BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MARK G. WEBB, M.D.** Holder of License No. 19868 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-14-0019A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND AND PROBATION**

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 3, 2015. Mark G. Webb, M.D. ("Respondent"), appeared with legal counsel, Mr. Stephen Myers, before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and Probation after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 19868 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-14-0019A after receiving a complaint regarding Respondent's care and treatment of a 30 year-old female patient ("JR") alleging inappropriate prescribing.

4. Patient JR established care with Respondent in July of 2007, at which time she reported a history of lumbar disc disease and the use of Percocet. Respondent noted that JR used alcohol and tobacco but the Respondent did not document any substance use evaluation of JR. Respondent initially diagnosed and treated JR for a UTI and vestibular problems. Beginning in February 2010, Respondent provided serial

prescriptions for Vicodin to JR for various complaints as well as Percocet in increasing dosages. Respondent failed to provide adequate documentation regarding the indications for the prescriptions or with regard to Respondent's reasoning for increasing the medication dosages. Respondent continued to prescribe pain medication to JR throughout her course of treatment without frequently seeing and examining the patient. Respondent last saw JR on December 12, 2013. During her treatment with the Respondent, JR received prescriptions for controlled substances from other providers.

5. During the course of the Board's investigation, Board staff queried the Controlled Substance Prescription Monitoring Program ("CSPMP") regarding Respondent's prescribing over the past year. Four additional patients' charts were reviewed from dates June 1, 2012 through the present time from charts selected based on review of the CSPMP data.

6. In patients SC, LC, and RI, Respondent failed to document subjective complaints or directed examinations that justified ongoing opioid management. Respondent's records for patient SC were lacking of chest x-ray follow up after treatment for pneumonia, and he failed to follow up on a urinalysis showing hematuria. Respondent provided patient LC with a long-term HS anxiolytic without documenting the indication and provided frequent early benzodiazepine refills.

7. In the case of patient RI, Respondent failed to document the patient's prior history or current use of alcohol/street drugs, provided a long-term anxiolytic without documenting the indication for the prescription, and provided Soma for long-term use with repeated duplicate prescriptions.

8. Patient DB received two different benzodiazepines from Respondent at the same time, with benzodiazepine dose escalation. Respondent failed to document his

reasoning for increasing the benzodiazepine dose, and frequently provided early and duplicated benzodiazepine refills for DB.

9. The standard of care required Respondent to obtain a substance use history and review medical imaging reports prior to initiating chronic narcotic prescribing; to evaluate and examine the patient on a regular basis to determine compliance, response to treatment, and need for additional valuation, consultation, or medication increase; and to monitor for, recognize, and address aberrant drug seeking behavior, including repeated early narcotic refill requests. Respondent deviated from the standard of care by failing to perform a thorough evaluation of JR's pain, failing to obtain a substance use history on JR prior to initiation of chronic narcotic prescribing, and by failing to obtain or review medical imaging reports prior to prescribing narcotic medications; by continuing to prescribe narcotic medications to patient JR without seeing the patient for regular follow up evaluations and examinations, and by failing to document subjective complaints or directed examinations to justify ongoing opioid management with continual dose escalation; and by failing to recognize aberrant drug seeking behavior and repeatedly providing early narcotic prescriptions.

10. The standard of care required Respondent to avoid prescribing two different benzodiazepines to the patient at the same time with long-term prescribing of temazepam for sleep; to document the reasoning for dose escalation; and to avoid frequent early and duplicate refills for benzodiazepine prescriptions. Respondent deviated from the standard of care by providing two different benzodiazepines to DB at the same time with long-term prescribing of temazepam for sleep; by escalating the lorazepam dose without documentation of the reason for dose escalation; and by providing frequent early benzodiazepine refills and duplicated benzodiazepine prescriptions.

