BEFORE THE BOARD IOWA BOARD OF MEDICINE

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

ANDRZEJ SZCZEPANEK, M.D., RESPONDENT

FILE No. 02-11-626

TERMINATION ORDER

Date: February 17, 2017.

1. Iowa Medical License: Respondent was issued Iowa medical license 37643 on January 18, 2008. Respondent’s Iowa medical license is active and will next expire on November 1, 2018.

2. Jurisdiction: The Board has jurisdiction in this matter pursuant to Iowa Code chapters 147, 148 and 272C.

3. Statement of Charges: On January 11, 2013, the Board filed a Statement of Charges against Respondent alleging that he engaged in professional incompetency, inappropriate prescribing and improper pain management in violation of the laws and rules governing the practice of medicine in Iowa when he failed to provide appropriate pain management to numerous patients in Des Moines, Iowa, between 2011 and 2012.
4. **Findings of Fact, Conclusions of Law, Decision and Order:** A hearing was held before the Board on October 10-11, 2013. On December 12, 2013, the Board issued a Findings of Fact, Conclusions of Law, Decision and Order. The Board concluded that Respondent violated the laws and rules governing the practice of medicine in Iowa when he failed to provide appropriate pain management to numerous patients in Des Moines, Iowa, between 2011 and 2012. The Board issued Respondent a Citation and Warning and ordered him to pay a $2,500 civil penalty. The Board also ordered Respondent to practice in a Board-approved practice setting with respect to his opioid prescribing and complete a Board-approved medical recordkeeping course. The Board also placed Respondent on probation for a period of three (3) years subject to Board monitoring including a practice monitoring plan and a worksite monitor.

5. **Termination of Probation:** On December 12, 2016, Respondent successfully completed the terms of his probation.

6. **Board-Approved Group Practice Setting:** Recently, Respondent asked the Board to terminate the requirement that he practice in a Board-approved practice setting with respect to his opioid prescribing. On February 17, 2017, the Board voted to terminate the requirement that Respondent practice in a Board-approved practice setting with respect to his opioid prescribing. The Board concluded that Respondent has fully complied with the terms and conditions established in the December 12, 2013, Findings of Fact, Conclusions of Law, Decision and Order.
THEREFORE IT IS HEREBY ORDERED: that the requirement that Respondent practice in a Board-approved practice setting with respect to his opioid prescribing is terminated and Respondent’s Iowa medical license is returned to its full privileges, free and clear of all restrictions.

This Order is issued by the Board on February 17, 2017.

Diane L. Clark, R.N., M.A., Chair
Iowa Board of Medicine
400 SW 8th Street, Suite C
Des Moines, Iowa 50309-4686
BEFORE THE IOWA BOARD OF MEDICINE

IN THE MATTER OF THE
STATEMENT OF CHARGES AGAINST
ANDRZEJ SZCZEPANEK, M.D.
Respondent.

DIA No. 13IMB003
File No. 02-11-626

FINDINGS OF FACT,
CONCLUSIONS OF LAW,
DECISION AND ORDER

Date: December 12, 2013.

On January 11, 2013, the Iowa Board of Medicine (Board) filed a Statement of Charges against Andrzej Szczepanek, M.D., Respondent, charging him with: (1) professional incompetency pursuant to Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2), and 653 IAC 23.1(2)(a)-(g); (2) inappropriate prescribing pursuant to Iowa Code section 148.6(2)(i) and 653 IAC 23.1(7); (3) improper pain management pursuant to Iowa Code section 148.6(2)(i) and 653 IAC 13.2; and (4) unethical of unprofessional conduct pursuant to Iowa Code sections 147.55(3), 148.2(g) and 272C.10(3), and 653 IAC 23.1(4). Respondent filed an Answer, denying the allegations contained in the Statement of Charges.

A contested case hearing was held on October 10-11, 2013, before the following Board members: Diane Clark, Acting Chair and public member; Hamed Tewfik, M.D., Vice-Chairman; Julie Carmody, M.D.; Analisa Haberman, D.O.; Julie Perkins, M.D.; and Monsignor Frank Bognanno, public member. The hearing was closed to the public at Respondent’s request, pursuant to Iowa Code section 272C.6(1) and 653 IAC 25.18(12). The hearing was reported by certified court reporters. Administrative Law Judge Heather Palmer assisted the Board in conducting the hearing. Assistant Attorney General Julie Bussanmas represented the State. Attorney James Shipman represented Respondent. Board Investigator James Machamer, Gordon Bearwood, M.D., Mark Kline, M.D., Arnold Parenteau, M.D., and Muhammad Sami Iqbal, M.D. appeared and testified on behalf of the State. Respondent appeared and testified. Scott Glaser, M.D. and David Ketroser, M.D. testified on behalf of Respondent. Andrea Trescot, M.D. appeared by video deposition and transcript. The Board’s Executive Director, Mark Bowden, and Legal Director, Kent Nebel, also attended the hearing.

Prior to the hearing the parties raised objections to the offered exhibits. Following a prehearing conference the Administrative Law Judge issued an Order on Objections to Exhibits, sustaining the State’s objections to Exhibits O through Q and overruling Respondent’s objections to Exhibits 5 and 6. The parties later agreed Exhibit O could be admitted. Respondent appealed the evidentiary ruling to the Board regarding Exhibits P and Q. After argument, the Board upheld the ruling of the Administrative Law Judge and sustained the State’s Objection to Exhibits P and Q. The State also objected to Respondent’s Hearing Brief because it contained references to Exhibits P and Q. The
Board overruled the State’s objection to Respondent’s Hearing Brief. Exhibits 1 through 7 and A through M, O and R through UU were admitted into the record. After testimony and examining the exhibits, the Board convened in closed executive session, pursuant to Iowa Code section 21.5(1)(f), to deliberate its decision. The Board instructed Administrative Law Judge Heather Palmer to draft a Findings of Fact, Conclusions of Law, Decision and Order, in conformance with their deliberations.

**FINDINGS OF FACT**

I. **Background Training, Certifications and Licensure.**

Respondent graduated from the College and Medical School of the Medical University of Lublin in Poland in 1998. Respondent participated in an internship with Holy Cross Cancer Center in Kielce, Poland from October 1998 through September 1999. From January through June 2000, Respondent worked as a general practitioner for the Voivod Psychiatric Hospital in Morawica, Poland.


Respondent is licensed to practice medicine in Poland, the European Union, Florida, Illinois and Iowa. He was initially issued Iowa medical license number 37643 on January 18, 2008.

From July 2008 through December 2010 Respondent served as the Medical Director of Pain Services for Anesthetix of Iowa, PC, located at Trinity Regional Medical Center in Fort Dodge, Iowa. Respondent testified his practice involved a mix of anesthesia and pain management. About six months after he started practicing in Fort Dodge, Respondent’s practice began focusing on pain management.

Respondent became Board certified by the American Board of Anesthesiology in Pain Medicine in September 2009 and in Anesthesiology in October 2009. Respondent became Board certified in Pain Medicine by the American Board of Pain Medicine in April 2010, and became a Fellow of Interventional Pain Practice with the World Institute of Pain in February 2012. He also completed a competency examination in controlled substance management through the American Society of Interventional Pain Physicians in February 2012.

II. **Iowa Health Pain Management Clinic**

While working in Fort Dodge Respondent learned of an employment opportunity with Iowa Health Pain Management Clinic of Des Moines (Clinic). Primary care physicians
within the Iowa Health System referred their chronic pain patients to the Clinic for opioid pain management.

Respondent met with Daniel Baldi, D.O., the primary physician working for the Clinic, and management from Iowa Health. He later accepted a position as a staff physician and moved his practice to Des Moines. Respondent commenced his employment with the Clinic in January 2011. When Respondent arrived, he did not have many of his own patients. Some of Dr. Baldi’s patients agreed to see Respondent. And some of Respondent’s patients from Fort Dodge followed him to Des Moines. Dr. Baldi, Respondent, and Advanced Registered Nurse Practitioner (“ARNP”) Karen Mellody worked with the patients at the Clinic.

Drs. Szczepanek and Baldi and ARNP Mellody served approximately 2,000 patients at the Clinic.

Respondent testified when he sees a new patient seeking opioid therapy, he takes the patient’s history, performs a physical exam, reviews the patient’s medical records, reviews the Iowa Prescription Monitoring Program (PMP) report printed out by the unlicensed CMA, and performs a risk-stratification. Respondent reported when he worked for the Clinic more than 95% of the patients were from the Iowa Health System, so he had access to their medical records, including their radiographic studies. For the risk stratification, Respondent uses the SOAPP-R and history of prior substance abuse. Respondent reported the Clinic used pain management agreements with its patients.

