COMMONWEALTH of VIRGINIA

Sandra Whitley Ryals
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

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TEL (804) 367- 4400
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June 2, 2008

Mario H. Gomez, M.D.
4906 Cutshaw Ave., Suite 104
Richmond, Virginia 23230

CERTIFIED MAIL
7160 3901 9845 1844 7092

RE: License No. 0101-042524

Dear Dr. Gomez:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Friday, July 11, 2008, at 11:45 a.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Richmond, Virginia**. The conference will be conducted pursuant to Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

A Special Conference Committee ("Committee") will inquire into allegations that you may have violated certain laws and regulations governing the practice of medicine and surgery in Virginia. Specifically:

1. You may have violated Sections 54.1-2915.A(3), (13), and (16) of the Code, in that, from approximately 2004 to 2007, you failed to properly manage the care and treatment of Patients A-I, in that:

a. You failed to obtain a complete patient history prior to prescribing controlled substances, including prior psychiatric and substance abuse history, as well as past intervention and treatment for chronic pain conditions.

b. You regularly prescribed narcotics and benzodiazepines to patients without performing a proper evaluation or assessment of the patient, diagnosing a medical condition justifying such prescriptions, or documenting your reasons for selecting the types of medications prescribed. Further, you prescribed narcotics to patients on dates when the patients did not present to your office for a visit.

c. You failed to develop a comprehensive treatment plan and/or to periodically review and monitor the efficacy of treatment for patients, including monitoring and managing patients' usage of narcotic and/or benzodiazepine medications. In many instances, you did not have a pain management or similar contract in place with patients for whom you regularly prescribed these medications or failed to enforce the pain management contracts that you had with patients. You repeatedly authorized early refills of medications, without any medical indication other than information provided to you by the patients themselves. You routinely replaced medications reported as "lost" or "stolen" by patients. Further, you failed to order any drug urine/serum screens, to conduct pill counts, or to take other appropriate measures to determine whether your patients were taking their medications as prescribed and were otherwise compliant with their medication regimen.

d. You prescribed controlled substances to patients who exhibited drug-seeking behavior or who you knew or should have known were abusing or had become addicted to or dependent upon their medications, as well as to patients who used illegal drugs. Further, you failed to address (or document that you had addressed) signs and symptoms of escalation or abuse of narcotic therapies, nor did you appropriately treat or refer patients for treatment of substance abuse, despite having information that patients were exhibiting signs of abuse, such as hospitalizations for drug overdose and/or drug addiction, information from family members and/or other physicians that the patient was overusing or abusing his/her medications, information that patients were receiving pain medications from other doctors, and reports of dismissal from other doctors' practice due to medication misuse/overuse.

e. You failed to appropriately consider, recommend, or prescribe to your chronic pain patients treatment modalities other than the prescription of controlled substances.

f. You failed to make appropriate patient referrals to, and/or to consult and coordinate treatment with, other physicians, nor did you consistently obtain medical records from other physicians involved in the care of your patients.

2. You may have violated Sections 54.1-2915.A(3), (12), (13), and (16) of the Code, and 18 VAC 85-20-26(C) of the Board Regulations, in that, you failed to properly manage and maintain timely, accurate, legible, and complete records for Patients A - I. Specifically, your records are illegible, often lack any documentation of a physical examination or other assessment at office visits, and sometimes do not document, or incorrectly document, the quantity and dose of medications prescribed. Further, your records are incomplete, in that you failed to or are unable to produce records for large blocks of time for your patients.

3. You may have violated Sections 54.1-2915.A(3), (13), (16), and (17) and 54.1-3408.01 of the Code, in that you post-dated numerous prescriptions for Patients B, C, D, G, H, and I.

4. You may have violated Section 54.1-2915.A(12) and (18) of the Code, and 18 VAC 85-20-105 of the Board of Medicine Regulations, in that, notwithstanding two written requests from a Department of Health Professions' Investigator, dated October 30, 2007 and December 6, 2007, respectively, that you provide a verbatim transcription of all of your illegible, handwritten notes for Patients E, F, G, and H, you failed to provide a complete transcription of said records. Instead, you provided transcriptions of only small portions of these patients' records.

