COMMONWEALTH *of* VIRGINIA

Dianne L. Reynolds-Cane, M.D.
Director

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May 1, 2012

Joel W. Match, M.D.
1850 Town Center Parkway, Suite 207
Reston, Virginia 20190

UPS OVERNIGHT

RE: License No.: 0101-040957

Dear Dr. Match:

I enclose a certified copy of the Virginia Board of Medicine's Order of Summary Suspension entered May 1, 2012, affecting your license to practice medicine and surgery in the Commonwealth of Virginia.

Effective immediately, it shall be unlawful for you to treat patients, prescribe medications, or otherwise practice medicine and surgery, or hold yourself out as a licensed physician in the Commonwealth of Virginia.

Further, in accordance with Sections 54.1-105, 54.1-110, 54.1-2408.1, 54.1-2920, 2.2-4020 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), you are hereby given notice that the Virginia Board of Medicine ("Board") will convene a formal administrative hearing to receive and act upon evidence that you may have violated certain laws and regulations governing the practice of medicine and surgery in Virginia, as set forth in the attached Statement of Particulars.

The formal administrative hearing will be held in accordance with the provisions of Sections 54.1-2400(11) and 2.2-4024.F of the Code, before a panel of the Board, with a member of the Board presiding. You have been scheduled to appear before the Board on **Friday, May 25, 2012, at 1:00 p.m., in the offices of the Department of Health Professions, 9960 Mayland Drive, 2nd Floor, Henrico, Virginia.** A map is enclosed for your convenience. Please register with the receptionist on the 2nd floor and be seated in the waiting area. You will be called when the Board is ready to meet with you.

You have the following rights, among others: to be accompanied by and represented by counsel, to submit oral and documentary evidence and rebuttal proofs, to conduct such cross-examination as may elicit a full and fair disclosure of the facts, and to have the proceedings completed and a decision made with dispatch. Should you wish to subpoena witnesses, requests for subpoenas must be made, in writing, in accordance with the enclosed Instructions for Requesting Subpoenas.

Please carefully read the following paragraphs, which contain date-sensitive and important information regarding this proceeding.

COMMONWEALTH'S EVIDENCE

You have the right to the information that will be used by the Board in reaching a decision regarding this matter; therefore, I enclose the Commonwealth's evidence. Please note that these documents are enclosed only with the original notice sent by UPS overnight mail. Further, if you are represented, it is your responsibility to provide the enclosed materials to your attorney. If you have any questions regarding the content of this package, you must contact Assistant Attorney General Corie E. Tillman Wolf at (804) 786-9593.

Should you wish to file any objections to the Commonwealth's evidence, you must send your written objections to me, at the address on this letterhead, no later than **May 9, 2012**. If you have not filed any objections by **May 9, 2012**, the exhibits will be distributed to the Board members for their review prior to your hearing, and will be considered by the Board as evidence when it deliberates upon your case. If you do file objections, the Commonwealth has until **May 11, 2012**, to file a response to the objections, in writing and addressed to me at the Board office. The chairperson of the proceeding will rule on the motion.

RESPONDENT'S EVIDENCE

Further, should you wish for the Board to consider additional information relative to this proceeding, you must submit fifteen (15) copies of any such documents to Reneé S. Dixson, Discipline Case Manager, Virginia Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia, 23233, by **May 14, 2012**. You may not submit your documents by facsimile or e-mail

The Commonwealth must file any objections to your submissions in writing, addressed to me at the Board office, no later than **May 16, 2012**. If no objections have been received by **May 16, 2012**, the evidence will be distributed to the Board members for their review, and will be considered by the Board as evidence when it deliberates upon your case. If the Commonwealth raises objections, you have until **May 18, 2012**, to file your response to

the objections, in writing and addressed to me at the Board office. The chairperson of the proceeding will rule on the motion.

OTHER PRE-HEARING MOTIONS

If you or Assistant Attorney General Corie Wolf wish to make any pre-hearing motions regarding matters other than the exhibits, including offers of settlement, each of you is directed to file motions, in writing, addressed to me at the Board office by **May 10, 2012.** Responses to motions filed must be submitted by **May 14, 2012.** The chairperson of the proceeding will rule on the motion.