III. Treatment and Investigation

The Board received information during a separate investigation that raised concerns about Respondent’s opioid prescribing practices. The Board assigned James Machamer to perform an investigation. Machamer obtained patient records, interviewed witnesses, obtained narratives, and information from the Iowa Prescription Monitoring Program (“PMP”). Machamer prepared a report and supplemental report for the Board.

The Board asked Mark Kline, M.D., Arnold Parenteau, M.D. to serve on a peer review committee to review Respondent’s care of ten (10) patients. Drs. Kline and Parenteau are Iowa licensed physicians who practice pain management. Drs. Kline and Parenteau issued a written report on December 12, 2012, concluding Respondent failed to conform to the minimum standard of care ordinarily exercised by the average physician in Iowa acting in the same or similar circumstances with respect to his treatment of seven (7) patients. Drs. Kline and Parenteau testified at hearing regarding their findings.

A. Patient J.L.:

J.L. became a patient of Dr. Baldi in May 2010. J.L. had a history of pain dating back to a motor vehicle accident in 1963. J.L. was a passenger in the back of car that hit a pole. He fractured his left femur and tibia. He had a past medical history of heart failure, arthritis and hypertension. J.L. also had a previous left knee replacement and laminectomy.
J.L. complained of pain in his lower back, feet, left leg, and abdominal pain secondary to an abdominal wall defect. J.L. described his pain as “a burning, stabbing, throbbing, cramping, sharp, penetrating, deep, shooting, aching pain that is consistent.” (Exhibit 5 at 86). He also reported “numbness, itching, spasms, weakness, changes in skin color, coldness, swelling, and sweating” and stated his pain was aggravated by sitting, standing, lying, cold, and walking. (Exhibit 5 at 86).

From 2001 through 2008 J.L. was a patient of Dr. Hendricks. Dr. Hendricks started J.L. on methadone and J.L. reported taking up to 320 mg of methadone per day. While he was being treated by Dr. Hendricks, J.L. experienced respiratory distress. J.L. saw two other physicians between 2008 and 2010.

During his initial visit with Dr. Baldi in May 2010, Dr. Baldi ordered an ECG, which revealed a slow sinus rhythm. Dr. Baldi reviewed J.L.’s x-rays which showed multilevel degenerative disk disease of the lumber spine and some spondylotic changes. J.L. continued treatment with Dr. Baldi.

Dr. Baldi noted J.L. had tried nerve blocks, injections, physical therapy, exercise, epidural steroid injections, facet injections, chiropractic care, surgery, canes, walkers, braces, relaxation, and PCA pumps. He had also tried Darvocet, TYLENOL, Valium, Lorcet, anti-inflammatory drugs, morphine, hydrocodone, Prozac, Demerol, Vicodin, amitriptyline, methadone, oxycodone, and aspirin to treat his pain.

J.L.’s initial visit with Respondent occurred on April 22, 2011, as part of his three month follow-up at the Clinic. J.L. presented with cluster headaches and generalized pain throughout his body. Respondent noted:

Currently, he is maintained on methadone 200 mg per day. In this past, he has tried numerous medications without any significant benefit. He states that methadone is the only medication which relieves his pain. In the past, he was using methadone up to 320 mg per day. Unfortunately, he overdosed on methadone when he was drinking alcohol; and subsequently the dose of methadone was decreased. The patient states that currently his pain is poorly controlled. He rates his pain on average as 8/10 on visual analog scale (VAS). He states that since the overdose, he is avoiding alcohol; and he has lost approximately 130 pounds . . . He inquires about the possibility of increasing his methadone up to 250 mg a day. Recently, the patient discussed this issue with Dr. Baldi who was reluctant to do so. . . . He denies any side effects related to methadone. No obvious drug-seeking behavior was noticed.

(Exhibit 5 at 101).

Dr. Parenteau testified that 200 mg of methadone per day is a high dose. Dr. Parenteau did not see Respondent’s rationale in J.L.’s chart for prescribing such a high dose other than J.L. had previously been on such a high dose. Respondent did not order a urinalysis. Respondent requested that J.L. return in a month and noted he would
consider increasing the methadone after speaking with Dr. Baldi. Dr. Kline testified Respondent’s plan to discuss the case with Dr. Baldi was proper.

J.L. returned to Respondent on May 20, 2011, complaining of multifactorial pain in his lower back and lower extremities. Respondent noted J.L. reported poor pain control for many months and rated his pain on average as 8/10 or 9/10 on the visual analog scale. Respondent found J.L.’s dose was no longer effective and increased his methadone to 260 mg per day. Respondent did not request a urine specimen from J.L. before he increased J.L.’s medication. Dr. Kline testified Respondent did not document his rationale for increasing J.L.’s dosage to 260 mg per day.

On June 2, 2011, Respondent’s office called J.L. to come in to provide a urine specimen. J.L. initially refused, but eventually came in. The urinalysis results revealed that J.L. was not taking the prescribed amount of methadone because the methadone level was too low for the prescribed dose. J.L.’s medical records indicate Respondent would not do anything at that time, but J.L. would need to provide another urine specimen during his next appointment.

The day before, on June 1, 2011, Medicap Pharmacy received an anonymous call indicating J.L. was selling his methadone. The caller reported he was J.L.’s neighbor and he had been watching J.L. and noticed a lot of traffic in and out of J.L.’s apartment. The staff pharmacist who took the call contacted the Clinic and the DEA about the reported diversion. J.L.’s medical records do not reference the call. Medicap Pharmacy did not make the report directly to Respondent. There was no evidence presented at hearing indicating Respondent was aware of the call.

On July 22, 2011, J.L. returned for a follow-up visit with Respondent. Respondent noted he increased J.L.’s methadone to 260 mg per day in May and J.L “reports significant improvement of his pain. . . he still rates his pain on average as 7/10 to 8/10 on the visual analog scale (VAS).” (Exhibit 5 at 113). The record does not indicate Respondent discussed J.L.’s urinalysis results with J.L. and Respondent did not require J.L. to provide another urine specimen.

J.L. returned to Respondent’s office on August 24, 2011. He did not bring his pills with him, but provided a urine specimen. Respondent’s office informed J.L. he had 24 hours to bring in his pills for a pill count if he wanted to continue to receive methadone. J.L. admitted he had taken more than the prescribed dosage and stated he had 23 pills left from his last prescription. The nurse found he should have had 192 pills left.

On August 25, 2011, J.L. brought his pills into Respondent’s office. He had 20 methadone pills. The nurse noted J.L. should have had approximately 168 pills, so there were over 140 pills missing. Respondent’s medical records for J.L. do not identify a plan of action for the missing pills.

When J.L. returned to the clinic on September 13, 2011, his urinalysis results and pill count were normal.
During J.L.’s visit on December 14, 2011, Respondent documented J.L. had a history of medication misuse in the past and his pill count was correct. Respondent noted he would “continue all of his medications without change, at least at this moment.” (Exhibit 5 at 133). J.L.’s medical records do not indicate whether Respondent discussed the earlier pill count and urinalysis discrepancies with J.L.

On February 16, 2012, Respondent’s office called in J.L. for a pill count. The office determined J.L. had an extra 153 methadone pills. J.L. indicated he had been sick and was unable to take the prescribed dose. J.L.’s medical records do not reflect Respondent’s plan regarding the second aberrant pill count.

On February 29, 2012, Respondent’s office contacted J.L. and told him he needed to come in for an ECG. J.L. came into the office on March 6, 2012, to discuss his ECG results, which revealed “worsening of QTC interval.” (Exhibit 5 at 150). Respondent decreased his methadone to 160 mg per day and started J.L. on oxycodone.

J.L. died on March 10, 2012, following an accident with his scooter. Toxicology showed methadone in his system, but no oxycodone derivatives.

The peer reviewers found Respondent failed to properly respond to multiple “red flags” with respect to J.L.’s methadone usage. J.L. admitted overuse and underuse and his pill counts were off. The peer reviewers believed he was a high-risk patient with troublesome drug screens. J.L.’s urinalysis results showed at times he was taking too much medication and at times not enough medication. Respondent identified the need to request another urine specimen after he found J.L. was not taking the proper amount of medication. However, Respondent did not obtain another specimen at J.L.’s next visit. Respondent did not document discussing the troublesome urinalysis results or aberrant pill counts with J.L. during any of his visits. The peer reviewers believe Respondent should have more closely monitored J.L., addressed the inconsistencies and documented his findings.

