

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **MOHAMMAD ZAFAR QURESHI, M.D.**

4 Holder of License No. **8269**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-06-0950A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**

(Decree of Censure and Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on June
8 6, 2007. Mohammad Zafar Qureshi, M.D., ("Respondent") appeared before the Board with legal
9 counsel Stephen Myers for a formal interview pursuant to the authority vested in the Board by
10 A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of
11 Law and Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

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

15 2. Respondent is the holder of License No. 8269 for the practice of allopathic
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-06-0950A as a result of a medical record
18 review required by the terms of a consent agreement entered in resolution of another case. The
19 records of three patients, DR, RK, and SZ were reviewed. The record in each case revealed
20 Respondent injected large volumes of solution containing dilute concentrations of DepoMedrol,
21 Ketorolac, and Lidocaine and that each patient was routinely pre-medicated with Morphine and
22 Benadryl.

23 4. Respondent billed DR for injections on five dates of service, but there are medical
24 records only for four dates of service. DR established care with Respondent for a stated problem
25 of right upper extremity pain. Respondent diagnosed bilateral shoulder enthesopathy, bilateral

1 shoulder trigger points, bilateral lateral epicondylitis, right median neuraigia, cervical thoracic
2 neuralgia, and post-traumatic myofacial pain. Over the four documented dates of service
3 Respondent documented or billed for right shoulder muscle bursa, ligament and tendon
4 injections; multi-level cervical and thoracic paravertebral nerve block; and unspecified peripheral
5 nerve block. On the date of service billed to the insurance company, but without a corresponding
6 record, Respondent billed the insurance company for two cervical facet joint injections, two
7 unspecified peripheral nerve blocks, radial nerve block, median nerve block, and greater occipital
8 nerve block.

9 5. The billing records provided for RK indicate that between April 2005 and January
10 2006 Respondent billed for twenty facet injections, fourteen unspecified peripheral nerve blocks,
11 six lateral cutaneous nerve blocks, five sciatic nerve blocks, one femoral nerve block, four
12 intercostal nerve blocks, three median carpal tunnel injections, and one radial nerve block.
13 Respondent could not provide medical records that correspond to these billing dates. Respondent
14 did provide medical records for three dates of service in June 2006 when RK presented with
15 complaints related to the right side of the head, neck and the left upper extremity. Respondent
16 diagnosed trigger points, lumbar neuralgia, cervical neuralgia, occipital neuralgia, brachial
17 neuralgia, left shoulder enthesopathy, and left triceps trigger point. Respondent reportedly
18 performed right occipital nerve block, multi-level bilateral cervical paravertebral nerve blocks, left
19 axillary plexus blocks, supraspinatus and infraspinatus tendon injection, lumbar trigger point
20 injections, left L5-S1 plexus block, and unspecified peripheral nerve blocks.

21 6. Respondent provided records for SZ from March 2006 through September 2006.
22 However, the billing records indicate Respondent billed SZ for multiple injections earlier in 2006
23 and every year since 2002. The records indicate Respondent made multiple diagnoses, including
24 thoracic sprain and strain, lumbosacral sprain, bilateral lumbar neuralgia, bilateral hip
25 enthesopathy, bilateral posterior tibial tendonitis, bilateral posterior tibial neuralgia, right lateral

1 femoral neuralgia, right iliopsoas tendonitis, right peroneal tendonitis, right sciatica, right lateral
2 tibial neuralgia, and right lateral tibial tendonitis. Respondent reportedly performed injection
3 procedures including right posterior branch blocks at T8 through T12, right paravertebral blocks at
4 L1 and L5, right lumbar plexus blocks at L2 and L5, right lateral femoral nerve block, bilateral
5 posterior tibial nerve block, right lateral tibial nerve block, right peroneal tendon injection, right
6 iliopsoas tendon injections, right iliopsoas muscle injections, right iliopsoas nerve injection,
7 bilateral hip and thigh tendon injections, right lateral cutaneous nerve injections, right sciatic
8 nerve block, left L5 paravertebral block, left posterior tibial tendon injection, left hip and thigh
9 ligament and bursa injections, and various trigger point injections. "Lateral tibial nerve," "lateral
10 tibial tendon," and "iliopsoas nerve" are not found in standard anatomy textbooks.

