State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

December 9, 2020

Case number: 20-CRF-0195

Wade Lowell Banker, M.D.
1500 Holland Rd.
Maumee, OH 43537

Dear Doctor Banker:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to grant or register or renew or reinstate your license or certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) During the time period of in or around June 2014 to in or around May 2018, you provided care in the routine course of your practice to nine patients as identified in the attached Patient Key Number 1, identified as Patient 1 through Patient 9 (Patient Key Number 1 is confidential and to be withheld from public disclosure). You inappropriately treated and/or failed to appropriately treat; and/or you failed to appropriately document your treatment of these patients, and/or you departed from, or failed to conform to, minimal standards of care for similar practitioners under the same or similar circumstances, which included:

- Inappropriate and/or inadequate management of patients' conditions, and/or inappropriate and/or inadequate monitoring of patients' medications;
- A failure to provide appropriate care and/or treatment to patients;
- Inappropriate prescribing; and/or
- Inadequate and/or incomplete documentation.

(2) Specific examples of such conduct and care to the nine patients include, but are not limited to, the following:

(a) Patient 1 treated at your office from in or around January 2017 to at least in or around January 2018 for complaints apparently related to hypogonadism and being overweight. In January 2017, the laboratory tests showed a low normal testosterone level of an unclear clinical significance, and the patient was given testosterone pellets. In a patient symptom form dated on or about March 20, 2017, there were generalized, non-specific complaints, and some symptoms possibly could be related to hypogonadism. The patient was given testosterone pellets but with anastrozole

because the patient's estradiol level was slightly elevated. On or about August 8, 2017, you prescribed phentermine to the patient, apparently for weight loss, and the testosterone therapy was modified to intramuscular testosterone and oral anastrozole. Your office notes were inadequate, as no past medical history was recorded and you failed to perform, and/or document performing, an appropriate physical examination. You also failed to appropriately establish a diagnosis of hypogonadism, and you further failed to have sufficient testing conducted in order to establish an appropriate diagnosis and the cause of any symptoms or complaints. The use of anastrozole to treat the elevated estradiol level was not supported by the documentation in the chart. In addition, your use of phentermine for weight loss was inappropriate. You failed to document a weight and diet history, or counseling prior to treatment, and an elevated blood pressure recorded on or about March 20, 2017 made the medication contraindicated. Further, the overall documentation was incomplete, and given your failure to appropriately establish a diagnosis, the use of the medications was not clinically indicated.

(b) Patient 2 was treated at your office from in or around July 2014 to at least in or around December 2016 for complaints apparently related to obesity and hypogonadism. When the patient was first seen by you on or about July 24, 2014, you prescribed phentermine, but there was no formal note of a history, review of symptoms, recording of vital signs or physical examination. When the patient returned to see you on or about October 4, 2014, there was no documentation of a meaningful interval history, including blood pressure, and you renewed the medication. You failed to do a formal workup to determine causes for obesity, and you failed to monitor the side effects from phentermine. Patient 2 next returned to your office on or about March 5, 2016, and he completed a symptom chart. Although there was a failure to document a complete history or physical examination, it was determined that the patient had hypogonadism and the only lab tests showed a low testosterone level and normal estradiol. The patient was started on testosterone and anastrozole pellets, which were continued through office visits that ended in December 2016. Blood work done in June 2016 showed normal testosterone and normal estradiol levels, although the patient's symptoms remained the same. Your treatment for obesity and hypogonadism was based on incomplete information to establish appropriate diagnoses. You failed to appropriately monitor the patient for complications from the treatment and medications. The overall documentation was incomplete, and given your failure to appropriately establish diagnoses, the use of the medications was not clinically indicated.

(c) Patient 3 was treated at your office for matters related to endocrinology from in or around November 2016 to at least in or around February 2018, for symptoms apparently related to hypogonadism. When the patient was seen on or about November 16, 2016, there was no documentation of past medical history, review of symptoms, or a physical examination. Based on a symptom sheet and a random low testosterone, the patient was diagnosed as having hypogonadism and started on testosterone pellets with anastrozole. The patient's treatment also included testosterone cypionate injections, and sermorelin was added on or about October 6, 2017. While Patient 3's initial random testosterone was low, his TSH was normal, and you failed to order other pituitary function tests to appropriately establish the cause of hypogonadism. You also failed to timely monitor the side effects for the

testosterone treatment, and the use of anastrozole and sermorelin was not supported by the documentation that was in the chart. The overall documentation also was incomplete, the use of the medications for unproven conditions was not appropriate, and the potential complications arising from the use of the medications was dangerous.