Respondent requested two pill counts and urine specimens from J.L. on August 24, and September 13, 2011, following the aberrant findings from his urinalysis in June 2011. Drs. Glaser and Ketroser testified Respondent’s testing was appropriate and within the standard of care.

The peer reviewers further found the Clinic did not have a consistent system of dealing with aberrant findings regarding opioids. With chronic high dose methadone use, a routine ECG should have been followed and when an ECG abnormality was discovered, the methadone dose should have been decreased.

Dr. Kline testified there were gaps in Respondent’s decision making. J.L.’s urinalysis result showed low methadone levels indicating he was not taking his prescribed dose. His pill counts were also off. On one occasion he was missing more than 100 pills, on another he had more than 100 extra pills. Dr. Kline testified he would expect to see these issues addressed immediately with the patient through counseling and/or
restricting of care. Respondent’s office did not have a system in place for scheduling a visit following an abnormal urinalysis result or pill count.

**B. Patient J.P.:**

J.P. was a patient of Dr. Kusner, M.D. in Iowa City while attending college. J.P. had a history of chronic, generalized abdominal pain secondary to multiple abdominal surgeries following childhood accidents. J.P. had a Davenport address at that time. During a visit on May 26, 2011, J.P. informed Dr. Kusner he was moving to Des Moines to finish school at Drake University so Dr. Kusner referred J.P. to Dr. Baldi in Des Moines. Dr. Kusner noted:

> Pt is reportedly on very high doses of Oxycontin ER, Percocet, and Demerol. I reduced the doses to:
> Oxycontin ER 80 mg 2-3/ d, #90
> Percocet 10/325 mg 1 tab TID prn, #90
> Demerol 100 mg injection 1 qd prn #15.

(Exhibit 5 at 220). Dr. Kusner noted J.P. had a history of drug abuse, including cocaine use in the recent past. J.P. attended a follow-up appointment with Dr. Kusner on June 29, 2011. Dr. Kusner noted he had reduced J.P.’s pain medications the month before.

J.P.’s first visit with Respondent was on July 18, 2011. J.P. was 31 at the time. Respondent noted J.P. was “fairly satisfied” with the relief he was receiving from the medications prescribed by Dr. Kusner, but reported “less relief of his breakthrough pain with Endocet.” (Exhibit 5 at 229). J.P. stated he had “diffuse abdominal pain which is most severe in the right and left lower abdominal quadrants. . . .[that is] sharp, shooting, and deep.” (Exhibit 5 at 229. J.P. also reported having intermittent nausea and vomiting.

J.P. acknowledged he had a history of cocaine abuse. Respondent found J.P.’s SOAPP-R score was nine, which indicated a low risk for medication abuse/misuse. J.P.’s PMP revealed that over the past year he had “received several prescriptions for opioids and anxiolytics from 4 different providers.” (Exhibit 5 at 229). Respondent continued J.P. on OxyContin and intramuscular Demerol or meperidine, but discontinued his Percocet and prescribed oxycodone 15 mg every four hours. Respondent did not request a urine specimen from J.P. during his initial visit and requested a follow-up visit in two months.

During his September 13, 2011, visit, J.P. reported the oxycodone was not adequately controlling his breakthrough pain. Respondent noted “[n]o obvious drug-seeking behavior was noticed.” (Exhibit 5 at 240). Respondent increased J.P.’s oxycodone from 15 mg every four hours to 30 mg every four hours, with a maximum of six pills per day. Respondent did not request a urine specimen from J.P. or conduct a pill or vial count. J.P.’s medical records do not indicate Respondent inquired into the amount of intramuscular meperidine J.P. had on hand.

J.P. returned for a follow-up visit on November 9, 2011. Respondent noted:
Overall [J.P.] reports satisfactory pain control. He states that recently he requires more intramuscular Demerol to adequately control his pain due to frequent nausea, vomiting, and poor tolerance of oral medications. He is satisfied with the degree of pain relief provided by OxyContin 80 mg every 8 hours along with oxycodone 30 mg 1-2 tablets every 4-6 hours p.r.n. with a maximum of 8 tablets daily. He states that intermittently he requires more oxycodone for breakthrough pain. He inquires about the possibility of increasing the total amount of monthly Demerol from 20 to 40 vials. (Exhibit 5 at 243). Respondent noted he did not notice any aberrant behavior.

Respondent recorded “taking into consideration worsening of pain and slightly higher need for intramuscular and oral opioids, I will increase his oral oxycodone to 30 mg 1-2 tablets every 3-4 hours p.r.n. with a maximum of 10 tablets daily. I will also increase his intramuscular meperidine 100 mg/ml up to 40 vials per month. He will continue oxycontin without change.” (Exhibit 5 at 244). Respondent did not request a urine specimen or conduct a pill count. Respondent stated J.P. could return to the clinic for additional management in three to four months.

On March 6, 2012, J.P. called the clinic and requested a refill of his medication. Respondent’s staff informed him he would need to come in with his pills for a pill count and provide a urine specimen before he would receive additional prescriptions. The clinic staff told J.P. he needed to come by 11:30 that day. J.P. responded he would be in on March 14, 2012.

J.P. came in for a follow-up visit on March 14, 2012, and provided a urine specimen. He reported his pain had worsened over the past few weeks because of an abdominal infection and admitted taking additional oxycodone. J.P.’s medical records do not contain any documentation that Respondent discussed J.P.’s refusal to come in for a random urinalysis and/or pill count on March 6, 2012. Respondent noted he was changing J.P. to two-week prescriptions “[d]ue to the high quantities of opioids he was taking.” (Exhibit 5 at 259). The record also provided “[n]o aberrant behavior was noticed.” (Exhibit 5 at 258). The urinalysis showed evidence of his prescribed opioids, morphine derivatives and heroin metabolite.

On March 21, 2012, Respondent’s clinic staff spoke with J.P. about the heroin metabolite in his urinalysis results. J.P. reported he had been hospitalized and brought in his discharge paperwork. Respondent noted the clinic needed to “watch him closely” and mailed out additional prescriptions for him. (Exhibit 5 at 260).

On April 18, 2011, the clinic mailed additional prescriptions to J.P.’s pharmacy. J.P. died on April 21, 2012, of mixed drug intoxication.

Respondent noted that J.P.’s SOAPP-R results during his initial visit in July 2011 indicated J.P. was at low risk of medication abuse. The peer reviewers determined J.P. would be considered high risk for aberrant opioid behavior due to his history. The peer
reviewers noted Respondent did not require J.P. to provide a urine specimen during his initial visit and a follow-up was not scheduled for two months, despite his history of cocaine abuse.

During J.P.’s September 2011 visit, Respondent increased J.P.’s opioids, but did not require J.P. to provide a urine specimen, conduct a pill and vial count, or schedule a follow-up appointment for two months.

Respondent saw J.P. in November 2011 and did not request J.P. provide a urine specimen or conduct a pill or vial count.

The first urinalysis Respondent ordered for J.P. was after he received a telephone call from J.P. in March 2012. The urinalysis showed evidence of his prescribed opioids, morphine derivatives and a heroin metabolite. During his November 2011 visit, Respondent switched J.P. to two-week scripts with a two-month follow-up. Respondent noted an increased need for vigilance given the troubling urinalysis results.

Respondent provided J.L. with refills on April 18, 2012. J.P. passed away on April 21, 2012, from a multidrug overdose.

Dr. Parenteau testified Respondent did not have J.P. provide a urine specimen for eight months, which he believes is below the standard of care. The peer reviewers noted intramuscular meperidine or Demerol for home use is highly unusual and very high risk. The use of parenteral opioids is generally reserved for hospice care in terminal patients. The peer reviewers found no adequate justification for prescribing intramuscular meperidine. Drs. Parenteau and Kline testified it is easier for patients to abuse injectable medications. They testified J.P.’s medical records did not contain the rationale behind the use of the injectable meperidine. Respondent testified he prescribed intramuscular meperidine for J.P. because of the unique nature of his pain. J.P. presented with diffuse visceral pain. Respondent viewed J.P. as a low risk patient. While he had a history of cocaine use and substance abuse treatment, he disclosed the use and treatment.

Drs. Glaser and Ketroser testified that abdominal or visceral pain is hard to treat because it involves the autonomic nervous system and traditional narcotics are less effective in treating the pain. Patients often have nausea and difficulty taking traditional narcotics.

