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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
TERRANCE MOE, M.D., RESPONDENT.	:	ORDER 0001485

ORDER OF SUMMARY SUSPENSION

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

The Petition for Summary Suspension of April 12, 2012 was noticed to be presented at 8:15 a.m., or as soon thereafter as the matter could be heard, on April 18, 2012. At that time, attorney Kim M. Kluck appeared for the Complainant, Department of Safety and Professional Services, Division of Enforcement. Despite receiving notice of the hearing, neither Respondent nor his counsel appeared at the hearing.

The Wisconsin Medical Examining Board, having considered the sworn April 12, 2012, Petition for Summary Suspension, and the April 17, 2012 Affidavit of Service of Notice of Presentation and Petition for Summary Suspension of Mitali Chatterjee, and having heard the arguments of counsel, hereby makes the following:

FINDINGS OF FACT

1. Terrance Moe, M.D., Respondent, date of birth December 2, 1949, is licensed and registered by the Medical Examining Board as a physician in the State of Wisconsin, pursuant to license number 30319, which was first granted June 22, 1989.

2. Respondent's last address reported to the Department of Safety and Professional Services is 150 Hospital Road, Eagle River, WI 54521-0150.

3. At the time of the events set out below, Respondent was self-employed as a physician at his office located at 150 Hospital Road, Eagle River, WI 54521-0150. He specialized in family practice.

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

2005 Treatment Summary

4. On June 20, 2005, Patient J.G. (D.O.B.: November 5, 1965; D.O.D.: February 24, 2010) presented to Respondent with a complaint of re-injuring an old rib fracture he suffered four months earlier. Patient J.G. reported that another physician had prescribed Percocet for the initial

rib injury and that he would like a prescription of Percocet for the re-injury. The Respondent did not order any x-rays. On examination, Respondent noted tenderness in the left lateral inferior thoracic cage and diagnosed "bruised/fx ribs." He prescribed OxyContin 10 mg, BID, #60, and Percocet 5/525, #30, as needed for breakthrough pain.

5. OxyContin is used to treat moderate to severe pain, is a Schedule II Controlled Substance pursuant to Wis. Stat. § 961.16(2)(a)7, and has habit-forming potential.

6. Percocet is a combination of a narcotic and an analgesic/antipyretic. It relieves moderate to moderately severe pain. Percocet is a Schedule II Controlled Substance pursuant to Wis. Stat. § 961.16(2)(a)7, and has habit-forming potential.

7. At the June 20th appointment, Patient J.G. signed an authorization permitting the Respondent to obtain previous treatment records from Ministry Healthcare where Respondent previously treated Patient J.G. in 2001 and 2002 for chronic back pain and where Lawrence Agre, M.D., had treated Patient J.G. in 2002 through 2004 for chronic pain. The Ministry records revealed that on September 25, 2003, Patient J.G. reported losing a full bottle of Percocet when his jacket containing the bottle flew off the back of his truck. Dr. Agre advised Patient J.G. that in the future, "he will not get a prescription early if he should lose his prescription or have any other problems." On October 30, 2003, Dr. Agre advised Patient J.G. that he would not prescribe narcotic medications in the future because he did not feel the use of chronic narcotics was in Patient J.G.'s best interests. Dr. Agre also noted in February of 2004, that he would not provide Patient J.G. with increasing amounts of narcotics because he has had a "significant tendency" in the past to increase his use of narcotics. Dr. Agre later noted that his plan for Patient J.G. was to taper off narcotic medications as of November of 2004 because it altered his mood and only masked the back pain.

8. On August 15, 2005, Patient J.G. presented to Respondent for re-check of his rib pain at which time he reported that the OxyContin made him drowsy. Respondent noted tenderness in costochondral junction and diagnosed "chest pain" for which he prescribed Percocet 5/325, #100. Respondent ordered a chest x-ray which was performed on August 29, 2005 and revealed healing fractures of the posterolateral arcs of the left 6th through 10th ribs.

9. On August 29, 2005, Patient J.G. telephoned the Respondent and advised that he had increased the amount of medication that he was taking to OxyContin 10 mg, TID, which was not adequate to control his pain. Respondent advised Patient J.G. that he must follow instructions regarding the medication. Patient J.G. advised that he was out of town on a job but that his secretary could pick up a prescription from Respondent. On that date, Respondent noted in the patient's records that a prescription of OxyContin 10 mg, TID, #80 was given. This was an increase from the amount prescribed on June 20, 2005 and was not supported by any physical examination findings.