(d) Patient 4 was treated at your office for matters related to endocrinology for one office visit in or around March 2018, for symptoms apparently related to hypogonadism. When the patient was seen on or about March 2, 2018, there was insufficient documentation of past medical or a physical examination. In a patient symptom form, there were generalized, non-specific complaints, and some symptoms that possibly could be related to hypogonadism. However, there was no appropriate differential diagnosis establishing the cause for hypogonadism. While blood tests showed serum testosterone was normal, you treated the patient with testosterone cypionate at 50 mg three times a week for a total of 300 mg every two weeks, which was more than the standard dose, and you failed to appropriately monitor the patient after starting the treatment. The overall documentation was incomplete, the use of the medications for unproven conditions was not appropriate, and the potential complications arising from the use of the medications was dangerous.

(e) Patient 5 was treated at your office from in or around November 2015 until at least in or around April 2018 for complaints apparently related to erectile dysfunction and narcolepsy. During the first office visit on or about November 20, 2015, there were some components of the patient's history that were supportive of these diagnoses. However, the history and physical examination needed to be broadened in order to make appropriate differential diagnoses. There was a failure to record vital signs, and while the blood tests showed a low testosterone, no attempt was made to establish whether it was primary or secondary, i.e., from testicular failure or pituitary failure. You started the patient on Viagra for erectile dysfunction and Concerta for narcolepsy. Subsequent office visits between November 2015 and April 2016 were for tapering Concerta. However, the documentation for these office visits was inadequate, as they contained insufficient information and did not include notations of blood pressure or weight. In mid-2016, you prescribed phentermine to the patient, but no mention was made of weight or blood pressure, and you failed to appropriately monitor the side effects or complications from this treatment. On or about February 26, 2017, you started the patient on subcutaneous pellets of testosterone and anastrozole, and the pellets were continued through office visits every four months. On or about April 26, 2018, the patient was started on sermorelin/ipamorelin. Your diagnosis of narcolepsy was inadequate, and you failed to appropriately investigate a cause for erectile dysfunction and hypogonadism. In addition, the overall documentation was incomplete, and your use of the medications for unproven conditions was not appropriate, and the potential complications arising from the use of the medications was dangerous.

(f) You first saw Patient 6 in or around December 2015 for a matter unrelated to hormone therapy. On or about June 16, 2016, you started Patient 6 on hormone replacement treatment with testosterone pellets with anastrozole. You failed to document a past medical history, review of symptoms, or a physical examination.

You also failed to record vital signs, such as blood pressure. The initial lab tests showed normal testosterone level, and you treated the patient with testosterone pellets throughout the summer of 2016. On or about November 4, 2016, the patient complained of weight gain, and Adipex was prescribed. The patient continued to take Adipex and testosterone pellets from November 2016 through January 2018. There was inadequate documentation of weight or blood pressure measurements before or after treatments. You failed to appropriately monitor the patient for side effects from those treatments. On or about April 26, 2018, ibutamoren was added. The diagnosis of a hormone deficiency was never appropriately established, and you failed to document an appropriate reason for the use of testosterone for hormone replacement. The overall documentation was incomplete, and the use of the medications for unproven conditions was not appropriate.

(g) Patient 7 treated at your office from in or around February 2016 to at least in or around March 2018, for several proposed treatments related to hormone replacement therapy (HRT), which included sildenafil and human chronic gonadotropin hormone. During the first office visit, you failed to document a history of present symptoms, past medical history, a review of symptoms, vital signs, a physical examination, or lab tests. On or about May 16, 2016, sermorelin was added; on or about August 6, 2016, Adipex was prescribed; and on or about January 12, 2017, pellets with testosterone and anastrozole were added. The testosterone was changed from pellets to injection in or around November 2017, and the patient continued to take testosterone supplements with Adipex through in or around March 2018. While it appeared that you made a diagnosis of hypogonadism in 2016, there was inadequate documented information for that diagnosis. In addition, treatment with HRT was based on generalized non-specific symptoms, and there was inadequate documentation to make an appropriate diagnosis. When the patient was started on Adipex, you failed to document weight or blood pressure, and you failed to appropriately monitor weight or blood pressure. In addition, the overall documentation was incomplete, and the use of the medications for unproven conditions was inappropriate.

