

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: SHRIHARSH LAXMAN POLE, M.D.
License No.: 0101-048251

CONSENT ORDER

By letter dated August 9, 2013, the Virginia Board of Medicine ("Board") noticed Dr. Pole for a formal 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. Pole, as evidenced by their signatures affixed below, agree to enter into this Consent Order affecting Dr. Pole's license to practice medicine and surgery in the Commonwealth of Virginia.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

1. Shriharsh Laxman Pole, M.D. was issued license number 0101-048251 by the Board to practice medicine and surgery in the Commonwealth of Virginia on July 1, 1992. By Order dated April 11, 2013, the Board summarily restricted Dr. Pole's license, prohibiting him from prescribing Schedule II and III medications.

2. By Consent Order entered June 2, 2009, the Board suspended Dr. Pole's license, allowing for its automatic reinstatement following completion of 15 hours of Board-approved continuing medical education ("CME") in recordkeeping, 15 hours of CME in the proper prescribing of controlled substances, and 15 hours of CME in the subject of addiction medicine. This action was based, in part, on findings of negligent and harmful treatment related to 13 chronic pain management patients, occurring between 1999 and 2008. Dr. Pole's license was reinstated to full and

unrestricted status by the Board on October 1, 2009.

3. Following completion of the CME courses described above and the reinstatement of his license in October 2009, Dr. Pole failed to properly prescribe benzodiazepines and opiates for chronic pain management provided to Patients A-E, and failed to monitor the patients' medication usage, and he represents a danger to the health and welfare of patients and the public, as follows:

a. Dr. Pole violated Sections 54.1-2915.A(3), (13), (16), and (17), 54.1-3303.A, and 54.1-3408.A of the Code in the care and treatment of Patient A, a 25-year-old female, from November 2011 through February 2012. Specifically, over a three-month period, he prescribed approximately 520 dosage units of Roxicodone (oxycodone, Schedule II) and 221 dosage units of Xanax (alprazolam, Schedule IV) for diagnoses of chronic low back pain and anxiety without sufficient objective evidence or diagnostic testing or studies to support the diagnoses and/or without an adequate medical indication for said prescribing. Moreover, Dr. Pole prescribed these medications notwithstanding awareness of drug-seeking behavior and information that should have indicated that the patient was abusing or had become addicted to the medications. For example:

- Based on Dr. Pole's previous treatment of Patient A from 2006 through 2008 for complaints of chronic back and neck pain, he was aware that she had a history of heroin addiction for an approximate two-year period.
- In February 2008, during Dr. Pole's prior treatment of Patient A for complaints of chronic low back pain, she had a normal lumbar x-ray.

- Documents in the patient’s file at Dr. Pole’s practice indicate that another pain management practice requested the patient’s records from Dr. Pole in or around September 2011, shortly before the patient returned to Dr. Pole’s care in November 2011. Dr. Pole stated to the Board’s investigator that Patient A told him that she was not able to afford treatment at the other practice.
- In November 2011, Dr. Pole referred Patient A for an x-ray of her lumbar spine, which she underwent later that month. The results were normal.

b. Dr. Pole violated Sections 54.1-2915.A(3), (13), (16), and (17), 54.1-3303.A, and 54.1-3408.A of the Code in the care and treatment of Patient B, a 35-year-old female, from approximately October 2009 through April 2012, in that he prescribed approximately 5,079 dosage units of oxycodone, 1,000 dosage units of Opana (oxymorphone, Schedule II), 80 Duragesic (fentanyl, Schedule II) transdermal patches, 20 dosage units of methadone (Schedule II), 50 dosage units morphine (Schedule III), and 836 dosage units of Xanax to the patient for complaints of chronic low back pain, hip pain, neck pain, groin pain, and anxiety which he diagnosed as lumbar radiculopathy, sciatica, and neuropathy, without sufficient objective evidence or diagnostic testing or studies to support the diagnoses. Moreover, Dr. Pole prescribed these medications notwithstanding awareness of drug-seeking behavior and information that should have indicated that Patient B was abusing or had become addicted to the medications. For example:

- The patient's file at Dr. Pole's practice does not contain radiology reports related to the patient's cervical spine, although he treated her for chronic neck pain for many years. Thoracic and lumbosacral spine x-rays taken in 2006 showed only minor spondylitic changes, and x-rays of the lumbosacral spine taken in 2007 and 2008 were normal. On June 10, 2010, Dr. Pole referred the patient for an MRI of her lumbosacral spine. Although Patient B never underwent the MRI, Dr. Pole continued to provide her with opiates for her complaints of neck and back pain at least through early 2012.
- From late 2009 through early 2012, Dr. Pole required Patient B to present for office visits for chronic pain management approximately every two weeks. However, during this time period, Patient B presented early for office visits by two or more days on approximately 29 occasions. Although Dr. Pole recorded in progress notes on at least nine of those occasions that the patient had presented earlier than he had ordered, at the early office visits he routinely provided her with prescriptions for opiates and benzodiazepines without adjusting the number of dosage units prescribed to take into account the early office visits.
- At an office visit with Dr. Pole on or about October 26, 2010, Patient B provided a police report indicating that her purse containing Roxicodone pills had been stolen from a vehicle on October 23, 2010, one day after the patient

had received prescriptions from Dr. Pole for 90 dosage units of Roxicodone and 30 dosage units of Xanax. At the October 26, 2010 office visit, Dr. Pole provided replacement prescriptions for the Roxicodone and Xanax, although the police report did not indicate that the patient's Xanax had been stolen.

- On or about April 18, 2011, the patient had an inconsistent urine drug screen (negative for benzodiazepines, although Dr. Pole had prescribed and the patient had reported taking Xanax), to which he did not take any responsive action.

c. Dr. Pole violated Sections 54.1-2915.A(3), (13), (16), and (17), 54.1-3303.A, and 54.1-3408.A of the Code in the care and treatment of Patient C, a 27-year-old female, from approximately May 2010 through April 2012, in that he prescribed approximately 3,040 dosage units of oxycodone, 90 fentanyl transdermal patches, 75 dosage units of methadone, 90 dosage units of morphine, 1,089 dosage units of alprazolam, and 750 dosage units of Soma (carisoprodol, Schedule VI) for the patient's complaints of chronic neck pain, back pain, and anxiety, notwithstanding awareness of drug-seeking behavior and information that should have indicated that Patient C was abusing her medications and/or that the medications were being used for illegal purposes. For example:

- A Prescription Monitoring Program ("PMP") report for Patient C that Dr. Pole printed on May 14, 2010, the date of her first office visit with him, showed that

she had obtained narcotics and benzodiazepines from at least nine prescribers over the prior 12-month period.

- Records from a prior provider, contained in the patient's file at Dr. Pole's practice, indicate that when the patient was told by another provider in March 2010 that her Roxicodone prescription had to be post-dated to the following week, the patient "start[ed] crying...and said she would pay cash because she needs the med now."
- On or about July 19, 2010, Dr. Pole referred Patient C to a pain management specialist. On August 4, 2010 and September 1, 2010, the specialist prescribed chronic pain medication to Patient C and ordered MRIs of the cervical and lumbar spine. However, the patient did not undergo the MRIs as ordered and she returned to Dr. Pole's care in or about mid-September 2010, at which time he prescribed buprenorphine (Schedule III) to her. Dr. Pole did not document why the patient stopped seeing the pain management specialist or why she returned to him for her chronic pain management.
- On or about October 19, 2010, per Dr. Pole's referral, Patient C saw an orthopedist who ordered x-rays and requested to see a recent MRI. However, nothing in the patient's file at Dr. Pole's practice indicates that she underwent x-rays of her neck or back, or that she returned to the orthopedist after that date.

- On or about December 7, 2011, Dr. Pole ordered an MRI of the cervical and lumbosacral spine. However, there is no indication in the patient's file that she underwent the MRI.
- Patient C had an inconsistent urine drug screen results, as follows:
 - A sample provided July 7, 2010 was positive for morphine and hydromorphone, although Dr. Pole had not prescribed those medications to Patient C;
 - A sample provided January 19, 2011 was negative for benzodiazepines, although Dr. Pole was prescribing alprazolam to the patient;
 - A sample provided June 8, 2011 was positive for benzodiazepines but negative for metabolites of alprazolam, although Dr. Pole was prescribing alprazolam to the patient.
 - A sample provided October 12, 2011 was negative for benzodiazepines, although Dr. Pole was prescribing alprazolam to the patient.
- On October 29, 2010, Patient C reported that her ex-boyfriend had stolen her medications nine days before, and that she had taken some of her father's medications. Additionally, records from a prior provider contained in the patient's file at Dr. Pole's practice indicate that in February 2010 she had reported to the other provider that her boyfriend had flushed her medications down the toilet.