5. You may have violated Section 54.1-2915.A(17) of the Code, in that, on numerous occasions from May to December, 2007, you prescribed Suboxone and/or Subutex (both Schedule III controlled substances) to Patient F in connection with narcotics that you had previously prescribed her, even though you are not qualified or registered to dispense narcotic drugs for narcotic treatment as required by federal law (Controlled Substance Act of 1970, 21 U.S.C. 801 *et. seq.*) and regulation.

Please see Attachment I for the names of the patients referenced above.

After consideration of all information, the Committee may:

1. Exonerate you;
2. Place you on probation with such terms it deems appropriate.
3. Reprimand you;
4. Impose a monetary penalty pursuant to Section 54.1-2401 of the Code.

Further, the Committee may refer this matter for a formal administrative proceeding when it has failed to dispose of a case by consent pursuant to Section 2.2-4019 of the Code.

You have the right to information that will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents that will be distributed to the Committee for its consideration when discussing the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. Further, if you retain counsel, it is your responsibility to provide the enclosed materials to your attorney.

To facilitate this proceeding, you must submit eight (8) copies of any documents you wish for the Committee to consider to Reneé S. Dixson, Discipline Case Manager, Virginia Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, Virginia 23233-1463, by **June 20, 2008**. Your documents may not be submitted by facsimile or e-mail. Should you or Adjudication Specialist Julia K. Bennett wish to submit any documents for the Committee's consideration after **June 20, 2008**, such documents shall be considered only upon a ruling by the Chair of the Committee that good cause has been shown for late submission.

You may be represented by an attorney at the informal conference. If you obtain counsel, you should do so as soon as possible, because absent good cause to support a request

for a continuance, the informal conference will be held on **July 11, 2008**. A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made, in writing, to me at the address listed on this letter and must be received by **June 16, 2008**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **June 16, 2008**, will not be considered

Relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia cited in this notice can be found on the Internet at **http://leg1.state.va.us.** To access this information, please click on the *Code of Virginia* for statutes and *Virginia Administrative Code* for regulations.

In its deliberations, the Committee may utilize the Sanction Reference Points System, as contained in the Sanction Reference Manual. The manual, which is a guidance document of the Board, may be accessed at **http://www.dhp.virginia.gov/medicine**. You may request a paper copy from the Board office by calling (804) 367-4513.

Please advise the Board, in writing, of your intention to be present. Should you fail to appear at the informal conference, the Board may proceed to a formal administrative hearing in order to impose sanctions.

If you have any questions regarding this notice, please contact Julia K. Bennett, Adjudication Specialist, at (804) 367-4427.

Sincerely,

for William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

WLH:fd0602N1.ifcnot.gomez.08

Enclosures:
Informal Conference Package
Map

cc: Stephen E. Heretick, J.D., President Virginia Board of Medicine
Sandra Whitley Ryals, Director, Department of Health Professions
Reneé S. Dixson, Discipline Case Manager, Board of Medicine
Julia K. Bennett, Adjudication Specialist
Lorraine McGehee, Deputy Director, APD
Vicki Garrison, Pharmacist, Pharmacy Inspector (116346 & 103992)

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: MARIO H. GOMEZ, M.D.
License No.: 0101-042524

ORDER

In accordance with Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Mario H. Gomez, M.D., on July 11, 2008, in Richmond, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Malcolm Cothran, M.D., Chair; Robert Mosby, Jr., M.D.; and Valerie Hoffman, D.C.

Dr. Gomez appeared personally and was represented by Charles Hundley, Esquire, and William Seymour, IV, Esquire. Julia K. Bennett, Adjudication Specialist, was present as a representative for the Administrative Proceedings Division of the Department of Health Professions.

