medical Board of Ohio

30 E. Broad St., 3 Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

August 11, 2021

Case number: 21-CRF-0131

Mahmood Rahman, M.D.
2286 South Ridge Court
Beavercreek, Ohio 45434

Dear Doctor Rahman:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to grant or register or issue the license/certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) In the routine course of your practice, from on or after January 1, 2012, you provided care and treatment for Patients 1 through 12, as identified on the attached Patient Key **(Key is confidential and to be withheld from public disclosure).** You inappropriately treated and/or failed to appropriately treat and/or failed to appropriately document your treatment of these patients. You failed to advise or document advising the patients of the risks, benefits and alternatives to the medications you prescribed and of the potential for abuse. Additionally, you also failed to consistently document the reason you prescribed medications, and your documentation was poor. Further, you failed to consistently order appropriate testing at appropriate intervals, and for Patients 1 through 4, 6 through 10 and 12, you failed to consistently document vital signs at appropriate intervals.

(2) Examples of such care and treatment and/or conduct identified in paragraph (1) include, but are not limited to, the following:

(a) You began treating Patient 1 on or about March 24, 2010, to at least on or about March 11, 2020, for conditions that included ADHD, panic disorder and bipolar 2 disorder. You prescribed medications, including clonazepam, risperidone, amphetamine/dextroamphetamine and trazodone. You failed to perform an appropriate work-up of Patient 1's diagnosis of panic attack and failed to administer the first-line treatment of SSRI antidepressants, instead initially prescribing a benzodiazepine. You also failed to document the reason you prescribed risperidone.

(b) You began treating Patient 2 on or about November 12, 2013, to at least on or about January 22, 2020, for conditions that included Bipolar Disorder type 2, PTSD and Panic Disorder. You prescribed medications, including clonazepam, gabapentin, risperidone, vilazodone, atomoxetine and cariprazine. You

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prescribed a high dose of clonazepam and failed to taper or attempt to taper the medication. You also failed to sufficiently document Patient 2's medical condition(s) and/or the changes in the patient's treatment plan, and you failed to appropriately document the reasons for your off-label use of medications.

(c) You began treating Patient 3 on or about May 16, 2013, to at least on or about January 21, 2020, for conditions that included Bipolar Disorder, ADHD and Panic Disorder. You prescribed medications, including clonazepam, gabapentin, lisdexamfetamine and topiramate. You failed to sufficiently document Patient 3's medical condition(s) and/or the changes in the patient's treatment plan. You also failed to consistently prescribe appropriate medications to treat Patient 3's Bipolar Disorder.

(d) You began treating Patient 4 on or about September 17, 2008, to at least on or about January 25, 2017, for conditions that included Bipolar Affective Disorder, PTSD, ADHD and narcolepsy. You prescribed medications, including lithium, bupropion, amphetamine/dextroamphetamine, lurasidone, aripiprazole, sodium oxybate, escitalopram and venlafaxine. You started antipsychotic medications and failed to appropriately document the reason(s) for the medication(s) in the patient chart. Additionally, you failed to appropriately test or conduct a work-up for Patient 4's narcolepsy diagnosis.

(e) You began treating Patient 5 on or about January 7, 2015, to at least on or about April 7, 2020, for conditions that included Bipolar Affective Disorder (depression with psychosis). You prescribed medications, including desvenlafaxine, lurasidone, gabapentin, zolpidem and brexpiprazole. Your rationale for prescribing the medications is poorly documented.

(f) You began treating Patient 6 on or about June 17, 2008, to at least on or about August 24, 2017, for conditions that included Bipolar Affective Disorder and Panic Disorder with Agoraphobia. You prescribed medications, including risperidone, ziprasidone, alprazolam, zolpidem, diazepam, gabapentin, clonazepam, levomilnacipram, eszopliclone and lurasidone. You failed to appropriately document mental status examinations of Patient 6; you also failed to appropriately consider a diagnosis of borderline personality disorder. You failed to advise or document advising Patient 6 of the potential for overdose or abuse potential of the prescribed hypnotics with opioids that also were prescribed for her.

(g) You began treating Patient 7 on or about June 6, 2007, to at least on or about September 13, 2017, for conditions that included Social Anxiety Disorder and Bipolar Affective Disorder. You also diagnosed either Attention Deficit Disorder or Antisocial Personality Disorder, although the patient record is unclear, and you failed to document symptoms to support either diagnosis. You prescribed medications, including methylphenidate, clonazepam, duloxetine, lithium, asenapine, brexpiprazole, lisdexamphetamine, quetiapine and gabapentin. You failed to consistently document the reason(s) for prescribing these medications,

and you failed to document the reason(s) for the changes you made in medications. You also diagnosed Patient 7 with Bipolar Affective Disorder, and you failed to document information to support this diagnosis. Patient 7 had a documented history of substance abuse disorder, and you prescribed stimulants and benzodiazepines without sufficient monitoring.