(h) Patient 8 was treated at your office for matters related to endocrinology from in or around January 2016 to at least in or around November 2017, for symptoms apparently related to hypogonadism. The patient initially was seen in or around April 2015 for the removal of tattoos, but there were no formal notes.
On or about January 28, 2016, a blood test showed a low testosterone level. And while there is a prescription for testosterone pellets with anastrozole for that date, there are no office notes for January 2016. There are notes for the testosterone pellets in May and June 2016, and for July, September, and October 2017. Phentermine was prescribed, apparently in April or May 2016, and continuing through November 2017. However, you failed to document weight or blood pressure, and you further failed to appropriately monitor the patient's treatment. After an initial low reading in January 2016, most of the testosterone levels listed in the chart are slightly elevated or normal. There was inadequate documented information for your diagnosis of hypogonadism and subsequent treatment with HRT, as your treatment was based on generalized non-specific symptoms. In addition, the overall documentation was incomplete, and the use of the medications for unproven conditions was inappropriate.

(i) Patient 9 was treated at your office from in or around June 2016 to at least in or around February 2018. Although there was inadequate documentation, you apparently determined that he was a good patient for hormone replacement therapy (HRT) and started him on testosterone pellets with anastrozole. During this first office visit on or about June 21, 2016, you failed to document a history of present symptoms, past medical history, a review of symptoms, vital signs, or a physical exam. The patient remained on testosterone pellets until on or about October 20, 2017 when he was started on testosterone cypionate pellets. Sermorelin was added on or about June 8, 2017, and the testosterone cypionate dose was doubled to 200 mg weekly on or about October 20, 2017. The patient's testosterone levels were measured on or about June 20, 2016 and were slightly above normal, and the levels were greatly elevated when measured on or about November 22, 2016. You failed to appropriately monitor the treatment or medications. The diagnosis of hypogonadism and subsequent treatment with HRT was inadequate, as the documentation in the chart indicated that it was based on clinical symptoms alone. In addition, the overall documentation was incomplete, and the use of the medications for unproven conditions was not appropriate.

(3) During the time period of in or around October 2016 to in or around May 2018, you provided care in the routine course of your practice to six patients as identified in the attached Patient Key Number 2, identified as Patient 10 through Patient 15 (Patient Key Number 2 is confidential and to be withheld from public disclosure). You inappropriately treated and/or failed to appropriately treat; and/or you failed to appropriately document your treatment of these patients, and/or you departed from, or failed to conform to, minimal standards of care for similar practitioners under the same or similar circumstances, which include:

- A failure to provide appropriate care and/or treatment to patients;
- Inappropriate and/or inadequate management of patients' conditions; and
- Inadequate and/or incomplete documentation.

(4) Specific examples of such conduct and care to the six patients include, but are not limited to, the following:

(a) Patient 10 treated at your office on or about December 19, 2016 regarding complaints related to facial aging. You provided laser treatment and possibly liposuction of the neck (as charting is not clear). Following your treatment, the patient was seen by another health care provider on or about December 29, 2019 and was sent to the emergency room where she was treated for a third degree burn of her neck. While your chart included pictures of a healing third degree burn, you failed to document the burn in the chart. Records from another health care provider indicated that in or around March 2017, the scar was reported to be tender, tethering and keloid-like.

(b) Patient 11 treated at your office from in or around October 2016 to at least in or around May 2018, and the treatments you provided were a tummy tuck and tummy

tuck revision under local anesthesia. The documentation in the chart was unclear about the patient's past medical history and other pertinent medical issues, and the operative note for the first surgery was not included in the chart. The second surgery you performed to improve the deformity was performed with a non-standard upper abdomen incision. The post-operative documentation was incomplete, and you failed to appropriately follow the patient post-operatively.

(c) Patient 12 treated at your office from in or around June 2017 to at least in or around March 2018. You performed three surgeries. The first surgery was for breast augmentation; there was possibly a second surgery for a hematoma (while complication was documented, the treatment was not); and a third surgery for upsizing the breast implant. The documentation in the chart is incomplete, as the operative note for the first surgery is not in the chart and it is unclear how the hematoma was treated. The post-operative documentation also was incomplete, and you failed to appropriately follow the patient post-operatively.