The purpose of the informal conference was to receive and act upon evidence that Dr. Gomez may have violated certain laws and regulations governing the practice of medicine and surgery in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated June 2, 2008.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Now, having properly considered the evidence and statements presented, the Committee makes the following Findings of Fact and Conclusions of Law in this matter:

1. Mario H. Gomez, M.D., was issued license number 0101-042524 by the Board to practice medicine and surgery in the Commonwealth of Virginia on July 1, 1988. Said license is currently active and will expire on October 31, 2008, unless renewed or otherwise restricted.

2. Dr. Gomez violated Sections 54.1-2915.A(3), (13), and (16) of the Code, in that, from approximately 2004 to 2007, he failed to properly manage the care and treatment of Patients A-I, in that:

a. He failed to obtain a complete patient history prior to prescribing controlled substances, including prior psychiatric and substance abuse history, as well as past intervention and treatment for chronic pain conditions.

b. He regularly prescribed narcotics and benzodiazepines to patients without performing a proper evaluation or assessment of the patient, diagnosing a medical condition justifying such prescriptions, or documenting his reasons for selecting the types of medications prescribed. Further, Dr. Gomez prescribed narcotics to patients on dates when the patients did not present to his office for a visit.

c. He failed to develop a comprehensive treatment plan and/or to periodically review and monitor the efficacy of treatment for patients, including monitoring and managing patients' usage of narcotic and/or benzodiazepine medications. In many instances, Dr. Gomez did not have a pain management or similar contract in place with patients for whom he regularly prescribed these medications or failed to enforce the pain management contracts that he had with patients. Dr. Gomez

repeatedly authorized early refills of medications, without any medical indication other than information provided to him by the patients themselves. Dr. Gomez routinely replaced medications reported as "lost" or "stolen" by patients. Further, Dr. Gomez failed to order any drug urine/serum screens, to conduct pill counts, or to take other appropriate measures to determine whether his patients were taking their medications as prescribed and were otherwise compliant with their medication regimen.

d. He prescribed controlled substances to patients who exhibited drug-seeking behavior or who he knew or should have known were abusing or had become addicted to or dependent upon their medications, as well as to patients who used illegal drugs. Further, Dr. Gomez failed to address (or document that he had addressed) signs and symptoms of escalation or abuse of narcotic therapies, nor did he appropriately treat or refer patients for treatment of substance abuse, despite having information that patients were exhibiting signs of abuse, such as hospitalizations for drug overdose and/or drug addiction, information from family members and/or other physicians that the patient was overusing or abusing his/her medications, information that patients were receiving pain medications from other doctors, and reports of dismissal from other doctors' practices due to medication misuse/overuse.

e. He failed to appropriately consider, recommend, or prescribe to his chronic pain patients treatment modalities other than the prescription of controlled substances.

f. He failed to make appropriate patient referrals to, and/or to consult and coordinate treatment with, other physicians, nor did he consistently obtain medical records from other physicians involved in the care of his patients.

3. Dr. Gomez violated Sections 54.1-2915.A(3), (12), (13), (16), and (18) of the Code, and 18 VAC 85-20-26(C) of the Board of Medicine General Regulations, in that, he failed to properly manage and maintain timely, accurate, legible, and complete records for Patients A - I. Specifically, his records are illegible, often lack any documentation of a physical examination or other assessment at office visits, and sometimes do not document, or incorrectly document, the quantity and dose of medications prescribed. Further, Dr. Gomez' records are incomplete, in that he failed to or is unable to produce records for large blocks of time for his patients.

4. Dr. Gomez violated Sections 54.1-2915.A(3), (13), (16), and (17) and 54.1-3408.01 of the Code, in that he post-dated numerous prescriptions for Patients B, C, D, G, H, and I.

