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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
BRIGG W. BARSNESS, M.D., RESPONDENT.	:	ORDER 0003163

Division of Legal Services and Compliance[1] Case No. 12 MED 242

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

Brigg W. Barsness, M.D.
1120 Main Street
Union Grove, Wisconsin 53182

Wisconsin Medical Examining Board
P.O. Box 7190
Madison, WI 53707-7190

Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 8366
Madison, WI 53708-8366

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final disposition of this matter, subject to the approval of the Medical Examining Board (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, Conclusions of Law and Order.

FINDINGS OF FACT

1. Respondent Brigg William Barsness, M.D., (dob February 22, 1979), is licensed in the State of Wisconsin to practice medicine and surgery, having license number 51515-20, first issued on April 23, 2008, with registration current through October 31, 2015. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 1120 Main Street, Union Grove, Wisconsin 53182. Respondent is certified by the American Board of Family Practice.

[1] The Division of Legal Services and Compliance was formerly known as the Division of Enforcement.

2. Respondent began treating Patient A, a woman born in 1976, on September 17, 2010. Patient A had a history of chronic back pain following a motor vehicle collision at age 16, and was under the care of a pain specialist, from whom she received morphine 30 mg BID, and oxycodone-acetaminophen 10 mg/650 mg, PRN. Patient A had been diagnosed with sarcoidosis, and was using fluticasone/salmeterol (Advair®) and albuterol. She also reported having gastroesophageal reflux disease (GERD), for which she took omeprazole. Due to concerns Patient A expressed about concentration and focus at school (where she was studying to be a nurse), irritability and depression, and after considering Patient A's treatment history, Respondent prescribed alprazolam and bupropion.

3. On October 15, 2010, Patient A reported alprazolam was helping but bupropion caused insomnia and worsened irritability, so desvenlafaxine (Pristiq®) was prescribed. On November 17, 2010, Patient A reported that the desvenlafaxine was working well; she expressed a desire to stop smoking so Respondent prescribed varenicline (Chantix®). Patient A reported past issues with sleeping while on varenicline so a prescription for zolpidem was also given, in addition to the alprazolam and desvenlafaxine. These prescriptions were continued on December 21, 2010.

4. At her next office visit on March 25, 2011, Patient A said she couldn't concentrate or focus, was concerned that she had ADD, and had lost her job. Lisdexamfetamine (Vyvanse®) 30 mg QD was added to her regimen to treat ADD, with the possibility of increasing or decreasing the dose, depending on response. At her next office visit on April 12, 2011, Patient A reported that the medication was helpful, but that she needed a second pill at midday; her prescribed dosage was increased to 30 mg BID. At her next appointment, May 13, 2011, Patient A stated the lisdexamfetamine was making her jittery after the second dose, so lisdexamfetamine was continued in the morning with amphetamine/dextroamphetamine (Adderall®) IR 10 mg for the afternoon. At the next office visit, June 13, 2011, Patient A reported that the amphetamine/dextroamphetamine was ineffective, and that she had resumed taking lisdexamfetamine twice a day. At the next office visit, July 15, 2011, Patient A reported that the lisdexamfetamine had been effective and all of her prescriptions were renewed. On November 29, 2011, Patient A identified worsened insomnia, so the lisdexamfetamine was stopped and amphetamine/dextroamphetamine IR 20 mg, TID, was prescribed, with a new trial of zolpidem.

5. Patient A returned to care on February 28, 2012, and reported doing well with amphetamine and dextroamphetamine XR, 20 mg in the morning, and 10 mg IR, 3 to 4 times daily thereafter. There is no documentation in the chart regarding how this change came about. Respondent then prescribed amphetamine/dextroamphetamine XR, 20 mg, #30, and amphetamine salt combination, 10 mg, #120. At her next office visit, on May 3, 2012, Patient A again complained of insomnia, and expressed concern that she might have Obsessive Compulsive Disorder. Respondent referred her to psychiatry, and prescribed amphetamine salt combination 10 mg, BID.