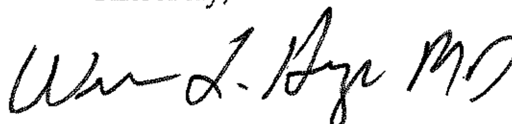
REQUEST FOR A CONTINUANCE

Absent exigent circumstances, such as personal or family illness, or the unavailability of counsel, a request for a continuance will not be considered unless received by **May 9, 2012.**

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 at http://leg1.state.va.us. To access this information, please click on *Code of Virginia* for laws and *Virginia Administrative Code* for regulations.

Please indicate, by letter to this office, your intention to be present.

Sincerely,



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

Enclosures:
- Order of Summary Suspension entered May 1, 2012
- Statement of Particulars
- Attachment I
- Commonwealth's Exhibits (18 volumes)
- Instructions for Requesting Subpoenas
- Map

cc: Core E. Tillman Wolf, Assistant Attorney General [*w/enclosures*]
Julia Bennett, Adjudication Specialist, APD
Lorraine McGehee, Deputy Director, APD
Naima Fellers, Senior Investigator [142476]

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: JOEL W. MATCH, M.D.
License No.: 0101-040957

STATEMENT OF PARTICULARS

The Virginia Board of Medicine ("Board") alleges that:

1. Dr. Match may have violated Sections 54.1-2915.A(3), (8), (13), (16), (17), and (18) and 54.1-3303.A and 54.1-3408.A of the Code with respect to his care and treatment of Patients A-J at Chantilly Specialists, a pain management clinic located in Chantilly, Virginia, from approximately December 2010 to December 2011, in that:

a. With respect to Patient A, a 53-year-old male whom Dr. Match saw and treated on approximately six occasions from May to December 2011:

i. Dr. Match diagnosed and treated Patient A for tension headaches, root lesion-cervical, cervical spondylosis, intervertebral disc disorder with myelopathy, cervicalgia-neck pain, failed back syndrome-cervical, disc disorder-lumbar, lumbago-low back pain, somatic dysfunction cervical region, somatic dysfunction lower extremities, and spondylosis lumbo/sacral, including prescribing oxycodone 30 mg and OxyContin 80 mg (both Schedule II controlled substances), without an adequate medical indication for doing so. Specifically, Dr. Match failed to obtain diagnostic testing or studies or other objective evidence to support these diagnoses or to determine the etiology of Patient A's reported pain and other symptoms.

ii. Dr. Match failed to properly manage and monitor Patient A's narcotics usage, especially in light of the history of aberrant and noncompliant behavior documented in his Chantilly medical record for the three-year period before his first visit with Dr. Match on or about May 13, 2011. Specifically, at that first visit, Dr. Match continued Patient A's narcotic therapy, even though he knew or should have known of this significant prior history of deviant behavior. Further, Dr. Match took no appropriate responsive action, other than requiring more frequent office visits, when Patient A continued such behavior by repeatedly violating the terms of his pain management contract and exhibiting abusive, drug-seeking and possibly diversionary behavior while under Dr. Match's care. Examples of such behavior, both historically, as documented in Patient A's Chantilly medical records, and while under Dr. Match's treatment include:

Information Indicating Drug-Seeking Behavior or Abuse/Misuse or Possible Diversion of Controlled Substances That Dr. Match Knew or Should Have Known
• Patient A reported that his medications had been confiscated by law enforcement on two occasions (5/12/09 and 5/14/10).
• Multiple urine drug screens were inconsistent with prescribed medications or were positive for cocaine (on or about 8/21/09, 9/8/09, 8/11/10, and 10/7/10).
•Patient A's claim to have "self-detoxed" in lieu of following up on a referral (given or about 9/15/09) for substance abuse evaluation and treatment made due to his continued use of cocaine and alcohol abuse.
•Patient A's report that he had been robbed of all his medications on or about 11/11/09 (though no police report was filed).
•Documented suspicion in a 2/26/10 office note of drug diversion and notation that Patient A was under criminal investigation.
•On or about 10/14/10, a pharmacist reported to the Chantilly practice that Patient A used counterfeit money given to him by a companion to pay for his narcotic prescriptions and then gave this individual all of his medications.
•Chronic requests for (and provision of) early fills or refills of narcotic medications during