Dr. Ketroser acknowledged intramuscular meperidine is very addictive, can be abused, and is not necessary for most patients, but sometimes it is the only option. Drs. Glaser and Trescot reported that using intramuscular meperidine improves the quality of life for their patients and can reduce trips to the emergency room.

Dr. Trescort noted she has had several patients with headaches and abdominal pain who have required intramuscular meperidine for intractable pain like the pain J.P. experienced. She further noted “[w]hile it is not ideal, its use is certainly not below the standard of care.” (Exhibit I at 4).
The peer reviewers also noted that despite the high dose of opioids, Respondent requested few urine specimens. Even when Respondent acknowledged J.P. needed more vigilance, he did not complete any further investigation between the time of the aberrant urinalysis results and J.P.’s death. The peer reviewers concluded the presence of heroin metabolites in J.L.’s urine screen following his hospitalization should have also triggered a restructuring of his opioid therapy or possibly discontinuation of opioid therapy altogether.

The peer reviewers also concluded there was a lack of adequate monitoring of J.P.’s medication usage, poor inter-staff communication regarding multiple “red flags,” poor documentation, and poor prescribing judgment.

C. Patient L.B.:

L.B. was a patient of Dr. Baldi. L.B.’s urinalysis from August 25, 2010, was positive for methamphetamine. Dr. Baldi sent L.B. a letter on September 9, 2010, informing her he would not prescribe her any opioids given her positive urinalysis result.

On April 18, 2011, L.B. attended her initial visit with Respondent. Respondent noted L.B. had a complex medical history including lumbar spondylosis, tension headaches, Arnold-Chiari malformation, myelopathic pain syndrome, and methamphetamine abuse. Dr. Baldi had prescribed L.B. butalbital, tramadol and etodolac. L.B. reported a worsening of her pain, including her headaches, rating her pain an average of 8/10 on the visual analog scale. Respondent reported “[n]o obvious drug-seeking behavior was noticed.” (Exhibit 5 at 316). L.B.’s urinalysis testing that day was normal. Respondent continued her etodolac and tramadol, but discontinued the butalbital and restarted her hydrocodone/acetaminophen 10/325 mg tablet every four hours as needed, with a maximum of five tablets per day. Respondent noted L.B. should return for reevaluation in four to six weeks. Respondent reported he delegated the scheduling of the appointment for the reevaluation to his staff.

Respondent continued to prescribe opiates to L.B. from April 18, 2011, through January 27, 2012, even though she never returned to the clinic for reevaluation of her opioid therapy. Respondent was unaware L.B. failed to return for reevaluation within four to six weeks after her April 18, 2011 appointment. There are documents in L.B.’s medical record regarding her return to work in June and July 2011. However, L.B.’s medical records do not reflect any physical examination by Respondent regarding her opioid therapy in June or July 2011.

On February 23, 2012, Respondent’s office called L.B. to come in to provide a urine specimen. L.B. replied she could not because she was out of town. Office staff told L.B. if she did not come in that day or the next day, her medication would be discontinued. L.B. did not return to the clinic.

Dr. Parenteau opined L.B. was a high risk patient for opiate abuse and diversion given her recent methamphetamine use. Dr. Glaser agreed she was a higher risk patient given her history of methamphetamine use. Dr. Parenteau concluded L.B.’s medical records
did not support Respondent was monitoring L.B. She did not have any random urinalysis screens or pill counts from April 18, 2011, until February 23, 2012, when she refused to come in to provide a urine specimen.

The peer reviewers determined Respondent’s documentation was poor. Respondent wrote multiple prescriptions without documentation or follow-up with a clinic visit or by telephone. The peer reviewers noted that despite the patient having a high-risk profile for aberrant drug use it appeared there was little to no follow-up until the February 2012 telephone call. The peer reviewers concluded the case had poor documentation and a significant lack of oversight of opioid use in a high risk patient.

D. Patient P.M.

Respondent’s initial visit with P.M. was on February 2, 2011. P.M. had a history of chronic mid and low back pain with intermittent radiation to the left lower extremity, depression, anxiety, fibromyalgia, headaches, seizures, and hypertension. She had a history of falls, resulting in a burst compression fracture at L1. P.M. described her pain as averaging 10/10 on the visual acuity scale.

Respondent reviewed P.M.’s PMP, which revealed that over the past year she had received controlled substances from 19 different providers and from six different pharmacies. Respondent requested a urine specimen from P.M. Respondent documented P.M.’s SOAPP-R results were borderline for drug misuse and/or abuse and noted she had positive Waddell’s signs (signs of pain). While Respondent found she had “signs of drug seeking behavior suggestive of nonorganic component,” he also determined she had legitimate pain issues. Respondent placed P.M. on transdermal fentanyl at 25 mcg/hr and told her the pain clinic would be her only provider of pain medication. He increased the dosage to 50 mcg/hr four days later.

On February 21, 2011, P.M. returned for a follow-up visit, complaining of minimal pain relief and side effects, including swollen eyes, itching and nausea. Respondent discontinued P.M.’s fentanyl and hydrocodone/acetaminophen and prescribed morphine sulfate extended release 30 mg every 12 hours and morphine sulfate immediate release 15 mg tablet every four hours, with a maximum of six tablets per day. He also ordered an MRI of her cervical spine and requested she return for reevaluation in one month. Drs. Ketroser and Glaser testified it was appropriate to switch P.M. to an opiate regiment following the reaction to the fentanyl.

On March 8, 2011, P.M. was found dead. Her death was due to acute morphine toxicity.

The peer reviewers initially found Respondent recognized P.M. had the potential for “doctor shopping”, had multiple controlled substance providers, and was concerned about her drug seeking behavior, but he did not act upon his concerns except for a pain management agreement. Dr. Parenteau questioned Respondent’s judgment given her previous opioid history and in light of the Waddell’s signs. The peer reviewers initially found it was questionable whether opioids should have been prescribed at all. Dr. Parenteau believed the patient may have been treated better with more conservative,
non-pharmacological methods first and noted there was no mention of physical therapy or rehabilitation in her plan. Dr. Kline testified he did not find any problems with P.M.’s care.

E. Patient C.M.:

On April 25, 2011, Respondent held his initial visit with C.M. C.M. had been a patient of Dr. Baldi and had returned for a follow-up visit at the Clinic. C.M. had a history of neck pain, herniated disk at C6-C7, lumbar disc degeneration L3-L4, lumbar spondylosis, knee pain, and migraine headaches. C.M.’s prior urinalysis did not show hydromorphone, which was prescribed for him, but did show he was using oxycodone. The urinalysis detected other controlled substances, but not at cutoff levels. Respondent noted C.M.’s pain control was suboptimal. Respondent discontinued C.M.’s hydromorphone and started him on Opana 20 mg every 12 hours, in addition to his oxycodone and diazepam.

ARNP Mellody saw C.M. on May 23, 2011. C.M. provided a urine specimen. C.M. reported his medications were working fairly well and his pain score was 8/10. ARNP Mellody increased C.M.’s Opana to three times per day to see if he received better pain control. C.M. returned for visits with ARNP Mellody in July and August 2011.

In September 2011, C.M. was found dead from bilateral pulmonary emboli with acute oxycodone toxicity. (Exhibit 5 at 499).

The peer reviewers concluded C.M. was on a high dose opioid therapy without adequate documentation of his need for the doses. The subjective reports indicated C.M.’s medication was working well, but there was no change in his pain scores. The peer reviewers concluded the appropriateness of chronic opioid therapy should have been reevaluated, citing APS/AAPM Guideline 7.4, which provides:

Clinicians should taper or wean patients off of COT who engage in repeated aberrant drug-related behaviors or drug abuse/diversion, experience no progress toward meeting therapeutic goals, or experience intolerable adverse effects.

Dr. Glaser testified that while C.M.’s pain scores were consistent while on Opana, he had improved functioning.

Respondent and ARNP Mellody provided care to C.M. The peer reviewers noted there was poor documentation of treatment protocols and communication between Respondent and ARNP Mellody.

