Arizona Medical Board

1740 W. Adams St., Suite 4000 • Phoenix, Arizona 85007
Home Page: http://www.azmd.gov
Telephone (480) 551-2700 • Fax (480) 551-2705 • In-State Toll Free (877) 255-2212

FINAL MINUTES FOR BOARD REVIEW COMMITTEE A MEETING
Held on Wednesday, August 6, 2025
1740 W. Adams St., Board Room B• Phoenix, Arizona

Committee Members
Gary R. Figge, M.D., Chair
Bruce A. Bethancourt, M.D., F.A.C.R., F.A.S.T.R.O.
Laura Dorrell, M.S.N., R.N.
R. Screven Farmer, M.D.

GENERAL BUSINESS

A. CALL TO ORDER
Chairman Figge called the Committee's meeting to order at: 12:35 p.m.

B. ROLL CALL
The following Committee members were present: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Farmer.

ALSO PRESENT
The following Board staff participated in the meeting: Nicole Samaradellis, Investigations Manager and Michelle Robles, Board Operations Manager. Seth Hargraves, Assistant Attorney General ("AAG") was also present.

C. OPENING STATEMENTS
Chairman Figge read the civility policy for the record.

D. PUBLIC STATEMENTS REGARDING MATTERS LISTED ON THE AGENDA
Individuals who addressed the Committee during the Public Statements portion of the meeting will appear under the case.

E. APPROVAL OF MINUTES
- June 4, 2025 Review Committee A Minutes

MOTION: Dr. Bethancourt moved to approve the June 4, 2025 Review Committee A Minutes.
SECOND: Dr. Farmer.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Farmer.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS
1. MD-23-0494A, HERAMB K. SINGH, M.D., LIC. #55413
   Dr. Singh was present with Counsel Steven Long.

Board Staff summarized that the Board initiated case number MD-23-0494A after receiving notification of a malpractice settlement regarding Dr. Singh's care and treatment of a 25-year-old female patient ("AM") alleging improper performance of a cervical epidural steroid injection resulting in right foot drop and right upper extremity weakness. On December 18, 2020, patient AM presented to Dr. Singh's office for complaints of headaches, neck pain, low back pain, and right ankle pain. AM reported the injuries were sustained during a motor vehicle accident in November 2020. After an exam, Dr. Singh administered lumbar trigger point injections and ordered a cervical and lumbar MRI. On December 23, 2020, the cervical MRI demonstrated "straightening of the spine with mild levoscoliosis, consistent with post-traumatic muscle spasm. At both C4-C5 and C5-C6, a posterior disc herniation with impingement on the thecal sac is noted, along with mild spinal stenosis. At C6-C7, there is severe narrowing of the right neural foramina with impingement of the right exiting C7 nerve root." On January 5, 2021, AM underwent cervical epidural steroid injection (CESI) at C5-C6 and lumbar epidural steroid injection (LESI) performed by Dr. Singh. The "procedure room notes" documented that the LESI went well, and that AM started to move following the needle placement for the CESI, despite the provider instructing her to not move. Post-procedure, AM reported right-sided numbness and tingling. An ice pack was applied, and AM was placed in the patient waiting room for observation. AM requested that EMS be called for transfer to the hospital. AM presented to University Hospital and was diagnosed with a C2-T7 intramedullary hematoma. AM was noted to have 0/5 strength in the right upper extremity and no sensation to the right side. AM was admitted to the ICU for intravenous steroids. AM's hospital course was complicated by a code blue that occurred during a possible seizure or vasovagal response. AM was discharged with outpatient physical therapy on January 13, 2021. On March 31, 2021, AM was seen by a physical medicine and rehabilitation physician who noted that she was ambulatory with significant effort using a front-wheeled walker and was still experiencing neuropathic pain with occasional electric shock sensations to the right upper extremity. The Board's Medical Consultant ("MC") reviewed the case and determined that Dr. Singh deviated from the standard of care by failing to timely recognize and address post-procedure complications. The MC stated that the patient suffered a C2-C7 intramedullary hematoma because of the CESI resulting in right sided hemiplegia requiring hospitalization. The MC expressed concern that the patient was placed in the waiting room for observation and that the patient had to request that EMS be called. The MC noted that there was not an actual procedure note that included the name and specific spinal levels of the procedure, type of anesthesia, type and amount of medication, evaluation of injection site and focused neurological exam, immediate complications with treatment and outcome. The MC also noted that the imaging for the procedures was not provided. The licensee stated that the patient was told not to move during the procedure but was uncooperative. He stated that the patient was immediately transferred to the hospital and discharged from the hospital after two weeks no longer requiring assistive devices for walking. SIRC recognized that Dr. Singh blamed the complication on the fact that the patient was not cooperative and moved during the procedure. However, SIRC noted that Dr. Singh did not provide additional documentation and/or the requested images to support his statements. SIRC also discussed the MC's supplemental report wherein it was noted that despite Dr. Singh's statement that the patient was immediately transported to the hospital and was discharged after two weeks without assistive devices needed, the MC expressed concern that the patient was placed in the waiting room for observation and that the patient had to request that EMS be called and the patient still required a walker until March 2021. SIRC remained troubled by the false statements provided by Dr. Singh as well as the lack of documentation and images noting that the patient suffered a C2-C7 intermedullary hematoma resulting in right-sided hemiplegia and without the images, the Board is unable to fully investigate the care rendered.

