STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Stephen P. Markus, MD
Master Case No.: M2018-94
Document: Amended Statement of Charges

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

Certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

> The identity of the complainant if the person is a consumer, health care provider, or employee, pursuant to RCW 43.70.075 (Identity of Whistleblower Protected) and/or the identity of a patient, pursuant to RCW 70.02.020 (Medical Records - Health Care Information Access and Disclosure)

If you have any questions or need additional information regarding the information that was withheld, please contact:

> Customer Service Center
> P.O. Box 47865
> Olympia, WA 98504-7865
> Phone: (360) 236-4700
> Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **STEPHEN P. MARKUS, MD** License No. MD.MD.00021837 Respondent.	**No. M2018-94** **AMENDED STATEMENT OF CHARGES**

The Executive Director of the Washington Medical Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in file numbers 2017-3445 and 2019-10700. The patient referred to in this Amended Statement of Charges is identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On July 25, 1984, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent is not board certified.

INAPPROPRIATE BUSINESS PRACTICES

1.2 From on or about July 2014 through at least May 2017, Respondent entered into agreements to be the Medical Director for multiple outpatient substance use disorder clinics in Washington.

1.3 The agreements set forth the following Medical Director duties and responsibilities: make recommendations on random urinalysis screenings; participate in administrative decision making and recommend policies and procedures; organize and coordinate physician services and services provided by other professionals as they relate to individual care; monitor all evaluations and recommendations including treatment and lab results; ensure agency compliance with law, regulations and contracts; laboratory services; and evaluate potential for withdrawal and order medications when appropriate for safe detoxification, including referral to a medical facility.

1.4 In exchange for Respondent's services, the agreements set forth a payment of $1,500 to $10,000 per month, plus an additional $350 per initial patient interview and an additional $130 per follow-up interview.

1.5 Several facilities for which Respondent served as medical director were owned by John Dorman. John Dorman had implemented a urinalysis testing scheme at outpatient substance use disorder clinics he owned and operated which involved the following:

a. Contracting with a specific laboratory for definitive urine drug screens (UDS).

b. Contracting with a specific physician to act as the center's medical director, to order the UDS.

c. Requiring all clients in intensive outpatient treatment undergo two UDSs each week, regardless of any determination of medical necessity.

d. Sending each urine sample to a laboratory for definitive testing of a large number of substances regardless of any prior medical history to maximize insurance reimbursements.

1.6 In approximately September of 2015, John Dorman brought the owner and the director of a chemical dependency treatment center to Respondent's office to discuss contracting with Respondent as medical director to implement this scheme. At this meeting, Respondent provided a proposed medical director services agreement to them. This scheme would increase profits for the treatment center.

1.7 In response to the Commission's investigator, Respondent indicated he had no knowledge of any such scheme. Respondent claimed that the facilities with which he contracted were using his signature without his knowledge to authorize unnecessary urine drug screens.

1.8 Medical directors are responsible for the medical care and treatment of patients in the healthcare facility or institution for which they have agreed to be the medical director. Respondent was responsible for setting laboratory testing policies and being aware that all policies are being followed correctly.

1.9 Respondent either knowingly participated in the scheme to order and bill unnecessary urine drug screens, or as medical director should have known of the scheme. Alternatively, if he did not know, he was deficient in his duty as medical director for the facilities with which he contracted.

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INADEQUATE CARE OF PATIENT A

1.10 On or about June 1, 2015, Respondent became the Medical Director of a licensed behavioral health agency.

1.11. On or about October 1, 2015, Respondent initially saw Patient A who was the owner of a behavioral health agency where Respondent served as Medical Director. In addition to being the owner, Patient A was a licensed chemical dependency counselor and provided treatment to vulnerable patients at his agency. Patient A presented with lumbar pain and was taking Buprenorphine – Naloxone (Suboxone), an opioid, to manage his pain. Respondent continued Patient A on Suboxone.

1.12 Respondent did not consult the Prescription Monitoring Program (PMP) prior to prescribing medication to Patient A. Patient A had been dispensed a 30-day supply of Tramadol, 50 mg., twice in August 2015. Tramadol is an opioid used to help relieve moderate to moderately severe pain.

1.13 Respondent ended the business relationship with the licensed behavioral health agency on or about March 31, 2016.

1.14 Respondent continued to see Patient A several times a year. Patient A described work stress, anxiety, sleep issues, and pain. Respondent continued to prescribe Suboxone and started him on Zolpidem Tartrate (Ambien) in January of 2017 for sleep issues.

1.15 In November 2017, Respondent started prescribing Alprazolam to Patient A while continuing him on Suboxone and Ambien.

1.16 Beginning in February 2018 and over the course of the next year, Patient A was prescribed oxycodone and hydrocodone by six different providers in addition to Respondent. Oxycodone and hydrocodone are both opioids with a risk for abuse and addiction. During this time, Respondent continued to prescribe Suboxone which was dispensed to Patient A.

1.17 In August 2018, Respondent started prescribing Lorazepam (used for anxiety) to Patient A.

1.18 Respondent last saw Patient A on February 14, 2019. However, Patient A continued to fill prescriptions from Respondent in March and April of 2019.