10. On October 3, 2005, Patient J.G. presented to the Respondent at which time Respondent noted that hydrocodone APAP 10 mg had previously been called in when Patient J.G. was unable to get to his OxyContin due to a funeral. However, there is no notation with

regard to when the hydrocodone was called in. The Respondent did not document any subjective complaints of back pain or any physical examination findings. He diagnosed Patient J.G. with "back pain" and prescribed hydrocodone 10/325, #120.

11. Hydrocodone 10/325 APAP is a combination of hydrocodone and acetaminophen, is used to treat moderate to severe pain, is a Schedule II Controlled Substance pursuant to Wis. Stat. § 961.16(2)(a)7, and has habit-forming potential.

12. On October 27, 2005, Patient J.G. presented to Respondent for medication refills at which time he reported that his rib pain had resolved but that his "back continues to be unbearable." Respondent did not perform, or document any findings of, a physical examination. He diagnosed the patient with "back pain" for which he prescribed Lortab 10/325, one tablet, QID, #120.

13. Lortab 10/325 is an analgesic combination of acetaminophen and hydrocodone. It is used to treat moderate to moderately severe pain. Lortab is a Schedule II Controlled Substance pursuant to Wis. Stat. § 961.16(2)(a)7, and has habit-forming potential.

14. On November 15, 2005, Respondent prescribed Norco #60 for Patient J.G. without examining the patient based on his report that he left all of his medications at a job site in Minnesota.

15. Norco tablets contain a combination of acetaminophen and hydrocodone. Norco is used to relieve moderate to severe pain. It is a Schedule II Controlled Substance pursuant to Wis. Stat. § 961.16(2)(a)7, and has habit-forming potential.

16. During the course of his treatment of Patient J.G. in 2005, Respondent's medical charting for Patient J.G. is incomplete, in violation of Wis. Admin. Code § Med 21.03(2).

17. Respondent's conduct in 2005 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient 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 medication; and he inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use in that he was aware that Dr. Agre documented concerns about Patient J.G.'s tendency to increase his use of narcotics and that chronic narcotic pain medications were not in Patient J.G.'s best interests.

18. Respondent's conduct in 2005 was negligent in the following respects: the physical examinations documented by Respondent are insufficient 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 medication; and he inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use in that he was aware that Dr. Agre documented concerns about Patient J.G.'s tendency to increase his

use of narcotics and that chronic narcotic pain medications were not in Patient J.G.'s best interests.

2006 Treatment Summary

19. On January 9, 2006, Respondent noted in Patient J.G.'s chart that the patient had called the previous week to request a replacement of OxyContin because his pills were in a cooler which "somehow bounced out or was stolen." Respondent had authorized an additional OxyContin prescription at that time. On January 9, 2006, Patient J.G. presented for medication refills. The patient advised that he refused to go on Methadone because of the perception of Methadone users. No physical examination findings are noted. Respondent diagnosed Patient J.G. with "back pain" and prescribed Norco 10/325, #210, which was intended to last until February 9, 2006. Respondent had Patient J.G. sign an "Informed Consent for Long-term Controlled Substances Therapy for Chronic Pain Management" agreement which provided, among other things, that "mysterious circumstances or irresponsible control of your medication may compromise our ability to continue prescribing controlled substances for you" and that increasing dosages "can only be done with specific instruction from your physician." The agreement also provided that the patient was to receive pain medication prescriptions from one physician.

20. On January 30, 2006, the Respondent prescribed OxyContin 20 mg, #90, and Norco 10/325, QID, #120, without seeing Patient J.G.

21. On February 13, 2006, the Respondent prescribed Norco #60 without seeing Patient J.G. because he was "stranded due to car trouble."

22. On March 1, 2006, Patient J.G. next presented to the Respondent for follow-up and advised that he wanted to be off all medications in a month. Respondent did not perform, or document any findings of, a physical examination. Respondent diagnosed the patient with "degenerative disc disease" with a plan to taper his medications.