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, it is hereby ORDERED that Mario H. Gomez, M.D., be, and hereby is, PERMANENTLY RESTRICTED from providing pain management treatment or services, including

consultation, to patients. Within 30 days of entry of this Order, Dr. Gomez shall give written notice of this restriction to all patients to whom he is currently providing pain management treatment. Dr. Gomez must transfer the care and treatment of all such patients to other appropriate healthcare providers, including, without limitation, Patients B-I.

It is further ORDERED that the license of Dr. Gomez be, and hereby is, placed on INDEFINITE PROBATION and subject to the following terms and conditions:

1. Within thirty (30) days from entry of this Order, Dr. Gomez shall provide the Board with a written statement certifying that he has read, and will comply with: (i) the laws governing the practice of medicine (Title 54.1, Chapter 29 of the Code); (ii) the Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic (18 VAC 85-20-10 *et. seq.*); (iii) Section 54.1-3303 of the Code; and (iv) the Drug Control Act (Title 54.1, Chapter 34 of the Code).

2. Within twelve (12) months from entry of this Order, Dr. Gomez shall complete a Board-approved Continuing Medical Education ("CME") course consisting of at least ten (10) hours in the subject of medical recordkeeping. Such CME shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (i.e., no home study, journal or Internet courses). Any CME hours obtained in compliance with this term shall not be used towards compliance with the Board's continuing education requirements for license renewal.

3. Within twelve (12) months from entry of this Order, Dr. Gomez shall complete a Board-approved Continuing Medical Education ("CME") course consisting of at least ten (10) hours in the subject of proper prescribing of controlled substances. Such CME shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (i.e., no home study, journal or Internet courses). Any CME hours obtained in compliance with this term shall not be used towards compliance with the Board's continuing education requirements for license renewal.

4. Within 21 days of completion of the required CME, Dr. Gomez shall submit a certificate or other evidence, satisfactory to the Board, of completion of such CME.

5. Upon receipt of evidence that Dr. Gomez has complied with Terms 1 - 4 of this Order, the Committee authorizes the Executive Director of the Board to terminate the indefinite probation imposed on Dr. Gomez's license or refer this matter to a Special Conference Committee for its review and final determination. However, any termination of the indefinite probation by the Executive Director shall have no effect on the permanent restriction imposed on Dr. Gomez' license with respect to pain management as set forth above.

Dr. Gomez shall maintain a course of conduct in his practice of medicine and surgery commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

Violation of this Order may constitute grounds for the suspension or revocation of Dr. Gomez' license. In the event Dr. Gomez violates any of the terms and conditions of this Order, an administrative proceeding may be convened to determine whether such action is warranted.

Pursuant to Section 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Pursuant to Sections 54.1-2400(10) of the Code, Dr. Gomez may, not later than 5:00 p.m., on August 26, 2008, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

Therefore, this Order shall become final on August 26, 2008; unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

for William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 7/24/2008

COMMONWEALTH of VIRGINIA

Sandra Whitley Ryals
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

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TEL (804) 367- 4400
FAX (804) 527- 4475

December 2, 2008

Mario H. Gomez, M.D.
P.O. Box 5567
Midlothian, Virginia 23112

CERTIFIED MAIL
7160 3901 9845 3426 5993

RE: License No.: 0101-042524

Dear Dr. Gomez:

This letter is official notification of my decision regarding your compliance with the Board's Order entered July 24, 2008.

I have received verification that you have successfully completed Terms #1 through #4 of the Board's Order. Therefore, pursuant to the authority granted by Term #5, I have determined that the indefinite probation and terms imposed on your license should be TERMINATED effective this date.

The record of the Board has been updated to reflect the above changes. However, please be reminded that this decision does not affect the permanent restriction imposed on your license with respect to pain management, as stipulated by Term #5 of the Board's Order.

Pursuant to §54.1-2400.2 (F) of the *Code of Virginia,* a signed copy of this letter shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

The Board wishes you well in your future endeavors.

Sincerely,

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

cc: Renée S. Dixson, Discipline Case Manager [116346]
Jennie Wood, Administrative Assistant
Susan Brooks, Office Manager, APD