1.19 Patient A passed away on April 16, 2019. The cause of death was cardiac arrest.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), (4), (7), and (13) and WAC 246-919-853, -854, -855, -857, and -860[1], which provide in part:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
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> (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
> …
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
> …
> (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
> …
> (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;
> ….
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> **WAC 246-919-853**
> **Patient evaluation.**
>
> The physician shall obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic noncancer pain.
>
> (1) The patient's health history shall include:

[1] The opioid prescribing rules were updated on January 1, 2019. The new rules for Chronic Pain Management are codified under WAC 246-919-905 through -955. The alleged violation reflects the rules that were in place at the time the alleged conduct occurred.

(a) Current and past treatments for pain;

(b) Comorbidities; and

(c) Any substance abuse.

(2) The patient's health history should include:

(a) A review of any available prescription monitoring program or emergency department-based information exchange; and

(b) Any relevant information from a pharmacist provided to a physician.

(3) The initial patient evaluation shall include:

(a) Physical examination;

(b) The nature and intensity of the pain;

(c) The effect of the pain on physical and psychological function;

(d) Medications including indication(s), date, type, dosage, and quantity prescribed;

(e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:

(i) History of addiction;

(ii) Abuse or aberrant behavior regarding opioid use;

(iii) Psychiatric conditions;

(iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;

(v) Poorly controlled depression or anxiety;

(vi) Evidence or risk of significant adverse events, including falls or fractures;

(vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;

(viii) Repeated visits to emergency departments seeking opioids;

(ix) History of sleep apnea or other respiratory risk factors;

(x) Possible or current pregnancy; and

(xi) History of allergies or intolerances.

(4) The initial patient evaluation should include:

(a) Any available diagnostic, therapeutic, and laboratory results; and

(b) Any available consultations.

(5) The health record shall be maintained in an accessible manner, readily available for review, and should include:

(a) The diagnosis, treatment plan, and objectives;

(b) Documentation of the presence of one or more recognized indications for the use of pain medication;

(c) Documentation of any medication prescribed;

(d) Results of periodic reviews;

(e) Any written agreements for treatment between the patient and the physician; and

(f) The physician's instructions to the patient.

WAC 246-919-854
Treatment plan.

(1) The written treatment plan shall state the objectives that will be used to determine treatment success and shall include, at a minimum:

(a) Any change in pain relief;

(b) Any change in physical and psychosocial function; and

(c) Additional diagnostic evaluations or other planned treatments.

(2) After treatment begins the physician should adjust drug therapy to the individual health needs of the patient. The physician shall include indications for medication use on the prescription and require photo identification of the person picking up the prescription in order to fill. The physician shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.

(3) Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

WAC 246-919-855
Informed consent.

The physician shall discuss the risks and benefits of treatment options with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without health care decision-making capacity.

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WAC 246-919-857
Periodic review.

The physician shall periodically review the course of treatment for chronic noncancer pain, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews shall take place at least every six months. However, for treatment of stable patients with chronic noncancer pain involving nonescalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.

(1) During the periodic review, the physician shall determine:

(a) Patient's compliance with any medication treatment plan;

(b) If pain, function, or quality of life have improved or diminished using objective evidence, considering any available information from family members or other caregivers; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the physician's evaluation of progress towards treatment objectives.

(2) The physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with current treatment plan is unsatisfactory. The physician shall consider tapering, changing, or discontinuing treatment when:

(a) Function or pain does not improve after a trial period;

(b) There is evidence of significant adverse effects;

(c) Other treatment modalities are indicated; or

(d) There is evidence of misuse, addiction, or diversion.

(3) The physician should periodically review information from any available prescription monitoring program or emergency department-based information exchange.

(4) The physician should periodically review any relevant information from a pharmacist provided to the physician.

WAC 246-919-860
Consultation—Recommendations and requirements.

(1) The physician shall consider, and document the consideration, referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic noncancer pain patients who are under eighteen years of age, or who are at risk for medication misuse, abuse, or diversion. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring,

documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold for adults is one hundred twenty milligrams morphine equivalent dose (MED)(oral). In the event a physician prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED (orally) per day, a consultation with a pain management specialist as described in WAC 246-919-863 is required, unless the consultation is exempted under WAC 246-919-861 or 246-919-862. Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged.

(a) The mandatory consultation shall consist of at least one of the following:

(i) An office visit with the patient and the pain management specialist;

(ii) A telephone consultation between the pain management specialist and the physician;

(iii) An electronic consultation between the pain management specialist and the physician; or

(iv) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the physician or a licensed health care practitioner designated by the physician or the pain management specialist.

(b) A physician shall document each mandatory consultation with the pain management specialist. Any written record of the consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the specialist provides a written record of the consultation to the physician, the physician shall maintain it as part of the patient record.

(3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist at any time. For the purposes of WAC 246-919-850 through 246-919-863, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.

2.2 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

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3. NOTICE TO RESPONDENT

The charges in this document affect public health and safety. The Executive Director of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: August 14, 2020.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

Melanie de Leon

MELANIE DE LEON
EXECUTIVE DIRECTOR

ROBERT W. FERGUSON
ATTORNEY GENERAL

Kristin G Brew

KRISTIN G. BREWER, WSBA NO. 38494
SENIOR COUNSEL

CONFIDENTIAL SCHEDULE

This information is confidential and is NOT to be released without the consent of the individual or individuals named below. RCW 42.56.240(1)

Patient A [redacted]