11 7. DR reported fifty percent improvement after four months with no long-term follow-
12 up available. RK underwent sixteen injections over a ten month period and, after a few month
13 hiatus, returned for more. SZ has undergone injections since 2002 and at one point even
14 Respondent document he was "somewhat concerned. She has had so many injections that by
15 now she should have gotten better."

16 8. Respondent does not necessarily expect relief to the distal area of distribution of
17 the nerve if the pain generator is a nerve and he blocks a proximal area of the nerve because
18 nerves can get entrapped all along the course. Respondent's example is the lateral cutaneous
19 nerve of the thigh about one centimeter medial to the inguinal ligament with fibers going through
20 the fascia lata. Respondent believes if there is any inflammation in the muscle it will catch
21 branches of the nerve and cause pain anywhere along the line or course of the nerve and just
22 injecting at one place is not enough. Respondent needs to see where it is being entrapped – if a
23 muscle is spasming there are multiple injuries and the muscle is spasming underneath the nerve,
24 he has to inject all along the area. Respondent believed it was possible to expect to still have pain
25 and sensation in the distribution of the nerves distally even if he blocked the plexus of the

1 interscalene space if the nerve is being entrapped. According to Respondent myofascial pain
2 involves multiple pain generator sites along the nerve. Respondent believes he has a selective
3 group of patients completely different than other pain practice physicians in Tucson.

4 9. One of Respondent's diagnoses for SZ was right hip enthesopathy with lateral
5 femoral neuralgia that he CPT coded as 726.5 and described as a difficulty moving the hip due to
6 any condition. Hip enthesopathy implies ligament and tendons around the hip area. Respondent
7 attempted to explain the lateral femoral nerve, but described the lateral femoral cutaneous nerve.
8 Respondent stated he treated SZ's condition, but used "enthesopathy" because of billing issues.
9 Respondent used to diagnose radial neuralgia and bill for a radial nerve block, but about three
10 years ago when insurance companies started to deny payment his staff inquired and was told to
11 use "enthesopathy" to get reimbursed for nerve blocks. SZ presented with problems with her hip
12 relating to soft tissue, not nerves, that Respondent did not treat.

13 10. In describing whether a peripheral nerve block typically refers to blocking a major
14 nerve at the proximal site, Respondent believes it depends and, if he wants to diagnose, he
15 injects medication where it is most easily accessible and there should be immediate therapy and
16 he has to feel where it is being impinged or inflamed. Respondent then goes on to the lateral side
17 of the thigh and the only thing that will ever cause pain is the lateral femoral nerve and if he gives
18 any injection in that area and the pain goes away, he has blocked branches of the lateral femoral
19 cutaneous nerve. Respondent considers this a peripheral nerve block and codes it for billing as a
20 64450.

21 11. One of Respondent's diagnoses for DR was epicondylitis that he coded as 726.31.
22 Epicondylitis (or tennis elbow) is an inflammation of the epicondyle usually involving local area
23 tissues such as tendons and ligaments. According to Respondent, DR had been in pain for one
24 year and the muscle had been in spasm for so long there was hypoxia, hypocarbia, under it and
25 the area was inflamed. In procedures such as paravertebral blocks there is a potential for spread

1 of injected substances, such as Toradol, into the spinal or epidural spaces. Because of alcohol
2 neurotoxicity there is a black box warning on Toradol about nonuse of Toradol in preparations
3 used in the central neuraxial area.

4 12. The medication for anxiety and pain for a procedure should be individualized in the
5 premedication procedure to the needs of the patient and the procedures anticipated, yet
6 Respondent routinely gives 30 milligrams of morphine PO, Benadryl 50 milligrams PO, and
7 Versed intermittently, two milligrams IM regardless of whether the patient is having a peripheral
8 type of block or more pain-provoking blocks and regardless of whether the patient weighs 130
9 pounds or 160 pounds. Respondent gives the patients sedation and, after waiting one-half hour, if
10 the patient is still uptight and the morphine does not seem to have fazed the patient, he will give
11 them one to two ccs intramuscular. Respondent's record for SZ reflects he gave the initial
12 medications and then five minutes later did the procedure even though the onset and/or peak
13 effects of the medications are not until much later. With all three patients Respondent's records
14 describe tendon injections or trigger point injections, yet he coded them and billed them as
15 peripheral nerve injections.