Mr. Long provided an opening statement to the Committee, where he clarified that the patient was never put into a waiting room on her own and that she was in an exam room with someone watching her for two hours after the procedure. Mr. Long stated that when the patient continued to report pain and numbness, it was Dr. Singh who suggested that she go to the hospital. Dr. Singh did not intend to misrepresent anything to the Board and

acknowledges the medical records, not including the dosage, were an error and will not happen again. Mr. Long requested dismissal in this case.

Dr. Singh stated that this case was litigated and settled. Mr. Singh informed the Committee that he was with the patient the whole time and that he does check in on his patients regularly.

During questioning, Dr. Singh confirmed that he had a conversation with the patient pre-operative, and he had staff translate the risks and benefits. Dr. Singh confirmed that a consent form is signed every time they do a procedure. Dr. Singh noted that a lot of the records were not provided by CareFor, who is the keeper of the records. Dr. Singh explained that CareFor is an outpatient pain management clinic that he was covering. Dr. Singh explained that he had met the patient before for a trigger point injection. Dr. Singh confirmed that he evaluated the patient preoperatively and that the patient is monitored during the procedure by the nurse. Dr. Singh stated that images were taken, unfortunately the images that he submitted in this record are totally black, not diagnostic. Dr. Singh stated that for some patients they give fentanyl and versed to take the edge off before doing the procedure. Dr. Singh stated that the procedure went well and that the pain was relieved. Dr. Singh informed the Committee he completed the procedure under fluoroscopy with a local anesthetic given. Dr. Singh described the needle placement when the patient jumped and that they asked her to stay still. When she could not sit still he pulled the needle out. The patient then complained of numbness and pain. The nurse took her vitals and they were stable so she was taken to the recovery room for observation. Dr. Singh explained that he called the ER and requested imaging for the patient. The patient had been in recovery between one and two hours and he did examine the patient, but it was not documented.

Dr. Singh confirmed that there were records available during the pre-trial but that he was not able to obtain records from the attorney who represented him during the pre-trial investigation and settlement. Dr. Singh noted that the insurance company recommended that he settle given the patient's young age. Dr. Singh confirmed that the handwritten incident report was written by him and acknowledged that he did inject the steroids after the patient moved. Dr Singh agreed that if the patient was moving the needle placement was incorrect and in hindsight continuing with the injection was not appropriate.

Mr. Long requested that the case be dismissed or at most an Advisory Letter be issued.

MOTION: Dr. Farmer moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27), (r) and (kk).
SECOND: Dr. Bethancourt.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Farmer.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Dr. Farmer commented that the outcome was bad and very serious. Dr. Farmer agreed that there is a mitigating factor of no prior board history however, the aggravating factors outweigh this. The records are inaccurate and egregiously there are false and misleading statements. Dr. Farmer stated that the discussion regarding the procedure was inaccurate and there is scanty records. Dr. Farmer opined that if there were mixed reports from the nurses he should go see the patient himself. Dr. Farmer found it egregious to make an injection on a patient who is moving and expressing discomfort. Dr. Farmer opined that given the disingenuous responses a Decree of Censure may be appropriate, but it is hard to prove given the lack of record.

