VIRGINIA:

BEFORE THE BOARD OF MEDICINE

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

CONSENT ORDER

By Order entered May 1, 2012, the Virginia Board of Medicine ("Board") summarily suspended the license of Joel W. Match, M.D., to practice medicine and surgery in the Commonwealth of Virginia. Simultaneously, by letter dated May 1, 2012, the Board noticed Dr. Match for a formal administrative hearing to inquire into allegations that he may have violated certain laws governing the practice of medicine and surgery in the Commonwealth of Virginia.

In lieu of proceeding to this formal administrative hearing, the Board and Dr. Match, as evidenced by their signatures affixed below, agree to enter into this Consent Order affecting the license of Dr. Match to practice medicine and surgery in the Commonwealth of Virginia.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Board adopts the following findings of fact and conclusions of law in this matter:

1. Joel W. Match, M.D., was issued license number 0101-040957 by the Board to practice medicine and surgery in the Commonwealth of Virginia on June 1, 1987. Said license was summarily suspended by Order of the Board entered May 1, 2012.

2. Dr. Match 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 of Virginia (1950), as amended ("Code"), with respect to his care and treatment of Patients A-C and E-I 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 five 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). 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. Specifically, at that first visit, Dr. Match continued and modified 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.
•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. 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.

e. 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 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. Dr. Match informed the urologist that Patient F was under a pain management contract with Chantilly.
•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. Dr. Match counseled Patient F not to use his partner's valium.
• 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 discharged Patient F from the practice and reported Patient F to the FBI on 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.

f. 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, 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.

g. 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, 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.

h. 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.

3. Dr. Match 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-C, E-I. Specifically, prior to prescribing medications to Patients A-C, E-I, Dr. Match failed to document a discussion with them of information concerning the risks/benefits associated with the medications being prescribed.

4. Dr. Match 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-C and E-I, 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 excessive oxycodone-based pills to approximately 600 Chantilly patients and other individuals during which time Dr. Match was the medical director of Chantilly and Nurse Practitioner Z's supervising physician.

5. Dr. Match provided the Board with certificates indicating that he received 24 continuing medical education ("CME") credits for completing a course entitled "Physician Prescribing Course" at the University of California-San Diego School of Medicine from July 16-18, 2012, and also received 6.25 CME credits for attending the Omnia-Prova Education Collaborative course "Women's Health Annual Visit" held in Washington, D.C. on May 18, 2012.

6. Dr. Match would testify to the fact that:

a. Dr. Match has specialized in OB/GYN for most of his career and only performed pain management for a brief period of time as a part-time employee of Chantilly Specialists. He began employment with Chantilly Specialists in October, 2010, and became the medical director in March of 2011.

b. Dr. Match was not the medical director at the time he first treated Patient B. Although Dr. Match takes responsibility for the treatment plan he instituted, he did so after consultation with the medical director given his limited experience with pain management. Patient B had been coming to Chantilly Specialists for years prior to being treated by Dr. Match. Dr. Match focused on weaning Patient B from his narcotics by cutting the Patient's dosages in half at each visit in an attempt to prevent narcotic withdrawal.

c. In general, the vast majority of the treatment and problems associated with Patient's A-C and E-I occurred prior to Dr. Match's employment at Chantilly Specialists. Dr. Match was unaware of the problems with the policies and prescribing practices at Chantilly Specialists when he began working for them in October of 2010. As Dr. Match became aware of the problems, he actively, and in good faith, attempted to develop and implement corrective policies and procedures as he was able, in light of his part time schedule and despite the concerted efforts and actions concealed from Dr. Match and taken without his knowledge by Nurse Practitioner Z and the management at Chantilly Specialists, whose motives and goals were not in line with Dr. Match. Specifically, Dr. Match implemented procedures to: 1) ensure that

patients received the appropriate diagnostic studies and referrals, 2) require and provide more thorough physical exams, 3) decrease or discontinue medications, 4) ensure consistent review of urine screens and PMP data with appropriate follow-up action, 5) ensure accurate entry of information in medical records, and 6) increase supervision of the nurse practitioners regarding adherence to the pain management policies and procedures instituted by Dr. Match.

