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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
TERRANCE MOE, M.D., RESPONDENT.	:	DHA Case No.: SPS-11-0076
		ORDER 0001485

Division of Enforcement Case Nos. 08MED323, 10MED430, 10MED431

The parties to this action for the purposes of Wis. Stat. § 227.53, are:

Terrance Moe, M.D.
150 Hospital Road
Eagle River, Wisconsin 54521-0150

Division of Enforcement
Department of Safety and Professional Services
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Medical Examining Board
Department of Safety and Professional Services
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

On April 22, 2011, the formal Complaint in 10MED430 and 10MED431 was filed. On August 18, 2011, the formal Complaint in 08MED323 was filed.

A Petition for Summary Suspension was filed and served upon Respondent's attorney, Mark Budzinski, on April 12, 2012 by regular U.S. mail and electronic e-mail and U.S. regular mail. On April 18, 2012, after The Petition for Summary Suspension (with affidavits) was presented to the Wisconsin Medical Examining Board by attorney Kim M. Kluck for the Complainant, Department of Safety and Professional Services, Division of Enforcement, with Respondent's counsel, Attorney Mark T. Budzinski, appearing at the hearing on Respondent's behalf, the Order of Summary Suspension was issued by the Board.

The parties in this matter agreed to the terms and conditions of an Interim Agreement and Order in this matter, which was approved by the Board on May 1, 2012.

The parties in this matter agree to the terms and conditions of the attached Stipulation to this order in this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Respondent, Terrance Moe, M.D., (date of birth December 2, 1949) is duly licensed and currently registered by the Medical Examining Board to practice medicine and surgery in the State of Wisconsin, pursuant to license number 30319, which was first granted June 22, 1989.

2. Respondent's most recent address on file with the Wisconsin Medical Examining Board is 150 Hospital Road, Eagle River, Wisconsin 54521-0150.

ALLEGATIONS RELATING TO 10 MED 430 (Patient J.G.)

3. In 2005, Respondent treated Patient J.G. (D.O.B.: November 5, 1965; D.O.D.: February 24, 2010) for pain complaints in his ribs and back on the following dates: August 15 and 29, October 3 and 27, and November 15. On those dates, Respondent prescribed OxyContin, Percocet, Norco, Lortab and hydrocodone. The physical examinations documented by Respondent on those dates are incomplete and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; and there was no justification for the continuation or increase in pain medications.

4. In 2006, Respondent treated Patient J.G. for back pain complaints on the following dates: January 9 and 30; February 13; June 22; July 5, 10 and 30; August 1; September 6, October 10; and December 18. On those dates, Respondent prescribed OxyContin, Methadone, Norco, and Duragesic patches. The physical examinations documented by Respondent on those dates are incomplete and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; there was no justification for the continuation or increase in pain medications; and he inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use (early refills due to medications being lost, stolen or destroyed in a tornado and the patient self-escalated his dosage of pain medications by tripling his dosage).

5. In 2007, Patient J.G. presented to Respondent for recheck on twenty dates. On many of those dates, Respondent did not document a physical examination to support the medical diagnoses before prescribing Norco, OxyContin and Duragesic patches. In addition, the diagnoses do not justify the medications prescribed; there was no justification for the continuation or increase in pain medication; and he inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use (repeated early refills; acknowledged abuse by Patient J.G).

6. In 2008, Respondent treated Patient J.G. for back pain complaints on the following dates: February 26; April 22 and 30; September 8; and November 11. On those dates, Respondent prescribed Fentanyl, Suboxone, ibuprofen, and Norco. Respondent inappropriately prescribed narcotic pain medication (Norco) Patient J.G. while he was taking Suboxone and

inappropriately continued to prescribe pain medications to Patient J.G. in the face of contraindications to their use (he was aware the patient had overdosed on opiates in May of 2008 and had opiate addiction/dependency issues; Patient J.G. was obtaining OxyContin from another physician in Wausau during the time he was treating with Respondent; Patient J.G. went through drug rehabilitation in 2008; and Patient J.G. admitted to cocaine use).

7. In 2009, Respondent treated Patient J.G. for back pain complaints on the following dates: February 28, July 18 and November 10. On those dates, Respondent prescribed Suboxone, Norco and Valium. Respondent inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use in that he was aware the patient had overdosed on opiates in May of 2008 and had opiate addiction/dependency issues.

8. On February 12, 2010, Respondent again prescribed OxyContin for Patient J.G.'s back pain. Respondent inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use in that he was aware the patient had overdosed on opiates in May of 2008 and had opiate addiction/dependency issues. On February 24, 2010, Patient J.G. died from a drug overdose.

ALLEGATIONS RELATING TO 10 MED 431 (Patient C.M.B.)