Respondent initially treated C.M. and then ARNP Mellody followed him. Respondent testified that ARNP Mellody came to him and told him she was unfamiliar with Opana. Respondent provided advice to ARNP Mellody on C.M.’s treatment. Respondent’s discussions with Mellody are not noted in C.M.’s medical records.
F. Patient C.B.:

C.B. attended her initial visit with Respondent on January 18, 2011. C.B. was diagnosed with cervical spondylosis with myelopathy, cervicalgia, and lumbar radiculopathy. C.B. traced her pain to a work injury in 1998, and reported her pain became worse following an automobile accident in 2006. C.B. rated her pain as a 6 or 7 out of 10 on the visual analog scale. C.B. did not have any recent radiological studies. Respondent ordered an MRI of the cervical spine, but did not order an MRI of the lumbar spine. Respondent continued C.B. on her previously prescribed medication and performed a lumbar epidural injection on February 15, 2011. C.B. was pronounced dead on March 10, 2011, of acute combined toxicity from promethazine, duloxetine, citalopram and hydrocodone.

The peer reviewers found C.B.’s multiple diagnoses listed in the initial evaluation were not supported by radiographic studies. The peer reviewers found the diagnosis of lumbar radiculopathy with no documentation of a potential supporting cause. The peer reviewers concluded the patient underwent an invasive procedure without further investigation as to a potential underlying mechanism. There also appeared to be a problem with review of the PMP which would have shown multiple providers prescribing controlled substances within the prior year. Respondent asserted the PMP had been checked, but it was not documented in the assessment.

Respondent testified he did not request an MRI of C.B.’s lumbar spine because her problem was clear to him, and he believed she needed a steroid injection. Respondent ruled out cancer as a cause of her pain because C.B. did not complain of fever, chills, weight loss or a change in pain in three years. Drs. Glaser and Ketroser testified an MRI of the lumbar spine was not needed to confirm the diagnosis of lumbar radiculopathy.

G. Patient C.G.:

On July 29, 2011, C.G. had her initial visit with Respondent. C.G. presented with abdominal pain, lower back pain, rheumatoid arthritis, psoriatic arthropathy, cervicalgia, and fibromyalgia. C.G. had been a patient of Dr. Baldi several years ago, but had been seeing Dr. Boesler. She reported pain averaging 7/10 on the visual analog scale. Dr. Boesler had prescribed morphine sulfate extended release every 12 hours with morphine immediate release 4 times a day as needed, gabapentin 600 mg twice per day and baclofen 20 mg three times per day as needed. Respondent found C.G.’s depression self-test score was suggestive of moderate depression. And while her SOAPP-R score was 15, which indicates a low risk for medication abuse/misuse, her PMP revealed she had received multiple prescriptions for opioid analgesics and diazepam from three different providers over the past year. Respondent testified that based upon his assessment of C.G., he believed she was a moderate risk for medication abuse/misuse.

Respondent decreased C.G.’s morphine sulfate extended release to 15 mg every 6 hours and switched her morphine sulfate immediate release to oxycodone 30 mg 1 tablet every 4 hours as needed, with a maximum of 6 tablets per day. He also switched her from
baclofen to cyclobenzaprine 10 mg 1-2 tablets at bedtime and restarted her diazepam 30 mg three times per day as needed.

C.G. had a follow-up visit with Respondent on August 24, 2011. C.G. continued to complain about inadequate pain control. Respondent increased her morphine extended release to 30 mg every 8 hours and switched her oxycodone 30 mg to hydromorphone 8 mg 1 tablet four times per day as needed. He also renewed her diazepam prescription.

During a September 16, 2011, visit, C.G. admitted she had been hospitalized for overusing her pain medication. Respondent shortened her prescriptions and instituted a two-week follow-up. After the first two-week follow-up her appointments were again set at one-month intervals. The peer reviewers concluded Respondent's initial plan of care following C.G.'s admission was appropriate, but believed Respondent's documentation of his management of C.G.'s opiate usage was poor. Respondent did not request urine specimens from C.G. or conduct any pill counts after her admission she had overused her medication in September 2011. The closer evaluation interval was only documented for the two weeks after her hospital admission. Her monitoring was then returned to its previous interval. Drs. Glaser and Ketroser testified that Respondent's two-week follow-up was appropriate.

IV. Ketamine Analgesic Ointment

During the investigation the Board learned Respondent was providing samples of topical ketamine to his patients. Dr. Kline did not find providing samples of ketamine violated the law governing the practice of medicine or the Board's rules. Dr. Ketroser confirmed there was nothing improper about providing the topical ketamine to patients.

V. Lunesta

The Board also learned Respondent prescribed five Lunesta pills for himself before he took a flight out of the country to visit his fiancé who had been diagnosed with cancer. Respondent wrote the prescription and obtained the pills from a pharmacy. The investigation did not reveal Respondent engaged in a pattern of prescribing controlled substances for himself. The peer reviewer concluded that self-prescribing controlled substances was inappropriate. Drs. Glaser, Ketroser and Trescot opined that it is not recommended to self-prescribe, but noted the prescribing was not unprofessional or a violation of the law.

CONCLUSIONS OF LAW

The Board oversees physician licensure and discipline in Iowa.\(^1\) The Board may issue an order to discipline any licensee for a ground set forth in Iowa Code chapter 272C, or Iowa Code sections 147.55 or 148.6.\(^2\) Iowa Code section 272C.4 grants the Board express authority to “[d]efine by rule acts or omission that are grounds for revocation or suspension of a license” under Iowa Code section 148.6. Pursuant to its express

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\(^1\) Iowa Code chapters 147, 148, and 272C (2013).
\(^2\) Id. § 148.6(1).
authority, the Board has adopted rules governing licensee discipline and sanctions found at 653 IAC chapters 23 and 25.

I. Professional Incompetency

The Board charged Respondent with: (1) professional incompetency pursuant to Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2), and 653 IAC 23.1(2)(a)-(g). Iowa Code section 147.55(2) authorizes the Board to discipline a licensee for engaging in professional incompetency.\(^3\) Pursuant to Iowa Code section 272C.10(2) the Board has established rules governing the revocation and suspension of a license for professional incompetency. The Board has adopted rules governing professional incompetency at 653 IAC 23.1(2).

The Board may discipline a licensee for a “willful or repeated departure from, or the failure to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery,” and for a “willful or repeated violation of lawful rule or regulation adopted by the board.”\(^4\) At hearing, the State argued Respondent engaged in professional incompetency, when he engaged in one or more of the following:

\[d.\] A substantial deviation by the physician from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting the same or similar circumstances;

\[e.\] A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances;

\[f.\] A willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice of medicine or surgery or osteopathic medicine and surgery in the state of Iowa.

While Respondent has extensive specialty training and credentials, and his patients had a clear need for pain treatment, the Board concluded that a preponderance of the evidence established that Respondent violated Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2), and 653 IAC 23.1(2)(d)-(f) with respect to his monitoring and documentation for patients J.L., J.P., and L.B.

J.L.’s June 2, 2011, urinalysis results revealed he was not taking the correct amount of methadone prescribed to him. Respondent noted J.L. would need to provide a urine specimen at his next appointment. However, Respondent did not request a urine specimen from J.L. during his next appointment.

During his July 22, 2011, visit J.L. provided a urine specimen, but he did not bring in his pills. After the clinic told J.L. he had 24 hours to bring in his pills, J.L. admitted he took

\(^3\) Iowa Code § 147.55(2).

\(^4\) Iowa Code § 148.6(g), (i).
more than the prescribed dosage and only had 23 pills left. The next day the nurse documented J.L. had 20 pills when he should have had 168 pills. J.L.’s medical records do not identify a plan of action or document that Respondent discussed the aberrant urinalysis results and pill count with J.L.

Respondent prescribed J.P. intramuscular meperidine, which Respondent’s experts described as highly addictive. Despite his history of drug abuse, including recent cocaine use, Respondent did not conduct a pill or vial count, or request a urine specimen from J.P. from the time of his initial visit on July 18, 2011, until March 6, 2012. J.P. refused to come in on March 6, 2012, and stated he would come in on March 14, 2012. While Respondent appropriately changed J.P. to two-week prescriptions, Respondent’s medical records do not reflect that Respondent discussed J.P.’s refusal to come in for a visit March 6, 2012, when requested.

Dr. Baldi had stopped prescribing opioids for L.B. in September 2010, following a positive test for methamphetamine. Following a normal urinalysis during her April 2011 appointment, Respondent prescribed L.B. opiates and noted she should return in four to six weeks. L.B. continued to receive opiates from April 18, 2011, through January 27, 2012. While there are documents in L.B.’s medical record regarding her return to work in June and July 2011, L.B.’s medical records do not document any physical examination by Respondent from April 2011 through January 2012. Despite her history, Respondent continued to prescribe opiates to L.B. for over nine months without a return office visit, pill count, or urinalysis.