the period before Dr. Match began treating Patient A.
•On or about 1/6/11, Patient A was arrested at the Chantilly medical office on charges of distribution of Schedule II controlled substances, an incident of which Dr. Match admits he was aware. Upon Patient A's release from jail on or about 3/26/11, bottles of Opana and oxycodone given to the office manager by the police at the time of the patient's arrest were returned to him, as evidenced by a signed Receipt for Return of Medicine in the patient's file.
•A message entered into the Chantilly practice's electronic medical record for Patient A indicates that, on or about 4/13/11, a police officer called and stated that Patient A had been charged with a lesser crime, i.e., obtaining Schedule II drugs under false pretenses, in connection with an ongoing criminal investigation of a physician assistant who had previously been employed at Chantilly.
•On or about 5/13/11, Dr. Match noted that Patient A presented with a chief complaint of having run out of his medications early that the patient's pill count was not correct, and that Patient A had "no good explanation" for the missing morphine sulfate instant release.
•A urine drug screen that Dr. Match ordered on or about 6/7/11 revealed the presence of methadone, a medication that was not being prescribed to Patient A. When confronted, Patient A admitted taking a couple of methadone pills from a supply he had left over from last year. Dr. Match responded by counseling the patient that taking old medications was a violation of his pain contract and that any further aberrant behavior would be reported to Patient A's probation officer and possibly be grounds for discharge from the practice; however, Dr. Match continued to prescribe the patient narcotics (OxyContin 80 mg, 5/day and oxycodone 30 mg, tid).
•A message from Patient A's probation officer entered into the electronic medical record on or about 8/31/11 indicated that the patient was receiving treatment for addiction.
•Evidence that Patient A was doctor-shopping and receiving narcotic prescriptions from multiple physicians who were not Chantilly providers based on numerous reports obtained by the practice from the Prescription Monitoring Program ("PMP").
• Records in Patient A's file from an emergency room visit on or about 11/16/11, subsequent to Patient A's release from a three-month incarceration for parole violations, reported the patient's history of cocaine abuse.

b. Even though narcotic therapy was contraindicated for Patient B based on his documented history of drug-seeking and aberrant behavior since becoming a Chantilly patient in 2008, Dr. Match prescribed narcotics to Patient B from December 2010 until March 28, 2011, when police arrested Patient B for attempted assault of office staff and destruction of property (punching a hole in the wall) during his office visit. Further,

during Dr. Match's treatment of Patient B, he failed to properly manage and monitor the patient's narcotics usage (i.e., OxyContin 80 mg, OxyContin 40 mg (Schedule II), and Roxicodone 30 mg (Schedule II)) in that he failed to adequately address or appropriately respond to clear indications of substance abuse/misuse and other noncompliance with his medication regimen and treatment plan. Examples of such behavior, both historically, as documented in Patient B's Chantilly medical records, and while under Dr. Match's treatment include:

Information Indicating Drug-Seeking Behavior or Abuse/Misuse or Possible Diversion of Controlled Substances That Dr. Match Knew or Should Have Known
•Inconsistent urine drug screens on 8/13/09, 9/10/09, and 4/8/10.
•Documentation that Patient B was hospitalized for an opiate overdose from 4/28 to 4/29/10.
•Patient B's documented inability (in 5/19/10 office note) to explain what had happened to, and enragement when confronted about, the current whereabouts of medications recently prescribed to him by multiple other providers for #252 OxyContin 80 mg, #60 Xanax 2 mg, #140 oxycodone 30 mg, #30 roxicodone 15 mg, and #15 Vicodin 7.5/750.
•Multiple referrals by Chantilly providers for psychiatric and substance abuse evaluations and to an addictionologist (on or about 4/19/10, 6/1/10, 10/13/10, 10/22/10, 11/19/10, 11/30/10), none of which were followed up on by Patient B.
•Documentation in Patient B's record on 11/19/10 that he continued to display behaviors (including raging and cursing when he did not get the medication he wanted) that confirmed "him being a high risk patient with dual diagnosis and possible diversion."
•Information in Patient B's record from multiple healthcare providers who treated him during his hospitalization from 12/1 to 12/6/10 for a toe amputation that: Patient B displayed aberrant, drug seeking, psychotic, delusional, abusive and addictive behaviors and needed to be treated by an addictionologist; the underlying cause of the patient's pain (uncontrolled diabetes causing neuropathies) needed to be treated without the use of opioids; Patient B's pain had been mismanaged for years and he needed to be titrated down if not completely taken off of his narcotic medications and placed on other treatment modalities; Patient B "could not possibly be taking the medication that he says he has been taking" under Chantilly's medication regimen because, when maintained on that regimen in the hospital, he slept for "hours upon hours" and was so lethargic that he could not be aroused to eat, sleep, or complete all the daily dosages prescribed; and Patient B bullied the physician who discharged him into writing the narcotic scripts that