11. The standard of care required Respondent to perform a thorough evaluation of the patient's pain and to document the nature of the pain, contributing factors, and identification of a pain generator; to document subjective complaints or directed examinations that justify ongoing opioid management; and to avoid providing repeated early narcotic prescriptions. Respondent deviated from the standard of care by failing to perform a thorough evaluation of SC's pain, including documentation of the nature of the pain, contributing factors, and identification of a pain generator; by failing to document subjective complaints or directed examinations that justified ongoing opioid management; and by repeatedly providing early narcotic prescriptions to SC.

12. The standard of care required Respondent to document subjective complaints or directed examinations that justify ongoing opioid management with continued dose increases; to avoid prescribing repeat early narcotic prescriptions; to document the indication for long-term HS anxiolytic; and to avoid providing frequent early benzodiazepine refills. Respondent deviated from the standard of care by failing to document subjective complaints or directed examinations that justified ongoing opioid management with continued dose increases; by repeatedly providing LC with early narcotic prescriptions; by providing LC with long-term HS anxiolytic without documenting the indication for the prescription; and by providing LC with frequent early benzodiazepine refills.

13. The standard of care required Respondent to document subjective complaints or directed examinations that justify ongoing opioid management with continued dose increases; to document the patient's prior history or current use of alcohol or street drugs; to avoid providing repeat early narcotic prescriptions; to document the indication for providing a long-term anxiolytic; and to avoid providing repeat prescriptions/refills for Soma for long-term use when the patient is noted to be filling new

Soma prescriptions while obtaining refills of prior prescriptions. Respondent deviated from the standard of care by failing to document subjective complaints or directed examinations that justified ongoing opioid management with continued dose increases; by failing to document RI's prior history or current use of alcohol or street drugs; by repeatedly providing RI with early narcotic prescriptions; by providing RI with a long-term anxiolytic without documenting the indication for the prescription; and by providing RI with repeated prescriptions/refills for Soma for long-term use, with RI noted to be filling new Soma prescriptions while obtaining refills of prior prescriptions.

14. There was potential for JR's, SC's, LC's, and RI's narcotic overuse, abuse and addiction with potential for overdose with respiratory suppression and death. There was also pontifical for diversion of JR's, SC's, LC's and RI's narcotic medications. JR reportedly developed a narcotics abuse problem, requiring detoxification and counseling.

15. There was potential for DB's, LC's, and RI's misuse and abuse of the anxiolytic medications. There was also increased potential for benzodiazepine overdose or injury related to falls.

16. Soma is subject to abuse, dependence, withdrawal, misuse and diversion. Soma abuse may risk CNS and respiratory depression, seizures and death.

17. During the course of the Board's investigation, Respondent completed the PACE prescribing and medical recordkeeping courses and provided Board staff with a plan for appropriate practice changes.

18. During a Formal Interview on the matter, Respondent testified that he found the PACE courses very useful, and implemented changes to his practice based on those courses, including improved documentation procedures, patient contracts, use of CSPMP reports, and utilizing urine drug screens to monitor for patient diversion and compliance.

CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[F]ailing or refusing to maintain adequate records on a patient.").

c. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[A]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

2. Respondent is placed on Probation for a period of one year with the following terms and conditions:

a. Chart Reviews

Board staff or its agents shall conduct two chart reviews during the probationary period. Based upon the chart review, the Board retains jurisdiction to take additional disciplinary or remedial action. The periodic chart reviews shall involve current patients' charts for a period of three years. Respondent shall bear all costs associated with the chart reviews. After two consecutive favorable chart reviews, Respondent may petition the Board to terminate the Probation. Respondent's request for termination will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 14 days prior to the Board meeting. The Board shall have the sole

discretion to determine whether Respondent met the terms of the Probation or whether to take any other action that is consistent with its statutory and regulatory authority.

b. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

c. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

3. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this 6th day of August, 2015.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTIVE COPY of the foregoing mailed this 6th day of August, 2015 to:

Stephen W. Myers
Myers & Jenkins
One East Camelback Road Suite 500
Phoenix, AZ 85012

ORIGINAL of the foregoing filed this 6th day of August, 2015 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Baker
Board Staff