23. On May 25, 2006, Patient J.G. presented to the Respondent complaining that he had slipped and re-injured his left ribs again and that he wanted to go back on OxyContin 40 mg, BID. At that time, Patient J.G.'s current medications included only Aleve. Respondent noted physical examination findings of symmetrical DTR ("deep tendon reflexes"), negative SLR ("straight leg raise"), paraspinous spasm and limited ROM. The Respondent did not document any physical examination findings with regard to the patient's ribs. He diagnosed Patient J.G. with "back pain" and increased the OxyContin prescription to 20 mg, TID, #90.

24. On June 22, 2006, Patient J.G. presented to the Respondent, advising that he tried a relative's Duragesic patches and that it provided "excellent pain relief without feeling 'dopey.'" Respondent did not perform, or document any findings of, a physical examination. He diagnosed Patient J.G. with "back pain" and prescribed Duragesic patches 7.5 mcg/hour, #10.

25. Duragesic is a skin patch containing fentanyl, a narcotic (opioid) pain medicine. The Duragesic skin patch is used to treat moderate to severe chronic pain. Duragesic is not for treating mild or occasional pain or pain from surgery.

26. On July 5, 2006, Patient J.G. presented to Respondent for medications. The Respondent did not note any pain complaints. Respondent did not perform, or document any findings of, a physical examination. He diagnosed the patient with "back pain" and prescribed OxyContin 20 mg, BID, #80 and Norco 10/325, BID, #100, as well. Patient J.G. also advised that he would be in Iowa on a job for the next 77 days.

27. On July 10, 2006, Respondent prescribed OxyContin 20 mg, #8, and Norco 10/325, #8, without seeing the patient.

28. On July 30, 2006, Respondent prescribed Norco 10/325, #70, for Patient J.G. who called to advise that he was in a tornado and that his medications were destroyed.

29. On August 1, 2006, Patient J.G. presented to the Respondent for medications and removal of a wart on his right hand. On that date, the patient advised that he had tripled his medication use and was using 40 mg of OxyContin, TID. Respondent only noted physical examination findings related to the removal of the wart. He diagnosed Patient J.G. with "chronic back pain" and increased the dosage of OxyContin to 40 mg, BID, #60 and Norco 10/325, BID, #60. The Respondent noted that he would not allow additional medications under any circumstances.

30. On August 11, 2006, the Respondent started Patient J.G. on Methadone 10 mg, two tablets, QID, #240, for back pain. He noted physical examination findings of "back severe paraspinous spasm with limited ROM."

31. Methadone is a narcotic pain reliever and is used as part of drug addiction detoxification and maintenance programs.

32. On September 6, 2006, Patient J.G. presented to Respondent for a re-check of back pain. Respondent did not perform, or document any findings of, a physical examination. The Respondent increased Patient J.G.'s Methadone to 10 mg, BID, and prescribed OxyContin 20 mg, BID, #60, and Norco 10/325, one tablet, Q4H prn, #60. The Respondent did not note any subjective or objective findings to justify the increase in pain medications to include Methadone.

33. On October 10, 2006 and November 6, 2006, the Respondent again prescribed OxyContin to Patient J.G. without performing, or documenting any findings of, a physical examination.

34. On November 17, 2006, Patient J.G. presented to the Respondent with a complaint of back pain and reporting that OxyContin 40 mg, TID, was inadequate to control his pain. The Respondent noted that "there is no rationale for ↑ baseline drug for the next couple

weeks." He prescribed OxyContin 40 mg, TID, #45, and noted that he could take 20 mg with evening dose.

35. On December 7, 2006, Patient J.G presented to the Respondent complaining of pain radiating from his low back into his left leg with numbness or tingling in his toes. The Respondent noted physical examination findings of positive SLR results, bilaterally, and that extension/flexion of left great toe was weakened. He diagnosed left L5 radiculopathy and ordered an MRI of the lumbar spine. He also prescribed OxyContin 80 mg, TID, #90 (a 30 day supply).

36. On December 18, 2006, Patient J.G. presented to the Respondent with concerns about diabetes. Patient J.G. did not report any complaints of back pain or radiating pain. Respondent did not perform, or document any findings of, a physical examination. He prescribed Norco 10/325, Q4H PRN, #160 and Methadone 10 mg, QHS, #30. On December 22, 2006, the Respondent prescribed OxyContin 40 mg, two tablets, TID, #180.