Respondent contends he followed up with his patients and properly monitored their care. However, even assuming Respondent addressed his concerns with his patients, the Board finds that he failed to document his discussions and thought processes in the patient’s medical records. The Board concluded that a preponderance of the evidence establishes that Respondent engaged in professional incompetency when he failed to provide appropriate monitoring and documentation for patients J.L., J.P., and L.B.

II. Inappropriate Prescribing

Iowa Code section 148.6(2)(i) grants the Board authority to discipline a licensee for a “[w]illful or repeated violation” of the Board’s rules. The Board has adopted a rule authorizing discipline for self-prescribing or self-dispensing controlled substances.5

The Board charged Respondent with inappropriate prescribing pursuant to Iowa Code section 148.6(2)(i) and 653 IAC 23.1(7) for willfully or repeatedly violating a lawful rule or regulation adopted by the Board when he indiscriminately or promiscuously prescribed, administered or dispensed drugs for other than a lawful purpose. Iowa law requires proof by a preponderance of the evidence that Respondent willfully or repeatedly violated the Board’s rule.

5 653 IAC 23.1(7).
Respondent prescribed five Lunesta pills for himself before he took a flight out of the country to visit his fiancé who had been diagnosed with cancer. The investigation revealed Respondent wrote a single prescription for five Lunesta pills on one occasion, and he filled the prescription at a pharmacy. The Board concluded that a preponderance of the evidence failed to establish that Respondent repeatedly prescribed controlled substance to himself.

The statute and the Board’s rules do not define the term “willful.” “When a statute or rule is plain and its meaning is clear, the rules of statutory construction do not permit courts to search for meaning beyond its express terms.”6 The courts generally presume words in agency rules “are used in their ordinary and usual sense with the meaning commonly attributed to them.”7 Webster’s Dictionary, a source of the ordinary meaning of words, defines the term “willful” as “done deliberately; intentional.”8 Respondent testified he prescribed the tablets for an overnight flight to see his fiancé who had been diagnosed cancer. While the Board believes Respondent exercised poor judgment by self-prescribing the five Lunesta pills, the Board does not believe his conduct was a willful violation of the Board’s rules. The Board concluded that a preponderance of the evidence failed to establish that Respondent willfully or repeatedly violated the Board’s rules when he prescribed five Lunesta pills for himself on a single occasion.

III. Improper Pain Management

The Board charged Respondent with improper pain management pursuant to Iowa Code section 148.6(2)(i) and 653 IAC 13.2 for willfully or repeatedly violating a lawful rule or regulation adopted by the Board when he violated the standards of practice for appropriate pain management. As noted above, Iowa Code section 148.6(2)(i) grants the Board authority to discipline a licensee for a “[w]illful or repeated violation” of the Board’s rules. The Board has adopted rules governing the standards of practice for appropriate pain management found at 653 IAC 13.2. Under 653 IAC 13.2(5):

Prescribing controlled substances for the treatment of chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented unrelieved pain. To ensure that chronic pain is properly assessed and treated, a physician who prescribes or administers controlled substances to a patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

a. Patient evaluation. A patient evaluation that includes a physical examination and a comprehensive medical history shall be conducted prior to the initiation of treatment. The evaluation shall also include an assessment of the pain, physical and psychological function, diagnostic studies, previous interventions, including medication history, substance

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7 Id. (citing Am. Home Prods. Corp. v. Iowa State Bd. of Tax Rev., 302 N.W.2d 140, 142-43 (Iowa 1981)).
8 Merriam-Webster’s Collegiate Dictionary (10th Ed. 1998).
abuse history, and any underlying or coexisting conditions. Consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or physician who specializes in the treatment of the area, system, or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient. Interdisciplinary evaluation is strongly encouraged.

b. Treatment plan. The physician shall establish a comprehensive treatment plan that tailors drug therapy to the individual needs of the patient. To ensure proper evaluation of the success of the treatment, the plan shall clearly state the objections of the treatment, for example, pain relief or improved physical or psychosocial functioning. The treatment plan shall also indicate if any further diagnostic evaluations or treatments are planned and their purposes. The treatment plan shall also identify any other treatment modalities and rehabilitation programs utilized. The patient's short- and long-term needs for pain relief shall be considered when drug therapy is prescribed. The patient's ability to request pain relief as well as the patient setting shall be considered. For example, nursing home patients are unlikely to have their pain control needs assessed on a regular basis, making prn (on an as-needed basis) drugs less effective than drug therapy prescribed for routine administration that can be supplemented if pain is found to be worse. The patient should receive prescriptions for controlled substances from a single physician and a single pharmacy whenever possible.

c. Informed consent. The physician shall document discussion of the risks and benefits of controlled substances with the patient or person representing the patient.

d. Periodic review. The physician shall periodically review the course of drug treatment of the patient and the etiology of the pain. The physician should adjust drug therapy to the individual needs of each patient. Modification or continuation of drug therapy by the physician shall be dependent upon evaluation of the patient's progress toward the objectives established in the treatment plan. The physician shall consider the appropriateness of continuing drug therapy and the use of other treatment modalities if periodic reviews indicate that the objectives of the treatment plan are not being met or that there is evidence of diversion or a pattern of substance abuse. Long-term opioid treatment is associated with the development of tolerance to its analgesic effects. There is also evidence that opioid treatment may paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve pain control and function.

e. Consultation/referral. A specialty consultation may be considered at any time if there is evidence of significant adverse effects or lack of response to the medication. Pain, physical medicine, rehabilitation, general surgery, orthopedics, anesthesiology, psychiatry, neurology, rheumatology, oncology, addiction medicine, or other consultation may be appropriate. The physician should also consider
consultation with, or referral to, a physician with expertise in addiction medicine or substance abuse counseling, if there is evidence of diversion or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management, including the use of adjunct therapies such as acupuncture, physical therapy and massage.

f. **Documentation.** The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient’s condition and treatment.

g. **Pain Management Agreements.** A physician who treats patients for chronic pain with controlled substances shall consider using a pain management agreement with each patient being treated that specifies the rules for medication use and the consequences for misuse. In determining whether to use a pain management agreement, a physician shall evaluate each patient, taking into account the risks to the patient and the potential benefits of long-term treatment with controlled substances. A physician who prescribes controlled substances to a patient for more than 90 days for treatment of chronic pain shall utilize a pain management agreement if the physician has reason to believe a patient is at risk of drug abuse or diversion. If a physician prescribes controlled substances to a patient for more than 90 days for treatment of chronic pain and chooses not to use a pain management agreement, then the physician shall document in the patient’s medical records the reason(s) why a pain management agreement was not used. Use of pain management agreements is not necessary for hospice or nursing home patients. A sample pain management agreement and prescription drug risk assessment tools may be found on the board’s Web site at [www.medicalboard.iowa.gov](http://www.medicalboard.iowa.gov).

h. **Substance abuse history or comorbid psychiatric disorder.** A patient’s prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient, monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

i. **Drug testing.** A physician who prescribes controlled substances to a patient for more than 90 days for the treatment of chronic pain shall consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion.

j. **Termination of Care.** The physician shall consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion, or a repeated pattern of substances abuse.
The Board concluded that a preponderance of the evidence established that Respondent repeatedly violated the Board’s rules when he failed to provide appropriate pain management to multiple patients pursuant to Iowa Code section 148.6(2)(i) and 653 IAC 13.2. The Board concluded that Respondent’s monitoring and documentation for patients J.L., J.P., and L.B. violated the Board’s rules governing the standards of practice for appropriate pain management. However, the Board concluded that a preponderance of the evidence failed to establish that Respondent’s conduct was willful.

Respondent failed to provide appropriate follow-up and monitoring J.L., J.P., and L.B. J.L.’s June 2, 2011, urinalysis results revealed he was not taking the correct amount of methadone prescribed to him, yet Respondent failed to request a urine specimen from J.L. during his next appointment.

During his July 22, 2011, visit J.L. provided a urine specimen, but he did not bring in his pills. After the clinic told J.L. he had 24 hours to bring in his pills, J.L. admitted he took more than the prescribe dosage and only had 23 pills left. The next day the nurse documented J.L. had 20 pills and he should have had 168 pills. J.L.’s medical records do not identify a plan of action or document Respondent discussed J.L.’s aberrant urinalysis results and pill count with J.L.

J.P. was prescribed intramuscular meperidine, a highly addictive injectable drug. Despite his history of drug abuse, including recent cocaine use, Respondent failed to conduct a pill or vial count, or request a urine specimen from J.P. between July 18, 2011, and March 6, 2012.