MOTION: Dr. Farner moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and Probation. Within six months, complete no less than 10 hours of Board staff pre-approved Category I CME in an intensive, in-person/virtual course regarding medical recordkeeping. The CME hours shall be in

addition to the hours required for license renewal. The Probation shall terminate upon proof of successful completion of the CME coursework.
SECOND: Dr. Bethancourt.
Dr. Figge agreed given the retractions, records and some unsettling comments there is cause for concern.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Farmer.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

G. FORMAL INTERVIEWS

1. MD-24-0721A, ROXANNE K. RICK, M.D., LIC. #26522
Dr. Rick was present without counsel.

Board staff summarized that Dr. Rick was granted an Arizona license on June 5, 1998. On or around March 2001, Dr. Rick requested her Arizona license be inactivated and affirmed that she was totally retired from the practice of medicine in Arizona and any other states. Therefore, on April 3, 2001, Dr. Rick's request for Inactivation was granted. On June 13, 2024, the Board received an application for reactivation from Dr. Rick wherein she disclosed a felony conviction related to controlled substances in 2002 and disciplinary action taken by the Pennsylvania Board. Additionally, Dr. Rick was excluded from Medicaid and Medicare due to her felony conviction. On November 4, 2003, the Pennsylvania Board suspended Dr. Ricks medical license based on her guilty plea to federal drug violations involving felonies. On January 4, 2013, Dr. Rick filed a Petition for Reinstatement of her Pennsylvania License, which was granted in December 2013, with a limited/restricted status and a probation for 5 years requiring her completion of a reentry program as well as disciplinary and PHP monitoring. The Pennsylvania Board also considered Dr. Rick's license to practice respiratory therapy and granted her license subject to 5 years of probation. In January 2019, The Pennsylvania board issued a Final Order Reinstating Dr. Rick's license to practice medicine and confirmed she completed all terms and conditions of disciplinary monitoring, PHP monitoring, and probation thus terminating her probation and reinstating her license to an active and unrestricted license. In March 2019, The Pennsylvania Board terminated Dr. Rick's probation and reinstated Dr. Rick's license to practice Respiratory Therapy to active and unrestricted status. Dr. Rick's practice is located in Pennsylvania and she resides in California. Dr. Rick did not disclose any gaps in practice from 2019 to present. Therefore, Board staff determined that Dr. Rick practiced medicine in Pennsylvania while her Arizona license was inactive in violation of A.R.S. § 32-1431(C). SIRC recognized that Dr. Rick is not board certified and is solely licensed in Pennsylvania and reported residing in California with the intention to provide telemedicine services to Arizona patients. SIRC acknowledged the serious criminal history disclosed by Dr. Rick and noted that Dr. Rick entered into the plea agreement, served a term of imprisonment, and rehabilitated her conduct after compliance with monitoring in Pennsylvania.

During questioning, Dr. Rick confirmed that she has had no issues since her Pennsylvania license was reinstated. Dr. Rick explained how she came to terms with accepting responsibility for her actions. Dr. Rick informed the Committee of her time out of practice and how she re-entered the practice of medicine. She confirmed how many CME credits she had obtained and that she was able to obtain a DEA license. Dr. Rick explained that she practiced telehealth during the pandemic and noted that telehealth provides a good income. Dr. Rick explained why she is seeking an Arizona medical license and that her goal is to be a part of creating a curriculum regarding marijuana. Dr. Rick informed the committee of what she was doing that resulted in the charges.

Dr. Figge clarified for the record Dr. Rick's out of practice and subsequent return to practice timeframe and that she returned to practice in 2014.

Dr. Rick stated that she did not know that when she Inactivated her Arizona license, she was not allowed to practice medicine anywhere else.

Board staff read the Board's statute for the record, confirming that she was not allowed to practice medicine with an inactive Arizona license.

Dr. Bethancourt inquired if this statute was in effect when she went inactive.

Mr. Hargraves confirmed that in 2001 correspondence Dr. Rick was informed of this.

During deliberations, Dr. Farmer requested that staff put out information regarding these statutory requirements to prevent these gaps in knowledge. Dr. Figge commented that she did in fact sign the attestation that she would not practice in Arizona or anywhere else until she went through the reactivation process. Dr. Bethancourt opined that she may have interpreted it as if she was not practicing anywhere else when she signed it. Dr. Figge reiterated that the fact is that she signed this document and has been practicing since 2014 when legally she had to go through the reactivation process.

MOTION: Ms. Dorrell moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(t) and A.R.S. § 32-1431(c).
SECOND: Dr. Farmer.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Farmer.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Ms. Dorrell commented that it has been 16 years since she went inactive. She has regained her Pennsylvania license and had five years of probation before getting an unrestricted license. Ms. Dorrell opined that this is a true example of remediation.