- Dr. Pole was aware that the patient was hospitalized on or about March 2, 2012, for overdosing on medication.

d. Dr. Pole violated Sections 54.1-2915.A(3), (13), and (16) of the Code in the care and treatment of Patient D, a 28-year-old female, from approximately December 2010 through April 2012. Specifically, on or about December 14, 2010, Patient D presented as a new patient requesting Suboxone for complaints of a three-year addiction to oxycodone that she reported had been prescribed for chronic back pain by her prior provider. Without obtaining records from Patient D's prior provider, Dr. Pole prescribed Suboxone (buprenorphine) at that office visit. When Patient D followed up with Dr. Pole on or about February 18, 2011, she reported that she had stopped taking Suboxone "as it did not work for pain," and stated that she had obtained oxycodone in the ER a few days before for complaints of abdominal and back pain. At that visit, without ordering or obtaining appropriate diagnostic tests or studies to determine the etiology of the patient's pain, Dr. Pole diagnosed Patient D with "back pain" and prescribed 45 dosage units of hydrocodone. During Dr. Pole's management of the patient's chronic pain complaints, he prescribed approximately 165 Duragesic (fentanyl) transdermal patches, 625 dosage units of oxycodone, 45 dosage units of hydrocodone, 20 dosage units of Fioricet (butalbital, Schedule III), 330 dosage units of Flexeril (cyclobenzaprine, Schedule VI), and 150 dosage units of tramadol (Schedule VI) for diagnoses of low back pain and scoliosis. However, Dr. Pole did not obtain records from Patient D's prior treating provider until approximately

June 2011, and he did not obtain prior radiology reports until approximately April 2012. A radiology report from a lumbosacral x-ray taken in August 2008 (which Dr. Pole did not obtain until approximately April 2012), includes the following impression: “Question a little scoliosis though examination was not made upright and this therefore may not be a real finding. The vertebral body heights and intervertebral disc spaces are well maintained.” Additionally, a report from a lumbar spine MRI conducted in December 2008 (which Dr. Pole also did not obtain until approximately April 2012) noted an unremarkable lumbar spine.

e. Dr. Pole violated Sections 54.1-2915.A(3), (13), (16), and (17), 54.1-3303.A, and 54.1-3408.A of the Code in the care and treatment of Patient E, a 26-year-old female, from approximately October 2009 through April 2012, in that he prescribed approximately 4,460 dosage units of oxycodone, 30 dosage units of Nucynta (tapentadol, Schedule II), 30 dosage units of Opana (oxymorphone), 5 fentanyl transdermal patches, 20 dosage units of methadone, 60 dosage units of morphine, 400 dosage units of hydrocodone, 60 dosage units of diazepam, 150 dosage units of tramadol, and 180 dosage units of Neurontin (gabapentin, Schedule VI) to the patient for complaints of chronic back pain which he diagnosed as sciatica, lumbar radiculopathy, cervical radiculopathy, and neuropathy, without sufficient objective evidence or diagnostic testing or studies to support the diagnoses. Moreover, Dr. Pole prescribed these medications notwithstanding awareness of drug-seeking behavior and information that should have indicated that Patient E was abusing or had become addicted to the medications. For example:

- X-rays of the patient’s cervical spine, taken in December 2007, showed findings compatible with muscle spasm. X-rays of the thoracic spine, also taken in December 2007, were normal. On multiple occasions Dr. Pole requested that Patient E obtain an MRI of her spine, but she never underwent the MRI.
- During the 29-month period between October 2009 and April 2012, on approximately 47 occasions Patient E presented early by two or more days for office visits for chronic pain management or called in to request additional medications. Dr. Pole documented explanations for some of these early medication requests, including:
 - On December 23, 2010, the patient reported that her medications “fell off accidentally from loose bottle cap [and she] tried to collect as many as possible.”
 - On December 27, 2010, Dr. Pole noted that Patient E “went skiing [over the] wk-end & was hurting badly esp[ecially] LBP.”
 - On October 25, 2011, Dr. Pole noted that the patient ran out of Roxicodone early because she had fallen while walking with her young son two to three days before and sprained her ankle.
 - On October 31, 2011, the patient reported that her Roxicodone “accidentally got dropped in sink.”