When Respondent’s office called J.P. to come in to provide a urine specimen and a pill count on March 6, 2012, J.P. refused to come in, and stated he would come in on March 14, 2012. While Respondent appropriately changed J.P. to two-week prescriptions, J.P.’s medical records do not state Respondent discussed J.P.’s refusal to come on March 6, 2012.

Dr. Baldi discontinued L.B.’s opiates following a positive methamphetamine test on August 25, 2010. Months later, in April 2011, Respondent resumed L.B.’s opioid treatment and stated L.B. should return for follow-up in four to six weeks. However, L.B. continued to receive opiates from between April 18, 2011, and January 27, 2012, without documentation of any formal examination by Respondent, requests for urine specimens or pill counts.

While Respondent contends he followed-up with his patients and properly monitored their care, he did not document his discussions and thought processes in their medical records. A preponderance of the evidence supports a finding that Respondent engaged in improper pain management with respect to his monitoring and documentation for patients J.L., J.P., and L.B.
IV. Unethical or Unprofessional Conduct

The Board charged Respondent with engaging in unethical or unprofessional conduct pursuant to Iowa Code sections 147.55(3), 148.2(g) and 272C.10(3) and 653 IAC 23.1(4). Pursuant to Iowa Code sections 147.55(3) and 272C.10(3), the Board may discipline a licensee for engaging in unethical or unprofessional conduct by committing “an act contrary to honesty, justice, or good morals” or by violating the standards and principles of medical ethics found in 653 IAC 13.7 or 13.20, as interpreted by the Board. The Board concluded that a preponderance of the evidence failed to establish that Respondent engaged in acts contrary to honesty, justice or good morals, or that he violated the standards and principles of medical ethics.

DECISION AND ORDER

IT IS THEREFORE ORDERED:

1. CITATION AND WARNING: Respondent is hereby CITED for violating the standards of practice for appropriate pain management with respect to his opioid prescribing, placing patients at risk of serious harm when he failed to properly monitor and document the care of multiple patients in 2011 and 2012 in Des Moines, Iowa, in violation of the laws and rules governing the practice of medicine in Iowa. Respondent is hereby WARNED that such practice in the future may result in further formal disciplinary action, including suspension or revocation of his Iowa medical license.

2. CIVIL PENALTY: Respondent shall pay a $2,500 civil penalty within 20 days of the date of this Order. The civil penalty shall be paid by delivery of a check or money order, payable to the Treasurer of Iowa, to the Board’s Executive Director. The civil penalty shall be deposited into the State General Fund.

3. BOARD-APPROVED PRACTICE SETTING: Respondent shall only practice medicine in a Board-approved practice setting with respect to his opioid prescribing only. He shall not change practice settings without obtaining prior written approval from the Board.

4. BOARD-APPROVED MEDICAL RECORDKEEPING COURSE: Respondent shall successfully complete a Board-approved medical recordkeeping course within 90 days of the date of this Order.

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9 Iowa Code § 148.6(2)(g); 653 IAC 23.1(4).
5. **THREE YEARS PROBATION:** Respondent shall be placed on probation for a period of three years, subject to the following terms and conditions:

A. **Board Monitoring Program:** Within 30 days of the date of this Order, Respondent shall establish a Board monitoring program with Mary Knapp, Compliance Monitor, Iowa Board of Medicine, 400 SW 8th Street, Suite C, Des Moines, Iowa 50309-4686, Phone Number (515) 281-5525. Respondent shall fully comply with all requirements of the monitoring program. If he fails to establish a Board monitoring program within 30 days of the date of this Order or fails to fully comply with the Board monitoring program, the Board will issue a notice to Respondent that his license will be suspended within 30 days of the date the notice is served on Respondent. The suspension shall occur automatically, and without further Board action, unless Respondent files a request for hearing on the notice with the Board within 10 days of the date the notice is served.

B. **Practice Monitoring Plan:** Within 30 days of the date of this Order, Respondent shall establish a Board-approved practice monitoring plan with respect to opioid prescribing only, agreed upon by Respondent and the Board. Respondent shall fully comply with the terms of the Board-approved practice monitoring plan.

1. Respondent shall submit the name and CV of an Iowa-licensed, board-certified, anesthesiologist, to serve as a practice monitor for his opioid prescribing only.

2. The Board shall provide the practice monitor with a copy of this Order, the practice monitoring plan, and all other relevant Board material in this matter.

3. The practice monitor shall provide a written statement indicating that the practice monitor has read and understands all Board material provided by the Board and agrees to serve as the practice monitor under the terms of the practice monitoring plan. The practice monitor shall meet with Respondent regularly, review selected patient records, and ensure Respondent provides appropriate care and treatment to his patients receiving opioids.

4. The practice monitor shall immediately contact the Board if there is evidence Respondent has provided substandard care to patients.

5. The practice monitor shall agree to submit written quarterly reports to the Board no later than 1/20, 4/20, 7/20, and 10/20 of each year of this Order.
6. The practice monitor may be asked to appear before the Board in-person, or by telephone or video conference. Such appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(e)(3).

C. **Worksite Monitoring Program:** Prior to the Board’s approval of this Order, Respondent shall establish a worksite monitoring program with the Board subject to the following terms and conditions.

1. Respondent shall submit for Board approval the name of a physician who regularly observes and/or supervises Respondent in his opioid prescribing only.

2. The Board shall provide a copy of all Board orders relating to this matter to the worksite monitor.

3. The worksite monitor shall provide a written statement indicating he or she has read and understands this Order and agrees to serve under the terms of this Order.

4. The worksite monitor shall agree to immediately inform the Board if there is evidence of professional incompetence, or a violation of the terms of this Order.

5. The worksite monitor may be asked to appear before the Board, in-person, by telephone, or by video conference. Such appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(e)(3).

6. The worksite monitor shall submit quarterly reports to the Board no later than 1/20, 4/20, 7/20 and 10/20 of each year of this Order.

D. **Quarterly Reports:** Respondent shall file sworn quarterly reports attesting to his compliance with all terms of this Order no later than 1/10, 4/10, 7/10 and 10/10 of each year of this Order.

E. **Board Appearances:** Respondent shall appear before the Board annually or upon request of the Board during this Order. Respondent shall be given notice of the date, time and location of each appearance. The appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(e)(3).

F. **Monitoring Fee:** Respondent shall make a payment of $100 to the Board each quarter for the duration of his probation to cover the Board’s monitoring expenses in this matter. The monitoring fee shall be received by the Board with all quarterly reports required during his probation. The monitoring fee shall be sent to: Mary Knapp, Compliance Monitor, Iowa Board of Medicine, 400 SW 8th Street, Suite C, Des Moines, Iowa 50309-4686. Each check shall be payable to the Iowa Board of Medicine.
6. **Obey All Laws and Rules:** Respondent shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Iowa.

7. **Compliance with Order:** In the event Respondent fails to comply with any terms of this Order, the Board may initiate action to suspend or revoke his license or to impose other license discipline, as authorized by Iowa Code chapters 148, 272C, and 653 IAC 25.

8. **Duration of Probation:** Periods in which Respondent does not practice medicine or fails to comply with the terms of this Order shall not apply to the duration of this Order, unless Respondent obtains prior approval from the Board.

Dated this 12th day of December, 2013.

[Signature]

Diane Clark, Acting Chair
Iowa Board of Medicine
400 S.W. 8th Street, Suite C
Des Moines, IA 40309-4686
BEFORE THE IOWA BOARD OF MEDICINE

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

ANDRZEJ SZCZEPANEK, M.D., RESPONDENT

FILE No. 02-11-626

STATEMENT OF CHARGES

COMES NOW the Iowa Board of Medicine on January 11, 2013, and files this Statement of Charges pursuant to Iowa Code section 17A.12(2). Respondent was issued Iowa medical license number 37643 on January 18, 2008. Respondent’s Iowa medical license is active and will next expire on November 1, 2014.

A. TIME, PLACE AND NATURE OF HEARING

1. Hearing. A disciplinary contested case hearing shall be held on April 11-12, 2013, before the Board. The hearing shall begin at 8:30 a.m. each day and shall be located in the conference room at the Board office at 400 SW 8th Street, Suite C, Des Moines, Iowa.