6. On June 18, 2012, Patient A had her next appointment with Respondent, and had not yet met with psychiatry, but had an appointment in August. Patient A reported having stopped amphetamine/dextroamphetamine and desvenlafaxine on her own, and experienced significant difficulty; she then resumed the desvenlafaxine. Respondent charted: "2. Psychiatric

concerns. I do think it is time to initiate Lamictal to see if this is helpful as a mood stabilizer. I do recommend that she keep her appointment with Dr. [psychiatrist]. We will see if we can set her up with a female counselor. She is otherwise to continue Adderall and Xanax. Will continue with Pristiq at this time as well. Pristiq may be kindling her mania. 3. Insomnia. Ambien has been helpful. Will continue this medication." Respondent prescribed lamotrigine (Lamictal®) 100 mg, #30, with instructions to take one tablet daily. Respondent, in response to an inquiry from the Board, wrote "[the patient] and I were concerned about the potential for Bipolar Affective Disorder as an explanation for her irritability, reaction to past medications and other psychiatric concerns. The decision was made to trial Lamictal as a mood stabilizer until she was able to meet with her psychiatrist."

7. In fact, lamotrigine is a medication which must be started at a low dose, and then gradually increased: 25 mg for 2 weeks, then 50 mg for 2 weeks, then 100 mg for 1 week, then 200 mg. There is also a black box warning for this medication concerning the risk of Stevens Johnson syndrome and toxic epidermal necrolysis; there is no indication in the chart that Patient A was informed of this risk, or about what to do if she experienced a rash.

8. Patient A took the medication as prescribed, and became extremely lethargic on June 19, 2012, requiring hospitalization.

9. The Board finds that Patient A had a complex polypharmacy with a psychiatric overlay. Respondent is a family physician and should not have been prescribing multiple psychiatric medications. He incorrectly dosed lamotrigine for the patient, causing harm, and failed to document informed consent. Instead, Respondent should have called Patient A's psychiatrist and asked for her to be seen sooner. If Patient A could not be seen sooner by the psychiatrist, Patient A should have been told to wait until the psychiatric appointment.

10. On September 15, 2010, Patient B, a woman born in 1982, established care with Respondent. Patient B reported a history of migraine headaches every other week, low back pain into her right hip and down the leg, irregular periods and endometriosis (for which she is followed by a gynecologist), depression and anxiety (for which she was seeing a psychiatrist, who prescribed alprazolam 0.5 mg, 5 times per day), acid reflux, low vitamin D, and fibromyalgia. She reported her pain as 5 on a scale of 0 to 10. Patient B reported that she did not drink alcohol, or use tobacco. Her medications included cyclobenzaprine 5 mg, take 1 or 2 TID PRN, and a hydrocodone 5 mg product, take one or 2 QD. Respondent added topiramate (Topamax®) 25 mg, HS, to increase by 25 mg weekly until maximum dose of 200 mg daily is reached.

11. Patient B returned to care on October 18, 2010. She reported that the topiramate was not helpful and caused confusion. Patient B further reported that in the past she had not tolerated duloxetine, pregabalin, or amitriptyline. She reported no migraines since her previous visit. Respondent added temazepam 15 mg, take one or 2 every evening PRN, for insomnia.

12. On November 10, 2010, Patient B requested a refill of her hydrocodone, via telephone. Respondent authorized hydrocodone-acetaminophen 5/500 mg TID, #90, no refills.

13. Patient B returned to care on November 19, 2010, with a report of continuing chronic low back pain. Patient B reported not having tried physical therapy recently, and that the cyclobenzaprine, hydrocodone-acetaminophen, alprazolam, and temazepam have all been helpful. Respondent referred Patient B to physical therapy, and continued all of her medications.

14. Patient B missed a scheduled appointment on December 5, 2010, but telephoned on December 8, 2010, for a refill of her hydrocodone. Respondent authorized an additional one month supply.

15. Patient B returned to care on December 30, 2010, reporting increased migraine headaches. Patient B stated that she had not yet been to physical therapy. Her medications were continued, together with a new prescription for sumatriptan 100 mg. Respondent noted, among other things: "5. Anxiety. We will continue Xanax. Potentially other medications such as Lexapro may be of benefit." There is no notation of any escitalopram (Lexapro®) samples being dispensed, or a prescription issued, for escitalopram.

16. On January 13, 2011, Patient B telephoned, reporting that she had received samples of escitalopram 10 mg, and that her left eye had swollen and developed yellow drainage. Patient B was referred to urgent care.