MOTION: Ms. Dorrell moved to grant License Reactivation and issue an Advisory Letter for practicing on an inactive license. While the licensee has demonstrated substantial compliance through rehabilitation or remediation that has mitigated the need for disciplinary action, the board believes that repetition of the activities that led to the investigation may result in further board action against the licensee.
SECOND: Dr. Bethancourt.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Farmer.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

H. FORMAL INTERVIEWS

1. MD-22-0334A, RALPH E. MAYBERRY, M.D., LIC. #16890
   Dr. Mayberry was present with counsel Chris Smith.

Board staff summarized that Case MD-22-0334A arose after receiving notification from the Arizona Pharmacy Board that in March of 2022, Dr. Mayberry was identified by the CSPMP task force as having failed to request a patient history report before prescribing an opioid or benzodiazepine during the timeframe of November 2021 – January 2022. Further, in over a 90 day period, Dr. Mayberry prescribed a total of 301 or more opioids and or benzodiazepines and performed zero queries. In his response, Dr. Mayberry explained that he sees patients every three months who are on chronic opioids and manages their medication and refills, some are managed monthly or quarterly. Dr. Mayberry admitted that he was not performing a PMP query but remained committed to reviewing and incorporating it moving forward. Based on the PMP information reviewed and Dr. Mayberry's acknowledgement, Board staff sustained the allegations that he failed to query the PMP despite extensive controlled substance prescribing.

Board staff reviewed Dr. Mayberry's prescribing history and selected three patient charts for review. Patient AL was a 41-yer-old female with chronic low back pain, keratonconus, and anxiety. Opiates were increased and she was diagnosed with fibromyalgia by

another physician while under Dr. Mayberry's care for chronic pain. Patient TB was a 61-year-old male transferred to Dr Mayberry's care in 2018 with low back pain, spinal cord injury, osteoarthritis of hips, myositis, migraine headaches, major depressive disorder, generalized anxiety disorder, and insomnia. TB was treated with OxyContin 80 mg Q12hr, oxycodone 10 mg 8 tabs daily for a MME of 360 mg/d. Zolpidem and ibuprofen were also prescribed. Patient JM was a 61-year-old male seen by a mid-level provider supervised by Dr. Mayberry then in February 2020 he was under Dr. Mayberry's direct care. JM had low back pain, bilateral hip and knee pain from a MVA 40 years ago. JM was prescribed MS Contin 60 mg Q12 hr, oxycodone 30 mg 8 tab daily, gabapentin and naproxen. MME was 480 MME and was unchanged during treatment. The first MC found that Dr. Mayberry deviated from the standard of care in all three cases by inappropriately prescribing controlled substances and failing to query the CSPMP. However, the first MC was unaware of the current standards of care regarding controlled substance prescribing. Therefore, a second MC was obtained to address Dr. Mayberry's prescribing in detail. The second MC found that Dr. Mayberry deviated from the standard of care in all three cases by inappropriately prescribing controlled substances, failing to obtain urine drug screens, failing to prescribe Narcan, and failing to query the CSPMP. None of the patients had pain contracts, updated histories, pain monitoring, or informed consents. Prescriptions for controlled substances were not documented. For JM, new pain and neuropathic symptoms were not evaluated. Adverse events of falls, osteopenia, and a new skin ulcer were not considered to be caused by or exacerbated by his medications. Dr. Mayberry's response states, "Dr. Mayberry has never claimed to make an "evidence-based argument" about his use of opioids on these three patients." SIRC noted that Dr. Mayberry has been querying the CSPMP since he was notified of the investigation. However, SIRC remained concerned regarding the prescribing of high doses of opioids without appropriate monitoring, especially with the concomitant use of benzodiazepines. SIRC was also troubled by the lack of documentation to justify the medications and combinations prescribed.

Dr. Mayberry provided an opening statement and informed the Committee of what he has been doing since he retired. Dr. Mayberry noted that he knew these patients and their medical history very well. Dr. Mayberry informed the Committee that TP was successful in tapering off all opioids, but that JM and AL were not ready to taper. Dr. Mayberry stated that they were taking their prescriptions as prescribed. He saw them at least every three months and they had pain contracts annually. Dr. Mayberry stated that once he was notified about querying the CSPMP requirements he made that change. Dr. Mayberry stated that he has learned a lot from this experience and although he is retired, he plans to be a volunteer physician. Dr. Mayberry informed the Committee that he does not have a DEA license.