d. Dr. Match was committed to "cleaning up" the pervasive problems with the pain management policies and procedures that existed for years prior to his employment at Chantilly Specialists. During the time Dr. Match was medical director of Chantilly Specialists, he believes he discharged approximately 400 patients, including several of the patients identified in this Order. Further, Dr. Match believes there were numerous entries in the medical records in which Dr. Match was listed as the prescribing and treating provider when in fact he was not present and did not treat the patient.

CONSENT

I, Joel W. Match, M.D., by affixing my signature hereto, acknowledge that:

1. I have been advised specifically to seek the advice of counsel prior to signing this document and am represented by Michael L. Goodman, Esq.;

2. I am fully aware that without my consent, no legal action can be taken against me, except pursuant to the Virginia Administrative Process Act, § 2.2-4000.A et seq. of the Code of Virginia;

3. I have the following rights, among others:

a. the right to a formal hearing before the Board;

b. the right to appear in person or by counsel, or other qualified representative before the agency; and

c. the right to cross-examine witnesses against me.

4. I waive all rights to a formal hearing;

5. I neither admit nor deny the truth of the above Findings of Fact and Conclusions of Law, but waive my right to contest the foregoing Findings of Fact and Conclusions of Law and any sanction in any future judicial or administrative proceeding where the Board is a party; and

6. I consent to the following Order affecting my license to practice medicine and surgery in the Commonwealth of Virginia.

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, in lieu of further administrative proceedings in this matter and with the consent of the licensee, it is hereby ORDERED that the license of Joel W. Match, M.D., to practice medicine and surgery in the Commonwealth of Virginia is CONTINUED ON INDEFINITE SUSPENSION until six (6) months from the date of the summary suspension of his license, i.e., until November 1, 2012. On such date, Dr. Match's license shall be reinstated on INDEFINITE PROBATION for six (6) months, i.e., until May 1, 2013, subject to the following terms and conditions:

1. Within fifteen days of entry of this Order, Dr. Match shall remit all fees associated with activating his license for the current biennium.

2. Dr. Match shall maintain a course of conduct in his practice of medicine commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

It is further ORDERED that, upon reinstatement of his license, Dr. Match shall be PERMANENTLY RESTRICTED from independently assessing, treating, managing, prescribing to, or consulting regarding patients with chronic pain (i.e., pain persisting beyond the usual course of an acute disease or healing of an injury that causes continuous or intermittent pain for more than 90 days) and he shall be prohibited from supervising the treatment of such patients by other healthcare providers.

On May 1, 2013, the Board authorizes the Executive Director to terminate the indefinite probation imposed on Dr. Match's license and close this matter; however, such closure shall have no effect upon the restriction imposed on Dr. Match's license with respect to chronic pain treatment as set forth above.

Violation of this Consent Order may constitute grounds for the suspension or revocation of Dr. Match's license. In the event Dr. Match violates any of the terms and conditions of this Consent Order, an administrative proceeding may be convened to determine whether such action is warranted.

Pursuant to Section 54.1-2400.2 of the Code, the signed original of this Consent Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection and copying upon request.

FOR THE BOARD:

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

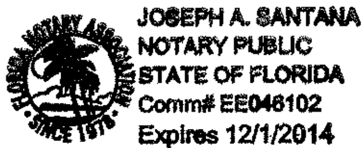
ENTERED: 10/17/2012

SEEN AND AGREED TO:

Joel W. Match, M.D.

COMMONWEALTH OF VIRGINIA
COUNTY/CITY OF ____________________, TO WIT:

Subscribed and sworn to before me, the undersigned Notary Public, in and for the Commonwealth of Virginia, at large, this 16th day of October, 2012, by Joel W. Match, M.D.



Notary Public

Registration Number: EE046102

My commission expires: 12/1/14