he wanted, even though that physician did not consider these to be "in the best interests and safe for the patient."
•On or about 12/7/10, Patient B's podiatrist informed Dr. Match that the patient did not need the amount of pain medication that had been previously prescribed, and that, during his recent hospitalization, he had been extremely belligerent (requiring the presence of security on several occasions) when he was not given the pain medications that he wanted.
•Multiple PMP reports revealed that Patient B was being prescribed narcotics by other practitioners.
•Patient B reported to Dr. Match on several occasions (12/15/10, 12/ 29/10, 12/30/10, and 1/31/11) that he had gone to, and would continue to go to, multiple emergency rooms and urgent care providers to obtain the pain medications that he wanted.
•A urine drug screen that Dr. Match ordered on 1/3/11 was inconsistent with the medications prescribed to Patient B, i.e., positive for hydromorphone (results that Dr. Match failed to address with the patient, instead incorrectly documenting that the UDS was consistent). On that same date, Dr. Match noted that Patient B was chronically early for his pain medication refills. Further, at the end of the patient's visit on his way out, Patient B became verbally abusive and cursed the nurses and front desk receptionist, from whom he grabbed the prescriptions and referrals that Dr. Match had written for him (events of which Dr. Match was informed by his staff).
•Dr. Match documented that Patient B became extremely agitated at his 1/31/11 visit when Dr. Match did not prescribe him the pain medications he desired, tearing up the specialist referrals that Dr. Match again gave him. Although Dr. Match noted that, during the five hours Patient B was in the office, he flailed and moved around the room, waving his arms with no impediment of his range of motion "unlike any patient in chronic intractable pain" Dr. Match had ever seen, he nevertheless prescribed the patient #224 dosage units of Roxicodone 30 mg, to be taken 8/day and #168 dosage units of OxyContin 40 mg, to be taken 12/day.

c. Although Dr. Match noted in Patient C's electronic record on or about August 3, 2011 that he needed to see this patient at his next office visit because Dr. Match had received information that the patient was selling his oxycodone and taking only his methadone, Dr. Match failed to follow up or act on this information in a timely fashion, i.e., he did not see Patient C until October 20, 2011, at which time he did not address the reported medication diversion with Patient C. On that date (Patient C's first and only

visit with Dr. Match), he prescribed the patient #84 Vicoprofen, even though the prescription of narcotics was contraindicated based on:

i. Patient C's history of aberrant and abusive behavior while a patient at Chantilly since 2009, to include multiple inconsistent urine drug screens (including a positive drug screen for methamphetamine on August 7, 2009), as well as a cardiology consult report from June 9, 2011 noting the patient's history of drug abuse and illicit drug use.

ii. The red-flag raised by the patient's residence in Grundy, Virginia, approximately 7 hours driving distance from the practice.

iii. Dr. Match's documentation in Patient C's electronic medical record on or about September 1 and 15, 2011, that the patient was to be given "no more narcotics, no more methadone, this is the medication plan, no exceptions" based on his review of recent cervical and lumbar spine MRI's that failed to reveal pathology that warranted the narcotic therapy that Patient C had been receiving at Chantilly.

iv. The urine drug screen submitted by Patient C on October 20, 2011 pursuant to Dr. Match's order was positive for methadone, a medication discontinued over six weeks prior; also, Dr. Match noted at this visit that not much was abnormal with the patient.

