#### BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

\*

\* CASE NO.: 21-CRF-00131

MAHMOOD RAHMAN, M.D.

#### **ENTRY OF ORDER**

On November 30, 2021, Mahmood Rahman, M.D., executed a Surrender/Retirement of his license to practice medicine and surgery in Ohio with consent to permanent revocation, which document is attached hereto and fully incorporated herein.

Wherefore, upon ratification by the Board of the surrender/retirement, it is hereby ORDERED that Certificate No. 35.066692 authorizing Mahmood Rahman, M.D., to practice medicine and surgery in the State of Ohio be permanently REVOKED.

This Order is hereby entered upon the Journal of the State Medical Board of Ohio for the 8th day of December 2021, and the original thereof shall be kept with said Journal.

Kim G. Rothermel, M.D.

Secretary

(SEAL)

December 8, 2021

Date

### STATE OF OHIO THE STATE MEDICAL BOARD PERMANENT SURRENDER/RETIREMENT OF CERTIFICATE TO PRACTICE MEDICINE AND SURGERY CASE NO. 21-CRF-0131

Do not sign this agreement without reading it. An individual who permanently surrenders a certificate issued by the Board is forever thereafter ineligible to hold a certificate to practice or to apply to the Board for reinstatement of the certificate or issuance of any new certificate. You are permitted to be accompanied, represented and advised by an attorney, at your own expense, before deciding to sign this voluntary agreement.

- I, Mahmood Rahman, M.D., am aware of my rights to representation by counsel, the right of being formally charged and having a formal adjudicative hearing, and do hereby freely execute this document and choose to take the actions described herein. I acknowledge and agree that I am entering into this agreement of my own free will and volition and have not been coerced to do so, nor am I under duress at the time of executing this agreement. I further acknowledge that I had an opportunity to ask questions concerning the terms of this agreement and that all questions asked have been answered in a satisfactory manner. I aver that I fully understand all of the terms and provisions of this voluntary agreement. I further agree that no representations have been made by the Board, its members, employees, agents, officers and representatives regarding any of the legal ramifications of this agreement, including but not limited to the effect this agreement may have on my current or future employment, my specialty board certifications, or any licenses, past, present or future, to practice in other states or jurisdictions.
- I, Mahmood Rahman, M.D., do hereby voluntarily, knowingly, and intelligently surrender/retire my certificate to practice medicine and surgery, License #35.066692, to the State Medical Board of Ohio [Board], thereby relinquishing all rights to practice medicine and surgery in Ohio.

I understand that as a result of the surrender/retirement herein I will no longer permitted to practice medicine and surgery in any form or manner in the State of Ohio.

I agree that I shall be ineligible for, and shall not apply for, reinstatement or restoration of certificate to practice medicine and surgery License #35.066692 or issuance of any other certificate pursuant to the authority of the State Medical Board of Ohio, on or after the date of signing this Permanent Surrender/Retirement of Certificate to Practice Medicine and Surgery. Any such attempted reapplication shall be considered null and void and shall not be processed by the Board.

I hereby authorize the State Medical Board of Ohio to enter upon its Journal an Order permanently revoking my certificate to practice medicine and surgery, License #35.066692, in conjunction with which I expressly waive the provision of Section 4731.22(B), Ohio Revised Code, requiring that six (6) Board Members vote to revoke said certificate, and further expressly and forever waive all rights as set forth in Chapter 119., Ohio Revised Code, including but not limited to my right to counsel, right to a hearing, right to present evidence, right to cross-examine witnesses, and right to appeal the Order of the Board revoking my certificate to practice medicine and surgery.

I, Mahmood Rahman, M.D., hereby release the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This document shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code. Further, this information may be reported to appropriate organizations, data banks and governmental bodies. I, Mahmood Rahman, M.D., acknowledge that my social security number will be used if this information is so reported and agree to provide my social security number to the Board for such purposes.

I stipulate and agree that I am taking the action described herein in lieu of further formal disciplinary proceedings in Case No. 21-CRF-0131, pursuant to Sections 4731.22(B)(2), (B)(6) and (B)(20) Ohio Revised Code, as set forth in the Notice of Opportunity for Hearing issued by the Board on August 11, 2021, a copy of which is attached hereto as Exhibit A and fully incorporated herein.

#### **EFFECTIVE DATE**

It is expressly understood that this Permanent Surrender/Retirement of Certificate is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below. Further, I specifically acknowledge that the electronic transmission of a scanned or photostatic copy of any executed signature to this Permanent Surrender/Retirement of Certificate, upon being received by the Board, shall be deemed to have the full legal force and effect as the original.

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MAHMOOD RAHMAN, M.D.	KIM G. ROTHERMEL, M.D.
11/30/21	Secretary
	<u>12/8/21</u> DATE
DATE	DATE
Cholin Bancin	Bun Men BM
JOHN R. IRWIN, MD, JD	BRUCE R. SAFERIN, D.P.M.
Aftorney for Dr. Rahman	Supervising Member
12/2/2/	12-8-21
DATÉ	DATE
	KYLE C. WILCOX
	Assistant Attorney General
	12-8-21
	DATE



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

August 11, 2021

Case number: 21-CRF- \$131

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:
  - 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- (I) 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

Notice of Opportunity for Hearing Mahmood Rahman, M.D. Page 5

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, 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.

#### 21-CRF-0131

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

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



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

August 11, 2021

Case number: 21-CRF- \$\text{\$\textit{Q}\$}\] 131

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.
- 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.
- (I) 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

Notice of Opportunity for Hearing Mahmood Rahman, M.D. Page 5

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, 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.

21-CRF-0131

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

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