(h) You began treating Patient 8 on or about February 8, 2011, to at least on or about April 3, 2020, for conditions that included ADHD, Bipolar Affective Disorder and narcolepsy. You prescribed medications, including sodium oxybate, citalopram, buproprion, carbamazepine, lisdexamfetamine, lorazepam, dextroamphetamine, modafinil, cariprazine, lithium and quetiapine. You documented a diagnosis of bipolar affective disorder without supporting documentation in the patient chart, and you failed to appropriately treat this condition. You also failed to appropriately document the reason you prescribed medications, including benzodiazepines, which you prescribed long term. You prescribed stimulants and benzodiazepines without sufficient monitoring.

(i) You began treating Patient 9 on or about March 9, 2005, to at least on or about January 23, 2018, for conditions that included Bipolar Affective Disorder and PTSD. You prescribed medications, including escitalopram, risperidone, lithium, lorazepam, venlafaxine, cariprazine, brexpiprazole, propranolol, levomilnacipram and asenapine. You failed to document symptoms directly related to PTSD. You also failed to document your rationale for continuing to prescribe benzodiazepines, and you failed to attempt to wean Patient 9 from controlled substances or find alternative treatments.

(j) You began treating Patient 10 on or about August 22, 2018, to at least on or about March 18, 2020, for conditions that included Major Depressive Disorder and ADHD. You prescribed medications, including quetiapine, buspirone, bupropion, vilazodone and lisdexamfetamine. You prescribed quetiapine without first trying other medications. Additionally, Patient 10 was prescribed opioids by another physician and you failed to appropriately monitor her medication use. You also failed to document an appropriate history to support the diagnosis of ADHD.

(k) You began treating Patient 11 on or about October 2, 2013, to at least on or about October 3, 2019, for conditions that included Bipolar Affective Disorder and panic disorder. You prescribed medications, including propranolol, lurasidone, carbamezapine, levomilnacipran, clonazepam, quetiapine, asenapine and brexpiprazole. You failed to taper or document tapering clonazepam, and you failed to advise and/or document advising Patient 11 on the dangers of failing to taper the medication. You also failed to discuss and/or document discussing with Patient 11 the abuse and overdose potential of benzodiazepines.

(l) You began treating Patient 12 on or about July 25, 2012, to at least on or about September 5, 2018, for conditions that included Bipolar Affective Disorder type 2, attention deficit disorder, panic disorder and post-traumatic stress disorder. You prescribed medications, including vilazadone, trazodone, gabapentin,

clonazepam, amphetamine/dextroamphetamine, and later cariprazine and oxcarbazepine. The initial medications you prescribed to treat Patient 12's Bipolar Affective Disorder did not include a first-line agent. Further, the combination of stimulants and benzodiazepines you prescribed to Patient 12 can create or cause side effects that can mimic other symptoms you treated, which you failed to consider and/or document considering, and you failed to explore alternatives.

(3) You prescribed controlled substances for Patients 1 through 12, which required you to access the Ohio Automated Rx Reporting System [OARRS] at certain intervals.

(a) During the time you treated Patients 1 through 9 and 11 through 12, on or after November 30, 2011, until December 30, 2015, you failed to access or document accessing the Ohio Automated Rx Reporting System [OARRS] at the times and frequency required by Rule 4731-11-11, Ohio Administrative Code, as in effect at that time.

(b) During the time you treated Patients 1 through 9 and 11 through 12, on or after December 31, 2015, you failed to access or document accessing OARRS at the times and frequency required by Rule 4731-11-11, Ohio Administrative Code, as in effect at that time.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) through (2) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) through (2) above, individually and/or collectively, constitute a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Additionally, your acts, conduct, and/or omissions that occurred on or after November 30, 2011, until December 30, 2015, as alleged in paragraph (3)(a) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Standards and Procedures for Review of "Ohio Automated Rx Reporting System" (OARRS), Rule 4731-11-11, Ohio Administrative Code, as in effect at that time.

Further, your acts, conduct, and/or omissions that occurred on or after December 31, 2015, as alleged in paragraph (3)(b) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Standards and

Procedures for Review of "Ohio Automated Rx Reporting System" (OARRS), Rule 4731-11-11, Ohio Administrative Code, as currently in effect.

Furthermore, for any violations that occurred on or after September 29, 2015, the Board may impose a civil penalty in an amount that shall not exceed twenty thousand dollars, pursuant to Section 4731.225, Ohio Revised Code. The civil penalty may be in addition to any other action the Board may take under section 4731.22, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to grant or register or issue the license/certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice medicine and surgery, or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Kim G. Rothermel MD

Kim G. Rothermel, M.D.
Secretary

KGR/CDP/jmb
Enclosures

CERTIFIED MAIL #91 7199 9991 7039 7801 3439
RETURN RECEIPT REQUESTED

IN THE MATTER OF MAHMOOD RAHMAN, M.D.

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AUGUST 11, 2021, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.