d. With respect to Patient D, a 25-year-old male whom Dr. Match saw and treated on approximately four occasions from June to October 2011:

i. Dr. Match diagnosed and treated Patient D for disc disorder-lumbar, sacroiliac disease-ankylosis of lumbosacral or sacroiliac joint, somatic dysfunction lumbar region, somatic dysfunction sacral region, somatic dysfunction lower extremities, pain-lower leg joint, and cervicalgia-neck pain, including prescribing methadone (Schedule II), oxycodone 30 mg and 15 mg, OxyContin 80 mg, and Opana (Schedule II)), without an adequate medical indication for doing so. Specifically, neither diagnostic tests/studies performed on or about November 2008 or January 5, 2011, nor any other objective evidence supported these diagnoses or showed significant pathology warranting the use of narcotic therapy, as Dr. Match acknowledged on or about October 13, 2011, when he finally reviewed Patient D's prior MRI reports and CT scans.

ii. Dr. Match failed to properly manage and monitor Patient D's narcotics usage in that he failed to adequately address or appropriately respond to indications of substance abuse/misuse, aberrant and potentially diversionary behavior, and other noncompliance with his medication regimen and pain management contract. Such behavior included two consecutive inconsistent urine drug screens on June 29, 2011 and July 27, 2011, both of which were negative for methadone, a medication Patient D was being prescribed, as well as the red-flag raised by the patient's residence in Grundy, VA (approximately 7 hours away from the Chantilly practice).

e. During Dr. Match's treatment of Patient E from January to December 2011 (over the course of approximately five office visits), he failed to properly manage and monitor the patient's narcotic and benzodiazepine usage, including oxycodone 30 mg, MS Contin (Schedule II), and Klonopin (Schedule IV). Despite the red-flag raised by Patient E's residence in Richlands, VA, approximately six hours from the Chantilly practice, Dr. Match failed to adequately address or appropriately respond to indications of substance abuse/misuse and other noncompliance with his medication regimen, e.g., positive urine drug screens for methadone on June 30, 2011, July 28, 2011, and August 25, 2011, when this medication was not prescribed to Patient E, and negative results for benzodiazepines (on February 10, 2011, March 10, 2011, April 7, 2011, May 5, 2011, June 2, 2011, June 30, 2011, July 28, 2011, August 25, 2011, October 20, 2011, November 17, 2011, and December 15, 2011) when Klonopin was being prescribed. Further, although Patient E was a newly established patient at the time of his first visit with Dr. Match on January 13, 2011, he failed to request or obtain prior medical records for Patient E, though he reported having received chronic pain treatment for over 10 years.

f. With respect to Patient F, a 52-year-old male whom Dr. Match saw and treated on approximately seven occasions from May to September 2011:

i. Dr. Match diagnosed and treated Patient F for, among other things, joint derangement-lower leg, joint derangement-hand pain, intervertebral disc disorder lumbar with myelopathy, spondylosis-lumbo/sacral, lyme disease, pain-shoulder joint, common migraine, failed back syndrome-thoracic, and

cervicalgia-neck pain, including prescribing methadone, OxyContin 80 mg, oxycodone 30 mg, Actiq 1600 mcg (Schedule II), and Duragesic patches (Schedule II), without an adequate medical indication for doing so. Specifically, Dr. Match failed to obtain diagnostic testing or studies, medical records regarding prior reported surgeries/injuries, or other objective evidence to support these diagnoses or to determine the etiology of Patient F's reported pain and other symptoms.

ii. Dr. Match failed to properly manage and monitor Patient F's narcotics usage, including failure to execute a pain management contract with the patient. Despite Patient F's prior history of aberrant behavior while a patient at Chantilly since 2009, e.g., numerous inconsistent urine drug screens, Dr. Match failed to adequately address or appropriately respond to numerous indications of substance abuse/misuse and other noncompliance with his medication regimen. Instead, Dr. Match continued to prescribe narcotic medications to Patient F, even though narcotic therapy was contraindicated for this patient based on such behaviors, to include the following:

Information Indicating Drug-Seeking Behavior or Abuse/Misuse or Possible Diversion of Controlled Substances That Dr. Match Knew or Should Have Known
•At his initial visit with Dr. Match on 5/10/11, Patient F responded negatively (and tearfully) to Dr. Match's significant reduction in his daily methadone dose (accompanied by the addition of OxyContin 80 mg tid to his medication regimen), arguing that he used to be a methadone clinic coordinator and knew of studies that contradicted Dr. Match's assertion that long-term use of high dose methadone was potentially damaging to the body. Although Dr. Match referred Patient F to an addictionologist and a psychiatrist for a substance abuse evaluation at this visit, the patient balled up these referrals and, when leaving, attempted to throw them at the front desk person (who interceded and took them

out of his hand). Further, Dr. Match failed to note or address with Patient F his inconsistent urine drug screen at this visit, which was positive for OxyContin/oxycodone, a medication that had not been prescribed to the patient by other Chantilly providers prior to this visit.
• At Dr. Match's next office visit with Patient F on or about 6/15/11, he failed to address with the patient another inconsistent urine drug screen from 5/24/11 that was negative for OxyContin/oxycodone (which Dr. Match had prescribed to him on 5/10 and 5/11/11). Further, Dr. Match failed to act on information documented in Patient F's record on 5/24/11 by the Chantilly nurse practitioner who saw him that date indicating that Patient F reported his neurologist would not see him until he was stable on his methadone dosing, a claim the neurologist denied and characterized as drug-seeking behavior by the patient.
•On 6/7/11 and at his 6/15/11 office visit, Dr. Match noted that Patient F received a prescription for Fentora (Schedule II) from his urologist; when contacted, the urologist reported he prescribed the medication because Patient F reported he was in so much pain.
•An 8/2/11 consult note from Patient F's neurologist reported that, without prior authorization, the patient took an unspecified amount of his domestic partner's Valium, in addition to the Klonopin that the neurologist was prescribing him for his headaches, and that the patient asserted nothing would help his pain except methadone.
• On 8/10/11, Patient F's urine drug screen was again inconsistent, i.e., positive for methadone, a medication discontinued for over 4 weeks. Dr. Match's response to this clear violation of his medication regimen was to prescribe Patient F 6 boxes of Duragesic 100 mcg patches, #112 Actiq 1600 mg lozenges, and #168 dosage units of OxyContin 80 mg and, if the inconsistent urine drug screen was confirmed, to require Patient F to come in weekly for 2 months. Dr. Match did not discharge Patient F from the practice until 9/7/11, when he obtained a PMP that revealed Patient F had received 3,000 dosage units of methadone on 8/10/11 from another physician.

g. At Patient G's initial (and only visit) with Dr. Match on or about December 21, 2011, he inappropriately prescribed MS Contin 60 mg, #112, oxycodone 30 mg, #84, and OxyContin 80 mg, #90, without first determining the etiology of, or obtaining objective indicia verifying, Patient G's alleged chronic pain conditions. Instead, Dr. Match diagnosed Patient G (husband of Patient H) with, among other things, degenerative joint disease-left leg, derangement meniscus, joint derangement-ankle, pain-forearm joint, pain-lumbago/low back pain, neuralgia or neuritis of sciatic nerve, chronic back pain, and spondylosis-lumbo/sacral, notwithstanding the absence of any recent diagnostic

tests/studies or consultation with orthopedists who had previously operated on Patient G's knee in 2006 and back in June 2009. Further, Dr. Match prescribed these narcotics despite Patient G's significant documented history of aberrant and noncompliant behavior since becoming a patient at Chantilly in 2008, to include:

Information Indicating Drug-Seeking Behavior or Abuse/Misuse or Possible Diversion of Controlled Substances That Dr. Match Knew or Should Have Known
•Multiple PMP reports showing that Patient G received prescriptions for controlled substances from other providers who were not part of the Chantilly team.
•A notation on or about 10/5/10 that Patient G was "now at the stages of possible addiction" and there was a growing risk of "addiction or possible diversion of [his] medications" that necessitated a change to a "conservative regimen" that was "feasible to monitor and not easy to divert for the sale of the medications."
•An inconsistent urine drug screen at Patient G's 12/21/11 visit with Dr. Match (i.e., negative for benzodiazepines, although this medication had been prescribed for quite some time by other Chantilly providers).
•Multiple inconsistent urine drug screens at Chantilly prior to Patient G's first visit with Dr. Match, i.e., on 10/27/10, 11/23/10, 1/19/11, 2/15/11, 3/16/11, 4/13/11, 5/11/11, 6/8/11, 7/6/11, 8/4/11, 8/31/11, 9/28/11, 10/26/11, and 11/23/11, which were negative for benzodiazepines or narcotics that were being prescribed to Patient G.

