BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MOHAMMAD ZAFAR QURESHI, M.D.** Holder of License No. **8269** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0950A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Decree of Censure and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 6, 2007. Mohammad Zafar Qureshi, M.D., ("Respondent") appeared before the Board with legal counsel Stephen Myers for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order 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 No. 8269 for the practice of allopathic medicine in the State of Arizona.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes 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"); A.R.S. § 32-1401(27)(u) ("[c]harging a fee for services not rendered or dividing a professional fee . . . .;") A.R.S. § 32-1401(27)(v) ("[o]btaining a fee by fraud, deceit or misrepresentation;") A.R.S. § 32-1401(27)(w) ("[c]harging or collecting a clearly excessive fee . . . .;") and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resukting in harm to or the death of a patient.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Decree of Censure for improper diagnosis and treatment of patients with chronic pain, specifically the improper use of medications, improper procedural premedication, inadequate understanding of anatomy, and improper billing.

2. Respondent is placed on probation for ten years with the following terms and conditions:

a. Respondent's practice is restricted in that he shall not perform pain management related injection therapies. Respondent may petition the Board for termination of probation upon successful completion of a Physician Assessment and Clinical Education Program evaluation of his global fund of knowledge in anesthesia, with specific emphasis in peripheral nerve blocks and upon demonstrating he has complied with the recommendations of the evaluation and further

demonstrating to the Board he is competent to resume pain management related injection therapies.

b. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

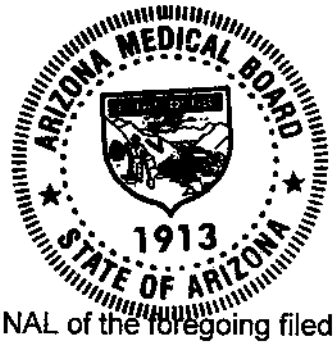
c. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. 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.

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 this 10th day of August 2007.



THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 10th 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 10th day of August, 2007, to:

Stephen Myers
Myers & Jenkins

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

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