- On December 30, 2011 the patient reported that her meds were “liquidated with pepper spray in her purse.”
- On February 28, 2012, Dr. Pole noted that the patient reported that her oxycodone had been stolen during a break-in at her home.
- On March 19, 2012, Dr. Pole noted that the patient came in one week early for her regular appointment because she was “recently in a car accident in L.A.” and was “going to L.A. tomorrow again” to work as a wedding planner.

On such occasions, Dr. Pole routinely provided Patient E with replacement prescriptions for opiates without adjusting the number of dosage units prescribed to take into account the early office visits.

- Patient E had inconsistent urine drug screens, as follows:
 - A sample collected on January 3, 2011 was positive for benzodiazepines, which Dr. Pole was not prescribing to Patient E at the time.
 - A sample collected on February 23, 2012 was negative for gabapentin, which Dr. Pole was prescribing to the patient, and positive for hydrocodone, which Dr. Pole had prescribed to the patient 13 days earlier, but which the patient had not reported on the laboratory report form.

CONSENT

I, Shriharsh Laxman Pole, 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, Esquire, and Eileen M. Talamante, Esquire;
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 Findings of Fact contained herein, however I agree not to contest the Findings of Fact, Conclusions of Law, or any sanction in any future judicial or administrative proceedings where the Board is a party; and
6. I consent to the following Order affecting my license to practice medicine in the Commonwealth of Virginia.

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, and with the consent of the licensee, it is hereby ORDERED that the Board accepts the VOLUNTARY

SURRENDER FOR SUSPENSION of the license of Dr. Pole to practice medicine and surgery in the Commonwealth of Virginia for a period of not less than twenty-four (24) months, effective October 12, 2013.

As of October 12, 2013, the license of Shriharsh Laxman Pole, M.D., will be recorded as SUSPENDED and no longer current.

Pursuant to Section 54.1-2920 of the Code, upon entry of this Consent Order, Dr. Pole shall forthwith give notice, by certified mail or e-mail with confirmation of receipt, to all patients to whom he is currently providing services that his license to practice medicine will be suspended effective October 12, 2013. A copy of this notice shall be provided to the Board when sent to patients. Dr. Pole shall cooperate with other practitioners to ensure continuation of treatment in conformity with the wishes of the patient. Dr. Pole shall also notify any hospitals or other facilities where he is currently granted privileges, and any health insurance companies, health insurance administrators or health maintenance organization currently reimbursing him for any of the healing arts.

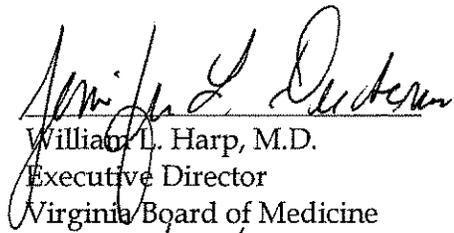
Dr. Pole shall not petition the Board for reinstatement of his license for twenty-four (24) months from the date this suspension takes effect (i.e., October 12, 2015). Should Dr. Pole seek reinstatement of his license, he shall be noticed to appear before the Board, in accordance with the Administrative Process Act. As petitioner, Dr. Pole has the burden of proving his competency and fitness to practice medicine in the Commonwealth of Virginia in a safe manner.

Violation of this Consent Order shall constitute grounds for the revocation of Dr. Pole's license. In the event Dr. Pole violates any of the terms and conditions of this Consent Order, an

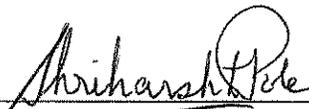
administrative hearing may be convened to determine whether such action is warranted.

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
9/13/2013
ENTERED

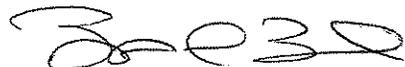
SEEN AND AGREED TO:


Shriharsh Laxman Pole, M.D.

COMMONWEALTH OF VIRGINIA
COUNTY/CITY OF RWC TO WIT:

Subscribed and sworn to before me, the undersigned Notary Public, in and for the Commonwealth of Virginia, at large, this 12th day of September, 2013 by Shriharsh Laxman Pole, M.D.




Notary Public
Registration Number: 293428
My commission expires: Dec 31, 2014