h. At Patient H's initial (and only visit) with Dr. Match on or about December 21, 2011, he inappropriately prescribed MS Contin 60 mg, #112, and oxycodone 30 mg, #56, without first determining the etiology of, or obtaining objective indicia verifying, Patient H's alleged chronic pain conditions. Instead, Dr. Match diagnosed Patient H, a 38-year-old female (and the wife of Patient G), with rheumatoid arthritis, joint derangement-pelvis, disc degeneration-lumbar, cervicalgia-neck pain, patellar tendinitis, somatic dysfunction lower extremities, and chronic fatigue syndrome, notwithstanding the absence of any diagnostic tests or studies or consultations with specialists relating to these conditions. Further, Dr. Match prescribed these narcotics to Patient H even though

her medical record documented a significant history of aberrant and noncompliant behavior since becoming a patient at Chantilly in 2008, to include:

Information Indicating Drug-Seeking Behavior or Abuse/Misuse or Possible Diversion of Controlled Substances That Dr. Match Knew or Should Have Known
•Every urine drug screen performed (a total of 17 in all, including one performed on the date of Patient H's first visit with Dr. Match on 12/21/11) was inconsistent with the medications being prescribed to Patient H, *e.g.*, they were positive for methadone and/or benzodiazepines, medications that Chantilly providers were not prescribing to Patient H but were prescribing to her husband, Patient G.
•Documentation in Patient H's record from 9/1/10 wherein she attempted to explain her positive urine drug screen for methadone by asserting that she may have mistaken her husband's methadone for her Ambien.
•A referral by a Chantilly nurse practitioner on or about 10/6/10 to an addictionologist to assess Patient H for addiction, as well as multiple other referrals to specialists and/or for diagnostic studies/tests over the preceding three years of treatment, none of which Patient H followed up on.
•PMP reports (including the PMP report dated 12/21/11 from Patient H's first visit with Dr. Match) indicated multiple early and excessive refills for narcotics prescribed by a Chantilly nurse practitioner and indicated that Patient H received 7,584 dosage units of oxycodone 30 mg, purportedly 509 days worth of prescriptions, during the 333 day period from 12/21/10 to 11/18/11.

i. Over the course of approximately nine visits from March to December 2011, Dr. Match prescribed Valium, Tylenol-codeine #3 (Schedule III), Butrans patches (Schedule III), fentanyl patches, and fiorinal with codeine (Schedule III) to Patient I (a new patient to the Chantilly practice), despite substantial evidence that she was abusing/misusing or otherwise engaging in aberrant behavior not in compliance with his medication regimen, to include:

Information Indicating Drug-Seeking Behavior or Abuse/Misuse or Possible Diversion of Controlled Substances That Dr. Match Knew or Should Have Known
•Numerous inconsistent urine drug screens (e.g., results from 4/13/11, 5/19/11, 6/1/11,

9/1/11, and 11/23/11 were all positive for OxyContin/oxycodone, a medication not prescribed to Patient I, and tests from 4/13/11, 5/11/11, 5/19/11, 6/29/11, and 9/1/11, were negative for controlled substances (benzodiazepine or buprenorphine) that were being prescribed to the patient).
•Documentation on 6/1/11 from a Chantilly nurse practitioner that Patient I was one week early for her appointment/medications because the patient reported Tylenol #3 was no longer working for her headaches since her recent hospitalization (with respect to which no records were requested or obtained).
•Further documentation from this nurse practitioner on 6/15/11 that Patient I's pill count was significantly inaccurate in that, instead of having 2 week's worth of Dilaudid left, as expected, the patient only had 3 dosage units remaining, which shortage the patient explained by stating she had spilled #20 pills down the drain.
•Copies of hospital diagnostic reports in Patient I's medical record indicating that she had overdosed, requiring intubation and hospitalization in the ICU from September 1-3, 2011.
•Several PMP reports (on 3/30/11, 6/14/11, and 12/13/11) indicating that Patient I had a history of doctor-shopping and received narcotic prescriptions from non-Chantilly providers while under Dr. Match's care.