16 13. Respondent's record for DR reflects she had pain in her right shoulder, was weight
17 lifting and doing pushups and situps, and the pain started to increase in intensity; she had some
18 cortisone injections; and her arms felt heavy, the pain was getting sharper, lasting longer and
19 radiating all the way down to the elbow. Respondent's physical examination of the nervous
20 system and painful areas was normal, but he did not test DR's reflexes. Loss of reflex in a patient
21 with shoulder pain and pain all the way down the extremity to the elbow indicates nerve damage.
22 In addressing numbness in the thumb and index finger Respondent injected the radial nerve even
23 though the radial nerve is located on the outside of the hand. The later entries show shoulder
24 enthesopathy, shoulder trigger shots in the deltoid and biceps muscles, radial neuralgia and
25 epicondylitis, supraspinatus and infraspinatus tendon, and radial nerve block at the elbow.

1 Respondent injected the nerve because he did not believe the muscle injection alone was enough
2 so he had to go deeper – all the way down to the bone and inject 30 or 40 ccs. Respondent billed
3 CPT code 64450. This code refers to peripheral nerves. There are other codes for injecting
4 muscles and tendons. Respondent has taken a course in coding and compliance and has
5 changed his office policies regarding coding and does not anticipate any issue in the future.

6 14. Respondent's records reflect he was giving patients injections based on subjective
7 complaints from the patient and not based on any objective reasons for the pain. Respondent had
8 an MRI for DR that showed a bulging disc that he believed could be from spasm of muscles and
9 he did peripheral nerve blocks for this. If Respondent blocks the main trunk he still believes he
10 needs to block the nerve distally in different locations. For instance, he states that if the posterior
11 tibial nerve under the gastrocnemius is being entrapped and there is extensive injury to the
12 muscle, he believes the nerve in the whole leg would be inflamed. Respondent injects anti-
13 inflammatory medications into the nerve and uses very dilute solutions of local anesthetic to guide
14 him to whether the area he is injecting has calmed down. Once it is calmed down, Respondent
15 goes up and down the nerve to see if there is any more tenderness along the course of the nerve,
16 and if there is, he will go and block it.

17 15. When Respondent performs a popliteal block he believes he blocks either the
18 sciatic nerve or two branches of the lateral and medial plantar and medial popliteal nerves and,
19 with a high concentration, the whole foot becomes numb. When doing a popliteal block the
20 saphenous nerve cannot be blocked because the femoral nerve does not go through the popliteal
21 fossa.

22 16. The standard of care requires a physician to perform nerve blocks for specific
23 diagnostic or therapeutic indications and requires therapeutic injection for pain management
24 based on identification of a pain generator appropriately addressed with a specific nerve block.
25

1 Respondent deviated from the standard of care by performing nerve blocks without therapeutic
2 indications.

3 17. The standard of care requires a physician to refrain from using Toradol for
4 injections with the risk of intrathecal spread. Respondent deviated from the standard of care by
5 using Toradol injections with the known risk of intrathecal spread.

6 18. The standard of care requires a physician to refrain from combining Toradol with
7 other NSAIDs. Respondent deviated from the standard of care by combining Toradol with other
8 NSAIDs.

9 19. The standard of care requires a physician to perform nerve blocks for specific
10 diagnostic and/or therapeutic indications and in a technically precise and anatomically accurate
11 manner. Respondent deviated from the standard of care by performing nerve blocks in a
12 haphazard and anatomically irrational manner.

13 20. The standard of care requires a physician to use rational timing for premedication.
14 Respondent deviated from the standard of care by failing to use rational timing for premedication.

15 21. The standard of care requires a physician to treat tendonitis by recommending
16 rest, ice application, splinting, and/or prescribing NSAIDs. Respondent deviated from the
17 standard of care by treating tendonitis with nerve blocks.

18 22. Respondent's patients received repeated injections without indications.
19 Respondent's patient's faced potential harm from the improper combination of NSAIDs, potential
20 neurotoxicity of Toradol, side-effects from the chronic administration of Toradol, and side-effects
21 from the chronic administration of steroids.

22 CONCLUSIONS OF LAW

23 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof
24 and over Respondent.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

DATED this 12th day of August 2007.



THE ARIZONA MEDICAL BOARD

By *Timothy C. Miller*
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 12th day of August, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this 12th
day of August, 2007, to:

Stephen Myers
Myers & Jenkins

Mohammad Z. Qureshi, M.D.
Address of Record

Chris Bandy