9. In 2006 and 2007, Respondent treated Patient C.M.B. for migraines, anxiety and back pain on the following dates: October 24; November 6 and 27; December 18, 2006; January 31; February 15; March 7; and June 28, 2007. On those dates, Respondent prescribed Oxycontin, Fioricet, Klonopin, Vicodin ES, and Xanax. Respondent failed to obtain or document a history of back pain or conduct a physical examination on October 24, 2006 before he started the patient on a prescription of OxyContin; the subsequent physical examinations documented by Respondent are insufficient and do not support the diagnoses given; and the diagnoses do not justify the medications prescribed.

ALLEGATIONS RELATING TO PATIENT N.R.

10. In 2005, Respondent treated Patient N.R. for hip pain on the following dates: January 10; February 3 and 25; March 23, April 18; May 16 and 26; June 3 and 13; July 8; August 25; September 22; November 10 and December 5. On each of the above dates, Respondent prescribed one or more of the following pain medications: OxyContin, Methadone, Duragesic, Norco, MS Contin and/or Vicodin. Respondent failed to perform or document physical examinations which either supported the diagnoses given or which justified the pain medications he prescribed.

11. Patient N.R. presented to Respondent on the following consecutive office visits in 2006 at which time Respondent failed to perform or document a physical examination of her hips prior to diagnosing hip dysplasia: April 3 and 24; May 23; June 19; July 18; August 15; September 13; October 10 and November 7. On each of the above dates, Respondent prescribed one or more of the following pain medications: OxyContin, Norco and/or MS Contin. Respondent failed to perform or document physical examinations which either supported the diagnoses given or which justified the pain medications he prescribed.

12. The first nine times that Patient N.R. presented to Respondent in 2007 (January 2 and 31; February 28; March 26; April 24; May 22; June 19; July 18 and 31) for medication refills for hip dysplasia complaints, Respondent failed to perform or document a physical examination of her hips prior to prescribing OxyContin, MS Contin and/or Dilaudid. Respondent failed to perform or document physical examinations which either supported the diagnoses given or which justified the pain medications he prescribed.

13. In 2008, Patient N.R. presented to Respondent for fourteen office visits for medication refills for hip pain. Respondent failed to perform or document a physical examination of her hips prior to prescribing OxyContin, Norco, Percocet, Tramadol and/or Oxy IR. Respondent failed to perform or document physical examinations which supported the diagnoses given and which justified the pain medications he prescribed.

14. In 2009, Patient N.R. presented to Respondent for twelve office visits for medication refills for her hip pain. Respondent failed to perform or document a physical examination of her hips prior on those twelve occasions prior to prescribing OxyContin, Norco, Percocet, Tramadol and/or Oxy IR. In so doing, Respondent failed to perform or document physical examinations which either supported the diagnoses given or which justified the pain medications he prescribed.

15. In January and September of 2010, Respondent prescribed OxyContin to Patient N.R. for hip pain without performing or documenting physical examinations which either supported the diagnoses given or which justified the pain medications he prescribed.

ALLEGATIONS RELATING TO PATIENT P.P.

16. In 2007, Respondent treated Patient P.P. chronic non-malignant pain on the following dates: May 14 and 21; June 4 and 22; July 2 and 30; August 27; September 24; November 29; and December 21. On those dates, Respondent prescribed OxyContin, Klonopin and Percocet. Respondent failed to perform or document physical examinations which either supported the diagnoses given or which justified the pain medications he prescribed and he continued to prescribe pain medications to the patient in light of contraindications (smoking pot on a regular basis; urine screen positive for presence of THC; breaking OxyContin pills in half; reports of drug diversion).

17. In 2008, Patient P.P. presented to Respondent in January, February, March, April, July, September, October and November, at which time Respondent did not perform or document a physical examination related to her chronic pain complaints. He prescribed OxyContin and Percocet on those dates. Respondent failed to perform or document physical examinations which either supported the diagnoses given or which justified the pain medications he prescribed and he continued to prescribe pain medications to the patient in light of contraindications (urine screen positive for presence of THC; patient report in July of 2008 that she had not been taking Oxycontin for "quite some time").

18. The Board has not made a determination as to the validity of the above allegations.

19. The Respondent denies the allegations as set forth above.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in this matter pursuant to Wis. Stat. § 448.02(3), and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

2. Respondent, by engaging in conduct which tends to constitute a risk of harm to patients, as set out above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(h) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

3. Respondent, by failing to maintain healthcare records which are consistent with the requirements of Wis. Admin. Code § MED 10.21, as set out above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

IT IS ORDERED THAT THE STIPULATION OF THE PARTIES IS ACCEPTED.

IT IS HEREBY ORDERED that Terrance Moe, M.D., Respondent, is hereby REPRIMANDED for the above conduct.