j. At Dr. Match's initial (and only) visit with Patient J on or about July 19, 2011, he gave the patient two prescriptions for Duragesic 100 mcg patches, #20 each, without an adequate medical justification for doing so, i.e., the patient's medical record was devoid of recent diagnostic tests/studies or consultation reports from a dentist or other specialist regarding Patient J's alleged chronic jaw pain due to TMJ and degenerative/arthritic changes of the mandibles. Further, Dr. Match prescribed these narcotics to Patient J in spite of the documented history of aberrant and/or drug-seeking behavior in his Chantilly file since July 2009, to include:

Information Indicating Drug-Seeking Behavior or Abuse/Misuse or Possible Diversion of Controlled Substances That Dr. Match Knew or Should Have Known
•A note from one of the Chantilly physician assistants entered on or about 10/18/10 (and on which Dr. Match was copied) that Patient J reported all of his medications were stolen by one or more family members (though no police report was provided).
•Documentation on 3/22/11 that Patient J had obtained pain medications from his PCP at the same time he was receiving pain management treatment at Chantilly.
•Dr. Match referred Patient J for addiction treatment on 7/19/11.

2. Dr. Match may have violated Sections 54.1-2915.A(3), (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 accurate and complete patient records for Patients A-J. Specifically:

a. On multiple occasions, Dr. Match copied and repeated the same assessment, findings, diagnosis, and other notes from visit to visit, even after such prior documentation was no longer relevant or accurate.

b. Prior to prescribing medications to Patients A-J, Dr. Match failed to document a discussion with them of information concerning the risks/benefits associated with the medications being prescribed.

3. Dr. Match may have violated Sections 54.1-2915.A(3), (13), (16), and (18) of the Code, and 18 VAC 90-40-100.B of the Regulations Governing the Practice of Nurse Practitioners and 18 VAC 85-50-110 of the Regulations Governing the Practice of Physician Assistants, in that, from approximately March 30, 2011 to December 31, 2011, he failed to properly manage and oversee the care and treatment that nurse practitioners and physician assistants whom he supervised provided to Patients A-J, as exemplified by the following:

a. These supervised providers regularly prescribed (often simultaneously) large quantities of narcotics to these patients without obtaining prior treatment records or diagnostic studies or tests to determine the etiology of patients' alleged chronic pain conditions. Further, they failed to take appropriate responsive action when these patients failed to follow up on their referrals to specialists or for diagnostic testing.

b. These supervised providers diagnosed various chronic pain conditions for these patients without obtaining objective evidence in support of such diagnoses.

c. These supervised providers failed to attempt non-narcotic treatment modalities with these patients before instituting narcotic therapy.

d. These supervised providers failed to monitor and manage these patients' usage of narcotics (and in some cases benzodiazepines) in that inconsistent urine drug screens and PMP reports, as well as other signs of noncompliant and aberrant behavior, were routinely ignored and/or no appropriate responsive action was taken with respect thereto (other than the ineffective policy of having patients come in for office visits more frequently).

e. These supervised providers cut and pasted office notes from visit to visit, even when the information therein was no longer applicable.

f. On or about December 2, 2011, Nurse Practitioner Z, whom Dr. Match supervised, was arrested by federal agents and charged with one count of Conspiracy to Improperly Distribute Schedule II Narcotics and three counts of Improper Distribution of Schedule II Narcotics, all felony charges. These charges relate to, among other things, Nurse Practitioner Z's alleged improper/illegal prescription of over 800,000 oxycodone-based pills to approximately 600 Chantilly patients and other individuals during the course of a one-year period, during which time Dr. Match was the medical director of Chantilly and Nurse Practitioner Z's supervising physician.

4. Dr. Match may have violated Section 54.1-2915.A (17) of the Code, in that, on or about March 28, 2011, he prescribed Suboxone (Schedule III) to treat Patient B's narcotics abuse/addiction, even though he is 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 related regulations.

Please see Attachment I for the identities of the individuals and patients referred to above.

FOR THE BOARD

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

DATE: 5/1/12