Mr. Smith stated that the CDC guidelines from 2022 talk about how they are not intended to replace clinical judgment and the treatment of individuals and their individual pain. They are not supposed to be just some iron clad standard of care. Dr. Mayberry, once notified, did update his electronic medical records (EMR) and he did query until he retired. Mr. Smith stated that there was no patient harm. Mr. Smith stated that Dr. Mayberry saw these patients every three months and monitoring their vital signs. MR. Smith noted that patients JM, TB were referred to pain clinics and that there are urine drug screens in the file. Mr. Smith stated that there were clinical rationales for these patients and there was no harm to the patients or the public.

During questioning, Dr. Mayberry explained his understanding of checking the CSPMP. Dr. Mayberry confirmed that he knows of the potential risks of prescribing opioids with benzodiazepines and that he informed the patient and monitored the risks. Dr. Mayberry stated that he does believe there is a risk but that he weighed the risks and benefits. Regarding patient AL, Dr. Mayberry stated that the patient was not on the prescriptions at high doses and not for a long period of time. Dr. Mayberry explained the difference between the 2016 and 2022 CDC guidelines and what he has learned from it. Dr. Mayberry confirmed that there were pain specialist referrals and explained his understanding of the purpose for urinary drugs screens.

Dr. Bethancourt commented that things were changed with regards to increasing or decreasing doses and nothing was documented regarding the rationale.

Dr. Mayberry confirmed that he does copy and paste in the medical records but that he would need to refer to the specific notes to further explain those notes. Dr. Mayberry stated that he is responsible for the notes in the record.

Dr. Figge commented that this was a Pharmacy Board complaint regarding Dr. Mayberry not checking the CSPMP and the criteria for the CSPMP was implemented in 2017. Dr. Figge opined that it was mitigating that Dr. Mayberry corrected this once informed but it does not mitigate that he didn't do it beforehand. Dr. Figge clarified that this is not a Board regulation, but a statute and the legislature passed this.

In closing, Mr. Smith noted the mitigating factors in this case and requested that the Board dismiss or at most issue an Advisory Letter.

Board staff commented that all the urine drug screens, all the referrals to pain clinics and all the Narcan prescriptions were done after staff's review, and therefore was not in the records that he presented. Board staff stated that there were no urine drug screens, no monitoring of abhorrent behavior and there was no documentation of informed consent.

Board staff further noted that the records Mr. Smith may have been referencing in his presentation were given to the Board two days ago and were done after the initiation of this case.

Mr. Smith noted that there were referrals to other specialists and there were additional referrals in 2023.

During deliberations, Dr. Bethancourt opined that there has been unprofessional conduct. Dr. Bethancourt stated that it is very clear that the controlled substance monitoring program was not checked until 2023. It is also quite clear that there was no reason in the records why medication doses were increased, and medications were changed. Dr. Bethancourt opined that the medical records were inappropriate and that there was a safety issue.

MOTION: Dr. Bethancourt moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(a (A.R.S. § 32-2606(F)), (e) and (r).
SECOND: Ms. Dorrell.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Farmer.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Dr. Bethancourt opined that a Letter of Reprimand and Probation as recommended by SIRC is appropriate.

MOTION: Dr. Bethancourt moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and Probation. Within six months, complete no less than 10 hours of Board staff pre-approved Category I CME in an intensive, in-person course regarding medical recordkeeping; and complete no less than 15 hours of Board staff pre-approved Category I CME in an intensive, in-person course regarding controlled substance prescribing. The CME hours shall be in addition to the hours required for license renewal. The Probation shall terminate upon proof of successful completion of the CME coursework.
SECOND: Ms. Dorrell.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Farmer.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.

MOTION PASSED.

CONSENT AGENDA

I. APPROVAL OF DRAFT FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

1. MD-24-0689A, CHARLES MATLIN, M.D., LIC. #13975

   Counsel Cody Hall addressed the Board during the public statements portion of the meeting.

   Mr. Hargraves confirmed that the correction is for FOF #12 and that it should be changed from “fastener” to “tacker”.

   MOTION: Dr. Farmer moved to approve the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand with the requested correction.
   SECOND: Dr. Bethancourt.
   VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Farmer.
   VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
   MOTION PASSED.

GENERAL BUSINESS

J. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

There was no discussion.

K. ADJOURNMENT

MOTION: Dr. Farmer moved for adjournment.
SECOND: Dr. Bethancourt.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Farmer.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

The meeting adjourned at 3:13 p.m.

Raquel Rivera

Raquel Rivera, Executive Director