IT IS FURTHER ORDERED that:

1. The license of Terrance Moe, M.D., to practice medicine and surgery in the State of Wisconsin is INDEFINITELY LIMITED, as follows:

   a. Within thirty days of the date of this Order, Respondent shall retain a professional mentor for prescription records, who shall be pre-approved by the Board or its designee. The professional mentor shall randomly select patient health care records from among patients seen during an evaluation period, and shall review the records to determine whether the medical records are accurate and complete and whether the prescriptions are properly prescribed.

   b. For one year from the date of this Order, the professional mentor shall review 15 randomly selected patient health care files which involve the prescribing of pain medications per month.

c. Respondent shall arrange for the professional mentor to submit formal written reports to the Department Monitor, Department of Safety and Professional Services, Division of Enforcement, P.O. Box 8935, Madison, Wisconsin 53708-8935, on a quarterly basis, or as otherwise directed by the Department Monitor. The professional mentor's reports shall verify that Respondent keeps and maintains patient health care records as described in paragraph (a) above.

d. A professional mentor shall have no relationship that could reasonably be expected to compromise the ability of the professional mentor to render fair and unbiased reports to the Department. For purposes of this Order, a professional mentor shall be a physician or other health care professional determined by the Board's designee to be appropriate. The professional mentor shall hold a valid Wisconsin credential in a relevant health care field, shall have read this Final Decision & Order, and shall agree to be Respondent's professional mentor.

e. Respondent's professional mentor shall immediately report to the Department Monitor any conduct or condition of the Respondent which may constitute unprofessional conduct—including any deficiency in prescribing or medical record keeping, any violation of this Order, or any other danger to the public or patient.

f. It is the responsibility of Respondent to promptly notify the Department Monitor of any suspected violations of any of the terms and conditions of this Order, including any failures of the professional mentor to conform to the terms and conditions of this Order.

g. Respondent may petition the Board for modification of the limitation requiring monitoring of his patient health care records following receipt by the Board of six monthly reports from the professional mentor. The determination of whether or not to modify the requirement is entirely within the discretion of the Board, and a decision by the Board not to remove or otherwise modify the requirement for a professional mentor shall not constitute a denial of licensure, and shall not entitle Respondent to a hearing on the Board's refusal to grant any such petition.

IT IS FURTHER ORDERED that:

2. The license of Terrance Moe, M.D., to practice medicine and surgery in the State of Wisconsin is INDEFINITELY LIMITED, as follows:

a. Dr. Moe will not prescribe any Schedule I or II medications, as well as tramadol, buprenorphine and tapentadol.

b. Dr. Moe may continue his general office practice duties as a physician and as an emergency room physician, subject to the prescribing limitations above in paragraph (a).

c. Dr. Moe is only permitted to prescribe the medications referenced in paragraph (a) in the emergency department where it is necessary to exercise reasonable care for the patient and no other licensed prescriber is available to administer or prescribe the needed medication.

d. Dr. Moe is only permitted to prescribe the medications referenced in paragraph (a) while on call at the Eagle River Memorial Hospital where it is necessary to exercise reasonable care for the patient and no other licensed prescriber is available to administer or prescribe the needed medication. Any such prescriptions shall be co-signed by another available physician within 48 hours.

e. Dr. Moe is permitted to prescribe Suboxone to patients for the treatment of drug addiction but may not prescribe Suboxone solely for the purpose of pain management.

3. Within sixty days of the date of this Order, Respondent shall read the following publications:

a. The Federation of State Medical Boards publication on "Responsible Opioid Prescribing, A Physician's Guide" by Scott Fishman, 2007; published by Waterford Life Sciences, Washington, D.C.

b. The "Opioid Prescribing: Clinical Tools and Risk Management Strategies" by Alfred V. Anderson, MD, DC, Perry G. Fine, MD, and Scott M. Fishman, MD.

c. American Academy of Pain Medicine, Volume 6, Number 2, 2005 Commentary entitled "Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain" by Douglas L. Gourlay, MD, MSc, FRCPC, FASAM, Howard A. Heit, MD FACP, FASAM, and Abdulaziz Almahrezi, MD, CCFP.

IT IS FURTHER ORDERED that:

4. Respondent shall, within 10 months of this Order, pay costs of this proceeding in the amount of TEN THOUSAND ($10,000.00) dollars. Payment shall be made to the Wisconsin Department of Safety and Professional Services, and mailed to:

Department Monitor
Department of Safety and Professional Services
Division of Enforcement

1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Telephone: (608) 267-3817
Fax: (608) 266-2264

5. Violation of any terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs or fails to comply with the ordered continuing education as ordered, the Respondent's license (no. 30319-20) may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs and completion of the continuing education.

6. This Order is effective on the date of its signing.

Wisconsin Medical Examining Board

By: _____ 7/13/12
A Member of the Board Date