37. During the course of his treatment of Patient J.G. in 2006, Respondent's medical charting for Patient J.G. is incomplete, in violation of Wis. Admin. Code § Med 21.03(2).

38. Respondent's conduct in 2006 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient 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 medication; 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).

39. Respondent's conduct in 2006 was negligent in the following respects: the physical examinations documented by Respondent are insufficient 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 medication; 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).

2007 Treatment Summary

40. In the year 2007, Patient J.G. presented to Respondent for recheck on twenty dates. On those dates, the Respondent documented the following physical examination findings and medical diagnoses in the patient's record:

Date	Objective/Physical Exam Findings	Impression/Medical Diagnosis(es)
January 12	None	CNMP
January 24	None	CNMP

February 6	None	CNMP
February 16	Positive straight leg raise, bilateral	Left S1 radiculopathy
March 9	None	DDD
March 20	HEENT: clear; COR: RRR 0; ABD: (illegible); NECK: no adenopathy; CHEST: clear.	CNMP
April 5	None	CNMP
April 18	None	CNMP
April 30	None	CNMP
May 4	None	CNMP
May 22	None	Neuropathic pain; narcotic abuse
June 6	None	Neuropathic pain
June 22	None	CNMP
July 26	None	CNMP
August 24	None	CNMP
October 9	"Antalgic gait, 3+ paraspinous spasm"	CNMP
October 22	"paraspinous spasm; limited ROM; SLR + bilaterally"	CNMP
November 14	"paraspinous muscle spasm; limited ROM; antalgic limp"	CNMP
December 21	"Antalgic gait; paraspinous spasm"	CNMP
December 28	"Antalgic gait; paraspinous spasm; chronic"	CNMP

41. On January 12, 2007, Patient J.G. presented to the Respondent for a medication refill and advised that he had not undergone the MRI which had been ordered in December of 2006. Respondent did not perform, or document any findings of, a physical examination. He prescribed Percocet 7.5/325, two tablets, TID, #180.

42. On January 17, 2007, Patient J.G. called and advised the Respondent that he forgot his pain medications in Iowa and needed additional medications for the weekend that he was in Wisconsin.

43. On January 24, 2007, Patient J.G. presented to the Respondent requesting a ten day supply of medications because his medication was in Iowa. Respondent did not perform, or document any findings of, a physical examination. The Respondent prescribed OxyContin 40 mg, two tablets, TID, #60.

44. On May 22, 2007, Patient J.G. presented to the Respondent at which time the Respondent noted a 270% increase in the amount of pain medications that the patient had been taking in the last six months. He was taking an average of 365 mg per day in the most recent six months as compared to 133 mg of pain medication per day prior to that. On that date, the Respondent's assessment included narcotic abuse. He switched Patient J.G. to the Duragesic patch in addition to his Norco prescription.

45. On June 11, 2007, Patient J.G. telephoned the Respondent and requested an early refill of Norco because his wife had his pills and went to her mom's house. The Respondent called in a prescription of Norco, #30.

46. On August 6, 2007, Patient J.G. telephoned the Respondent's office advising that he was out of town on a trip and his wife forgot to pack his Norco 10/325 and that he needed a prescription called in. The Respondent was out of the office on that date, but his practice partner called in a prescription for a three day supply of Norco 10/325.

47. On August 10, 2007, Patient J.G.'s co-worker (K.K.) delivered a hand written note from Patient J.G. to the Respondent in which he requested that the Respondent give K.K. 60 Norco to take with his patches until his wife returns from Georgia on September 27th. Patient J.G.'s note also indicated that he had to send K.K. to the Respondent for today's appointment.

48. On September 1, 2007, Patient J.G. telephoned the Respondent and advised that his wife had his medication in Georgia. The Respondent authorized a prescription of Norco 10/325 #40 on that date and, on September 5, authorized Duragesic 100 mcg, #5.

49. On September 12, 2007, the Respondent called in a prescription for Norco 10/325 #20 to a pharmacy in Fond Du Lac. The Respondent noted that a prescription had been given to a co-worker (K.K.) but that it never got to Patient J.G. because they are at different work sites.