(d) Patient 13 treated at your office from in or around February 2018 to at least in or around May 2018, and the treatment you provided was a breast augmentation with silicone implants under local anesthesia. The first surgery was on or about March 16, 2018, and the surgery was aborted due to patient loss of consciousness and desaturation. The patient apparently received mouth-to-mouth resuscitation during the desaturation, and this is an indication of a lack of basic preparation in the procedure room. The patient also had a second procedure that was aborted due to possible lidocaine toxicity. The documentation was unclear as to whether the surgery was completed, and the patient history in the chart also was incomplete. You further failed to appropriately follow the patient post-operatively.

(e) Patient 14 treated at your office from in or around October 2017 to at least in or around March 2018 , and the primary treatment you provided was a breast augmentation revision to remove saline implants and replace them with silicone implants under local anesthesia. You previously had provided some Botox treatment in 2016. The documentation in the chart was unclear about the patient's past medical history and other pertinent medical issues, including any previous mammograms or history of breast cancer in the family. While the pictures show a post-operative deformity around the areola, that was not appropriately documented in the chart. The post-operative documentation was incomplete, and you failed to appropriately follow the patient post-operatively.

(f) Patient 15 treated at your office from in or around August 2017 to at least in or around November 2017, and the treatment you provided was a breast augmentation with silicone implants under local anesthesia. The documentation in the chart was unclear about the patient's past medical history and other pertinent medical issues, including any previous mammograms or history of breast cancer in the family. Your over-all patient records were incomplete, including the post-operative documentation, and you failed to appropriately follow the patient post-operatively.

Your acts, conduct, and/or omissions, as alleged in paragraphs (1), (2)(a) through (2)(i), (3), and (4)(a) through (4)(f) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar

circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions, as alleged in paragraphs (1), (2)(a) through (2)(i), (3), and (4)(a) through (4)(f) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after June 1, 2014, through in or around May 31, 2018, as alleged in paragraphs (1) and (2)(a) through (2)(1) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: General Provisions, Rule 4731-11-02, Ohio Administrative Code, as in effect from September 30, 2008, through December 30, 2015; as subsequently in effect from December 31, 2015, through August 30, 2017, and as subsequently in effect from August 31, 2017, through December 22, 2018. Pursuant to 4731-11-02(F), Ohio Administrative Code, as in effect from September 30, 2008, through December 30, 2015, violation of Rule 4731-11-02, Ohio Administrative Code, also constitutes violation of Section 4731.22(B)(2), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code. Pursuant to Rule 4731-11-02(E), Ohio Administrative Code, as in effect from December 31, 2015, through August 30, 2017, and as subsequently in effect from August 31, 2017 through December 22, 2018, violation of Rule 4731-11-02, Ohio Administrative Code, also constitutes violation of Section 4731.22(B)(2), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after June 1, 2014, through in or around May 31, 2018, as alleged in paragraphs (1), (2)(a), (2)(b), and (2)(f) through (2)(h), above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Controlled Substances; Utilization for Weight Reduction, Rule 4731-11-04, Ohio Administrative Code, as in effect from June 30, 2000, through February 28, 2016, and as subsequently in effect from February 29, 2016, through the present. Pursuant to 4731-11-04(D), Ohio Administrative Code, as in effect from June 30, 2000, through February 28, 2016, and as subsequently in effect from February 29, 2016, through the present, violation of Rule 4731-11-04, Ohio Administrative Code, also constitutes violation of Section 4731.22(B)(2), Ohio Revised Code, Section 4731.22(B)(3), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Furthermore, for any violations that occurred on or after September 29, 2015, the board may impose a civil penalty in an amount that shall not exceed twenty thousand dollars, pursuant to Section 4731.225, Ohio Revised Code. The civil penalty may be in addition to any other action the board may take under section 4731.22, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to grant or register or renew or reinstate your certificate or license to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Kim G Rothermel MD/KLAper authorization

Kim G. Rothermel, M.D.
Secretary

KGR/MRB/jmb
Enclosures

CERTIFIED MAIL #91 7199 9991 7039 7791 1071
RETURN RECEIPT REQUESTED

cc: Mr. Tyler Overlock
Overlock Law
7860 Ron Ridge
Waterville, OH 43566

CERTIFIED MAIL #91 7199 9991 7039 7791 1088
RETURN RECEIPT REQUESTED

IN THE MATTER OF
WADE LOWELL
BANKER, MD

20-CRF-0195

DECEMBER 9, 2020, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.