2. Answer. Within twenty (20) days of the date you are served this Statement of Charges you are required by 653 IAC 24.2(5)(d) to file an Answer. In that Answer, you should state whether you will require a continuance of the date and time of the hearing.
3. **Presiding Officer.** The Board shall serve as presiding officer, but the Board may request an Administrative Law Judge make initial rulings on pre-hearing matters, and be present to assist and advise the board at hearing.

4. **Prehearing Conference.** A prehearing conference will be held by telephone on February 6, 2013, at 9:30 a.m., before an Administrative Law Judge from the Iowa Department of Inspections and Appeals (ALJ). Please contact Kent M. Nebel, J.D., Legal Director, Iowa Board of Medicine, at 515-281-7088 with the telephone number at which you or your legal counsel can be reached. Board rules on prehearing conferences may be found at 653 Iowa Administrative Code 25.15.

5. **Hearing Procedures.** The procedural rules governing the conduct of the hearing are found at 653 IAC 25. At hearing, you will be allowed the opportunity to respond to the charges against you, to produce evidence on your behalf, cross-examine witnesses, and examine any documents introduced at hearing. You may appear personally or be represented by counsel at your own expense. If you need to request an alternative time or date for hearing, you must review the requirements in 653 IAC 25.16. The hearing may be open to the public or closed to the public at the discretion of the Respondent.

6. **Prosecution.** The office of the Attorney General is responsible for representing the public interest (the State) in this proceeding. Pleadings shall be filed with the Board and copies should be provided to counsel for the State at the following address: Julie Bussanmas, Assistant Attorney General, Iowa Attorney General’s Office, 2nd Floor, Hoover State Office Building, Des Moines, Iowa 50319.
7. **Communications.** You may not contact board members by phone, letter, facsimile, e-mail, or in person about this Notice of Hearing. Board members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the Board office and serve upon all parties in the case. You should direct any questions to Kent M. Nebel, J.D., the Board’s Legal Director at 515-281-7088 or to Assistant Attorney General Julie Bussanmas 515-281-5637.

**B. LEGAL AUTHORITY AND JURISDICTION**

8. **Jurisdiction.** The Board has jurisdiction in this matter pursuant to Iowa Code chapters 17A, 147, 148, and 272C.

9. **Legal Authority.** If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under Iowa Code chapters 17A, 147, 148, and 272C and 653 IAC 25.

10. **Default.** If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with Iowa Code section 17A.12(3) and 653 IAC 25.20.
C. SECTIONS OF STATUTES AND RULES INVOLVED
COUNT I

11. Professional Incompetency: Respondent is charged with professional incompetency pursuant to Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2) and 653 IAC 23.1(2)(a),(b),(c), (d), (e), (f), and (g) by demonstrating one or more of the following:

a. Willful or repeated gross malpractice;

b. Willful or gross negligence;

c. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician’s or surgeon’s practice;

d. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;

e. A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances;

f. A willful or repeated departure from, or the failure to conform to, the minimal standard of acceptable and prevailing practice of medicine and surgery in the state of Iowa; or

g. Failure to meet the acceptable and prevailing standard of care when delegating or supervising medical services provided by another physician, health care practitioner, or other individual who is collaborating with or acting as an agent, associate, or employee of the physician responsible for the patient’s care, whether or not injury results.
COUNT II

12. **Inappropriate Prescribing:** Respondent is charged pursuant to Iowa Code sections 148.6(2)(i) and 653 IAC 23.1(7) for willfully or repeatedly violating a lawful rule or regulation adopted by the Board when he indiscriminately or promiscuously prescribed, administered or dispensed drugs for other than a lawful purpose.

COUNT III

13. **Improper Pain Management:** Respondent is charged pursuant to Iowa Code sections 148.6(2)(i) and 653 IAC 13.2 for willfully or repeatedly violating a lawful rule or regulation adopted by the Board when he violated the standards of practice for appropriate pain management.

COUNT IV

14. **Unethical or Unprofessional Conduct:** Respondent is charged pursuant to Iowa Code sections 147.55(3) 148.2(g) and 272C.10(3) and 653 IAC 23.1(4) with engaging in unethical or unprofessional conduct. Engaging in unethical or unprofessional conduct includes, but is not limited to, the committing by a licensee of an act contrary to honesty, justice or good morals, whether the same is committed in the course of the licensee’s practice or otherwise, and whether committed within this state or elsewhere; or a violation of the standards and principles of medical ethics or 653 IAC 13.7 or 13.20 as interpreted by the board.

**STATEMENT OF THE MATTERS ASSERTED**

15. Respondent is an Iowa-licensed physician who practices anesthesiology and pain medicine in Des Moines, Iowa.
16. The Board alleges that Respondent violated the laws and rules governing the practice of medicine in Iowa when he failed to provide appropriate pain care to numerous patients in Des Moines, Iowa, between 2011 and the present, including, but not limited to, the following:

A. Respondent indiscriminately and/or promiscuously prescribed, administered or dispensed controlled substances to numerous patients, some of whom suffered drug overdose and died;

B. Respondent prescribed large quantities of potentially lethal medications to numerous patients, some of whom suffered drug overdose and died;

C. Respondent failed to provide appropriate pain treatment to high-risk patients with histories of medication misuse, illicit drug abuse, overdose, suicide attempt, drug diversion and/or drug-seeking behavior;

D. Respondent failed to perform and/or document appropriate physical examinations, including comprehensive medical histories, pain assessments, physical and psychological function, diagnostic studies, previous interventions, substance abuse histories and underlying and coexisting conditions;

E. Respondent failed to perform and/or document appropriate assessment of patients’ need for opioid therapy for chronic pain management;

F. Respondent failed to perform and/or document appropriate assessment of patients’ need for interventional pain management procedures;

G. Respondent failed to document the etiology of pain prior to the use of interventional pain management procedures;
H. Respondent failed to review, perform and/or document appropriate imaging studies to establish and/or support a diagnosis for patients receiving opioid therapy and/or interventional pain management procedures;

I. Respondent failed to order and/or document appropriate psychological evaluation and follow-up care for patients;

J. Respondent failed to establish and/or document appropriate treatment plans; including clear treatment goals, expectations, potential risks and alternative treatment modalities;

K. Respondent failed to maintain and/or document appropriate pain management agreements that specify the rules for medication use and the consequences for drug abuse, misuse or diversion;

L. Respondent failed to obtain and/or document appropriate informed consent, including discussion of the risks associated with the use of controlled substances;

M. Respondent failed to perform and/or document appropriate opioid therapy monitoring, including consideration of opiate responsiveness, the appropriateness of continued opioid therapy, the use of alternative treatment modalities, urine drug testing and evidence of drug abuse, misuse or diversion;

N. Respondent failed to initiate and/or document appropriate efforts to address patients who demonstrated evidence of drug abuse, misuse or diversion;

O. Respondent failed to perform and/or document appropriate urine drug testing for high-risk patients who demonstrated evidence of drug abuse, misuse or diversion;
P. Respondent failed to initiate and/or document appropriate efforts to address patients who had troubling and/or inconsistent urine drug testing results;

Q. Respondent failed to initiate and/or document appropriate efforts to address patients who violated their pain management agreements;

R. Respondent failed to utilize and/or document his use of the Iowa Prescription Monitoring Program for patients who were at high risk for drug abuse, misuse or diversion;

S. Respondent failed to appropriately communicate and/or document his communication with other providers who provided care to patients;

T. Respondent failed to appropriately supervise and/or document his supervision of mid-level providers and other non-licensed providers who provided care to patients;

U. Respondent inappropriately prescribed IM Demerol for home use to a patient for the treatment of chronic nonmalignant pain;

V. Respondent failed to maintain appropriate medical records;

W. Respondent inappropriately self-prescribed controlled substances for his personal use on at least one occasion;

X. Respondent inappropriately ordered as office use, and dispensed, topical pain creams from his office to patients in violation of 657 IAC 8.19(1) and 8.19(3); and

Y. Respondent inappropriately self-prescribed and/or self-dispensed topical pain creams.
E. SETTLEMENT

17. Settlement. This matter may be resolved by settlement agreement. The procedural rules governing the Board’s settlement process are found at 653 IAC 25. If you are interested in pursuing settlement of this matter, please contact Kent M. Nebel, J.D., Legal Director at 515-281-7088.

F. PROBABLE CAUSE FINDING

18. On January 11, 2013, the Iowa Board of Medicine found probable cause to file this Statement of Charges.

Colleen K. Stockdale, M.D., M.S., Chairwoman
Iowa Board of Medicine
400 SW 8th Street, Suite C
Des Moines, Iowa 50309-4686