50. On October 9, 2007, Patient J.G. presented to the Respondent at which time the Respondent noted that he was having "difficulty" following the patient's "drug use" due to his working in various out of state locations which has resulted in "overlapping prescriptions." Patient J.G. "acknowledged abuse." On that date, the Respondent gave Patient J.G. prescription for OxyContin 40 mg, BID, #60.

51. During the course of his treatment of Patient J.G. in 2007, Respondent's medical charting for Patient J.G. is incomplete, in violation of Wis. Admin. Code § Med 21.03(2).

52. Respondent's conduct in 2007 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient 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 medication; and he inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use (repeated early refills due to medications being left in Iowa or in possession of his wife; acknowledged abuse by Patient J.G.; and Patient J.G.'s failure to present for the ordered MRI).

53. Respondent's conduct in 2007 was negligent in the following respects: the physical examinations documented by Respondent are insufficient 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 medication; and he inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use

(repeated early refills due to medications being left in Iowa or in possession of his wife; acknowledged abuse by Patient J.G.; and Patient J.G.'s failure to present for the ordered MRI).

2008 Treatment Summary

54. On February 26, 2008, Patient J.G. presented to the Respondent at which time they discussed the fact that the patient was seeing another physician in Wausau, Wisconsin. A note in the patient's medical chart indicates that Patient J.G. had been seeing a Dr. Scully in Wausau since March of 2006 and had been receiving approximately 250 Oxycodone tablets per month with "many early refills." The Respondent advised Patient J.G. to get medical detox but the patient declined to do so. The Respondent's examination findings including "3 mm pupils" and no tremor, skin – dry, no "gooseflesh." Respondent's impression included "substance abuse."

55. On April 22, 2008, the Respondent noted in his records that Patient J.G. "admits to cocaine use" and that the Respondent planned to refer him to Wausau Hospital for medical detoxification.

56. On April 30, 2008, Patient J.G. presented to the Respondent at which time he advised the Respondent that he could not afford drug rehabilitation and was entirely dysfunctional without something for pain. The Respondent did not perform a physical examination, but diagnosed CNMP, lumbar disc disease and substance abuse. He prescribed Fentanyl patch, 100 mg/hour, #5 which he noted was the "best option for pain control with least risk of abuse" and was a "stop gap until he can get into a rehab program."

57. n September 8, 2008, Patient J.G. presented to the Respondent after finishing rehabilitation. He reported doing well on Suboxone 8 mg, TID. The Respondent's documented physical examination findings included pupils 3 mm; skin dry without piloerection, chest clear and heart RRR. His diagnosis was opiate addiction, CNMP and lumbar disc disease. He prescribed Suboxone 8/2, 1 tablet, TID, #90, and Ibuprofen 600 mg, QID, #120.

58. On November 11, 2008, Patient J.G. presented to the Respondent complaining that he re-injured his back and wanted to go back on hydrocodone briefly for back pain. The Respondent noted severe back spasms, limited ROM and positive SLR, bilaterally. The Respondent diagnosed CNMP and lumbar disc disease. He gave the patient a prescription for Norco 10/325, two tablets, TID, #30.

59. During the course of his treatment of Patient J.G. in 2008, Respondent's medical charting for Patient J.G. is incomplete, in violation of Wis. Admin. Code § Med 21.03(2).

60. Respondent's conduct in 2008 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; he prescribed narcotic pain medication (Norco) to the patient while he was taking Suboxone; and he 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).

61. Respondent's conduct in 2008 was negligent in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; he prescribed narcotic pain medication (Norco) to the patient while he was taking Suboxone; and he 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).

2009 Treatment Summary

62. On February 28, 2009, Patient J.G. telephoned the Respondent at his home advising that he had stopped taking Suboxone due to abdominal pains and wanted another medication for his pain. The Respondent called in a prescription for Norco 10/325, #20 (one refill) and advised that he could not continue this treatment.

63. On July 18, 2009, Patient J.G. telephoned the Respondent's office requesting Norco 10/325. Patient J.G. had been doing well on Suboxone but needed greater relief due to work demands. He requested a two weeks' prescription of Norco so he could finish his last job contract. The Respondent authorized a prescription of Norco 10/325, #45, but noted that there would be no further consideration for continued opiates other than Suboxone.

64. On August 13, 2009, Patient J.G. presented to the Respondent with a right knee pain. Patient J.G. requested another prescription for Norco which the Respondent denied.

65. On November 10, 2009, Patient J.G. presented to the Respondent advising that he had a disability issue pending and that he had sustained nerve damage after "OD" and now had weakness in his right hand and right leg. No other information is noted about the overdose with regard to the timing or the drugs involved. On that date, the Respondent diagnosed the patient with "OBS" and opiate dependency for which he prescribed Suboxone and Valium.

66. Suboxone contains a combination of buprenorphine and naloxone. Buprenorphine is an opioid medication and is used to treat opiate addiction.

67. Valium is in a group of drugs called benzodiazepines. It affects chemicals in the brain that may become unbalanced and cause anxiety.

68. On December 7, 2009, Patient J.G. presented to the Respondent and advised that he had injured his back while getting out of bed and had radiating pain down the left leg. The

Respondent's physical examination revealed positive SLR results, bilaterally. The Respondent prescribed OxyContin 80 mg, 1 tablet BID, #20.

69. During the course of his treatment of Patient J.G. in 2009, Respondent's medical charting for Patient J.G. is incomplete, in violation of Wis. Admin. Code § Med 21.03(2).

70. Respondent's conduct in 2009 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; and he 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.

71. Respondent's conduct in 2009 was negligent in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; and he 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.

2010 Treatment Summary

72. On January 7, 2010, Patient J.G. telephoned the Respondent to request Suboxone and Valium. The Respondent authorized refills of those prescriptions but noted that the patient must have an appointment within a month and that there would be no more prescriptions if he was not seen.

73. On February 12, 2010, Patient J.G. presented to the Respondent for medication refills at which time he advised the Respondent he quit taking the Suboxone because it upset his stomach. He started taking Norco from an old prescription that he had. The Respondent's neuromuscular examination revealed very limited ROM in the patient's back; reduced sensation to light touch in right arm and left leg; diminished motor strength in right arm; left foot is always cold and reflexes absent in left patella and Achilles tendon. The Respondent diagnosed CNMP and lumbar disc displace for which he prescribed OxyContin 40 mg, one tablet, BID, #60.

74. On February 16, 2010, Patient J.G. telephoned the Respondent to advise that two 40 mg tablets of OxyContin was not working and that he was having trouble with insurance coverage of that tablet dosage. He requested OxyContin 80 mg tablets.

75. On February 19, 2010, Patient J.G. telephoned the Respondent's office and advised the Respondent that he would be leaving the state for a month and that the 80 mg of OxyContin was working "perfect." The Respondent did not see the patient on that date, but gave him two prescriptions for OxyContin, with one of them to be filled in March of 2010.

76. On February 24, 2010, Patient J.G. died from what was later determined to be a drug overdose.

77. During the course of his treatment of Patient J.G. in 2010, Respondent's medical charting for Patient J.G. is incomplete, in violation of Wis. Admin. Code § Med 21.03(2).

78. Respondent's conduct in 2010 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; he 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; and at no time during the period of treatment following Patient J.G.'s opiate overdose in May of 2008 did the Respondent ever refer Patient J.G. to a chronic pain management specialist, despite the fact that there were a number indications that the patient was demonstrating symptoms of drug addiction and/or abuse.

79. Respondent's conduct in 2010 was negligent in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; he 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; and at no time during the period of treatment following Patient J.G.'s opiate overdose in May of 2008 did the Respondent ever refer Patient J.G. to a chronic pain management specialist, despite the fact that there were a number indications that the patient was demonstrating symptoms of drug addiction and/or abuse.

80. Respondent was deposed on November 21, 2011. During the course of that deposition, Respondent testified to the following regarding his treatment of Patient J.G.:

a) That since he took a prescribing course at Case Western Reserve in 2007, he testified he has changed his prescribing practices and discharges patients suspected of diversion or abuse.

b) That he saw Patient J.G. on June 20, 2005 for a rib fracture that was likely healed as it occurred four months previously. On June 20th, Respondent did not perform an x-ray and thought it was likely that the rib pain that Patient J.G. reported was due to a bruise or soft tissue injury. Respondent prescribed OxyContin and Percocet on that date for Patient J.G.'s rib pain.

c) Respondent diagnosed Patient J.G. with back pain on October 3, 2005, by merely looking at him and seeing that he was in pain.

d) Respondent diagnosed Patient J.G. with back pain on March 1, 2006 by watching him walk down the hall which he felt allowed him to make an assessment of his physical condition.

e) On August 1, 2006, Patient J.G. reported to Respondent that he tripled his dose of OxyContin which Respondent acknowledged was a red flag and violation of the narcotics agreement. Although Respondent felt Patient J.G. clearly had issues with substance abuse at that time, he continued to prescribe OxyContin to the patient.

f) Respondent learned on February 26, 2008 that Patient J.G. had been obtaining pain medications from another physician, however he failed to contact that other physician, failed to discharge Patient J.G. from his practice for violating the narcotic agreement and continued to prescribe OxyContin to him.

g) Respondent continued to prescribe OxyContin to Patient J.G. in 2009 after he learned that the patient had overdosed on opiates and had been through rehabilitation for opiate addiction in 2008.

h) When asked in his deposition on November 21, 2011 if he felt "any responsibility for patient J.G.'s death", Respondent replied "No. None whatsoever."

82. There is probable cause to believe that it is necessary to suspend Respondent's license immediately to protect the public health, safety or welfare, based upon the following conduct by the Respondent:

a) That he saw Patient J.G. on June 20, 2005 for a rib fracture that was likely healed as it occurred four months previously. On June 20th, Respondent did not perform an x-ray and thought it was likely that the rib pain that Patient J.G. reported was due to a bruise or soft tissue injury. Respondent prescribed OxyContin and Percocet on that date for Patient J.G.'s rib pain.

b) Respondent diagnosed Patient J.G. with back pain on October 3, 2005, by merely looking at him and seeing that he was in pain.

c) Respondent diagnosed Patient J.G. with back pain on March 1, 2006 by watching him walk down the hall which he felt allowed him to make an assessment of his physical condition.

d) On August 1, 2006, Patient J.G. reported to Respondent that he tripled his dose of OxyContin which Respondent acknowledged was a red flag and violation of the narcotics agreement. Although Respondent felt Patient J.G. clearly had issues with substance abuse at that time, he continued to prescribe OxyContin to the patient.

e) Respondent learned on February 26, 2008 that Patient J.G. had been obtaining pain medications from another physician, however he failed to contact that other

physician, failed to discharge Patient J.G. from his practice for violating the narcotic agreement and continued to prescribe OxyContin to him.

f) Respondent continued to prescribe OxyContin to Patient J.G. in 2009 after he learned that the patient had overdosed on opiates and had been through rehabilitation for opiate addiction in 2008.

g) The physical examinations documented by Respondent are insufficient 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 medication; and he inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use in that he was aware that Dr. Agre documented concerns about Patient J.G.'s tendency to increase his use of narcotics and that chronic narcotic pain medications were not in Patient J.G.'s best interests.

h) Respondent inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use such as: early refills due to medications being lost, stolen or destroyed in a tornado; Patient J.G. self-escalated his dosage of pain medications by tripling his dosage; early refills due to medications being left in Iowa or in possession of his wife; acknowledged abuse by Patient J.G.; and Patient J.G.'s failure to present for the ordered MRI.

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

j) Respondent prescribed narcotic pain medication (Norco) to the patient while he was taking Suboxone.

k) Respondent failed to refer Patient J.G. to a chronic pain management specialist, despite the fact that there were a number of indications that the patient was demonstrating symptoms of drug addiction and/or abuse.

l) No minimally competent physician would have prescribed controlled substances to Patient J.G. in the manner prescribed by Respondent.

m) Respondent's prescribing of controlled substances to Patient J.G. exposed Patient J.G. and the public to risks of harm which are unacceptable to a minimally competent physician.

83. Respondent, by engaging in conduct which tends to constitute a risk of harm to patients, as set out above in paragraphs 4-80, 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)

84. Respondent, by failing to maintain healthcare records which are consistent with the requirements of Wis. Admin. Code § MED 21.03, as set out above in paragraphs 4-80, has committed unprofessional conduct, as defined by Wis. Adm. Code § MED 10.02 (2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

85. Respondent, by engaging in conduct which falls below the standard of care for a reasonable physician, as set out above in paragraphs 4-80, has committed negligence, and is subject to discipline pursuant to Wis. Stat. § 448.02(3)(b).

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter pursuant to Wis. Stat.§ 448.02(3) and has authority to summarily suspend Respondent's license to practice medicine and surgery in the State of Wisconsin, pursuant to Wis. Stats. §§ 227.53(3) and 448.02(4) and Wis. Admin. Code § SPS 6.

2. There is probable cause to believe that it is necessary to suspend Respondent's license immediately to protect the public health, safety or welfare, based upon the following conduct by the Respondent:

a) That he saw Patient J.G. on June 20, 2005 for a rib fracture that was likely healed as it occurred four months previously. On June 20th, Respondent did not perform an x-ray and thought it was likely that the rib pain that Patient J.G. reported was due to a bruise or soft tissue injury. Respondent prescribed OxyContin and Percocet on that date for Patient J.G.'s rib pain.

b) Respondent diagnosed Patient J.G. with back pain on October 3, 2005, by merely looking at him and seeing that he was in pain.

c) Respondent diagnosed Patient J.G. with back pain on March 1, 2006 by watching him walk down the hall which he felt allowed him to make an assessment of his physical condition.

d) On August 1, 2006, Patient J.G. reported to Respondent that he tripled his dose of OxyContin which Respondent acknowledged was a red flag and violation of the narcotics agreement. Although Respondent felt Patient J.G. clearly had issues with substance abuse at that time, he continued to prescribe OxyContin to the patient.

e) Respondent learned on February 26, 2008 that Patient J.G. had been obtaining pain medications from another physician, however he failed to contact that other physician, failed to discharge Patient J.G. from his practice for violating the narcotic agreement and continued to prescribe OxyContin to him.

f) Respondent continued to prescribe OxyContin to Patient J.G. in 2009 after he learned that the patient had overdosed on opiates and had been through rehabilitation for opiate addiction in 2008.

g) The physical examinations documented by Respondent are insufficient 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 medication; and he inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use in that he was aware that Dr. Agre documented concerns about Patient J.G.'s tendency to increase his use of narcotics and that chronic narcotic pain medications were not in Patient J.G.'s best interests.

h) Respondent inappropriately continued to prescribe opiate pain medications to Patient J.G. in face of contraindications to their use such as: early refills due to medications being lost, stolen or destroyed in a tornado; Patient J.G. self-escalated his dosage of pain medications by tripling his dosage; early refills due to medications being left in Iowa or in possession of his wife; acknowledged abuse by Patient J.G.; and Patient J.G.'s failure to present for the ordered MRI.

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

j) Respondent prescribed narcotic pain medication (Norco) to the patient while he was taking Suboxone.

k) Respondent failed to refer Patient J.G. to a chronic pain management specialist, despite the fact that there were a number of indications that the patient was demonstrating symptoms of drug addiction and/or abuse.

l) No minimally competent physician would have prescribed controlled substances to Patient J.G. in the manner prescribed by Respondent.

m) Respondent's prescribing of controlled substances to Patient J.G. exposed Patient J.G. and the public to risks of harm which are unacceptable to a minimally competent physician.

3. It is imperatively required and necessary to suspend Respondent's license to practice medicine and surgery immediately to protect the public health, safety and welfare.

ORDER

NOW THEREFORE IT IS HEREBY ORDERED that the license of Terrance Moe, M.D., to practice medicine and surgery in the state of Wisconsin be and is summarily suspended until the effective date of a final decision and order issued in the disciplinary proceeding against Respondent, unless otherwise ordered by the Board.

IT IS FURTHER ORDERED that a Notice of Hearing commencing a disciplinary proceeding shall be issued no more than 10 days following the issuance of this Order of Summary Suspension.

IT IS FURTHER ORDERED that Respondent is hereby notified of his right, pursuant to Wis. Admin. Code § SPS 6.09, to request a hearing to show cause why this summary suspension order should not be continued and is further notified that any request for a hearing to show cause should be filed with the Wisconsin Medical Examining Board, 1400 East Washington Avenue, P.O. Box 8935, Madison, WI 53708.

IT IS FURTHER ORDERED that in the event that Respondent requests a hearing to show cause why the summary suspension should not be continued, that hearing shall be scheduled to be heard on a date within 20 days of receipt by the Board of Respondent's request for hearing, unless Respondent requests or agrees to a later time for the hearing.

Wisconsin ~~Medical~~ Examining Board

By: _____ 4/18/12
A Member of the Board Date