17. Patient B missed a scheduled appointment on January 24, 2012.

18. Patient B returned to care on January 26, 2011. The intake note states: "Last in on December 30, 2010. Here today for a one-month follow-up on Lexapro samples." Patient B reported that the escitalopram had been helpful for her anxiety, she had not yet been able to do physical therapy, and that the sumatriptan made her migraine headaches worse. Respondent noted, among other things: "1. Depression/anxiety. We will continue the Lexapro 10 mg. We will see if we can get this approved with her insurance. She is provided with 2 more samples today." Respondent also prescribed rizatriptan for migraine headaches.

19. Patient B telephoned the clinic on February 9, 2011, reporting that her insurance company would not cover escitalopram until she tried other medications. She reported that Respondent also gave her citalopram (Celexa®), but that this medication was causing worse anxiety and heart palpitations. There is no notation anywhere in the chart of any dispensing of citalopram.

20. Patient B returned to care on March 11, 2011, reporting pain in her hands and up into her arms. Respondent referred her to rule out or treat carpal tunnel syndrome, and charted that he increased her hydrocodone product to the 7.5 mg strength. He also prescribed amitriptyline 25 mg HS for fibromyalgia. He noted that Patient B's insurance had approved the escitalopram, and that she was taking this together with the alprazolam, cyclobenzaprine, and temazepam. Notwithstanding the narrative note, the medication list for this visit shows that the patient was prescribed hydrocodone-acetaminophen 10 mg/325 mg, take one every 6 hours PRN, #60.

21. On March 23, 2011, Patient B telephoned Respondent's office and requested a refill of her hydrocodone. Respondent authorized 60 tablets, with the same instructions, of the 10 mg strength.

22. Patient B returned to care on March 25, 2011. Patient B reported that her arm pain had resolved when she stopped the escitalopram, so she did not follow up with the referral. Patient B reported using the hydrocodone product more frequently as a result of pain from strep throat. Respondent charted, among other things: "2. Bilateral arm pain. I am uncertain why Lexapro would supposedly worsened these symptoms. There is no family history of anything like serotonin syndrome or malignant hyperthermia. I do wonder if this may be some type of odd extrapyramidal affect though she had no changes to her face whatsoever. I do think potentially follow-up with Dr. [...] would be of benefit; however, discontinuing the medication appears to have been helpful alone. 3. Depression/anxiety. I do recommend that she follow-up with Dr. [psychiatrist] as well as he may have a better idea of what the Lexapro side effects were causing. We will not make any changes to medication at present. She will go without this medication. 4. Back pain. We will continue the Vicodin as helpful. I would consider Butrans in the future."

23. On April 4, 2011, Patient B telephoned Respondent's clinic to request a refill of her hydrocodone product. Respondent authorized an additional 60 tablets with the same dosage instructions.

24. Patient B returned to care on April 11, 2011. She reported having some pain with writing, but still improved without the escitalopram. Patient B further reported that the hydrocodone-acetaminophen 10/325 was no longer effective for her back pain. Respondent then prescribed oxycodone-acetaminophen 5/325, take one every 6 hours PRN, #30. He also prescribed pregabalin (Lyrica®) 75 mg BID for fibromyalgia.

25. On April 18, 2011, Patient B telephoned the clinic and requested a refill of her oxycodone, and a larger quantity. Respondent issued a prescription for 120 tablets.

26. Patient B returned to care on May 13, 2011, and reported that she had not attempted the pregabalin because she was concerned about side effects which this medication had caused in her mother. The medication list shows the amitriptyline is discontinued, but there is no explanation for this. Respondent issued a prescription for 120 tablets of oxycodone 5/325, to be filled "on or around" May 18, 2011.

27. On June 3, 2011, Patient B telephoned the clinic and stated that an impacted wisdom tooth was causing problems and that she was in significant pain, taking 2-3 oxycodone at a time. She requested a stronger medication. Patient B was informed not to take her medication in this manner, and to use the emergency room if necessary.

28. Patient B returned to care on June 15, 2011. Respondent charted "regarding her back pain, this does persist particularly on the right side with radiation into the right leg. We have previously tried to set up referral as well as physical therapy; however she has difficulty with transportation and cannot make these appointments. MRI performed in April showed no significant abnormalities. Patient B's medication list shows that temazepam was discontinued, but there is no explanation for this in the chart. Respondent's plan included: "5. Back pain: we will continue Percocet. She is also provided with samples of Lidoderm." The chart reflects that another prescription for 120 tablets of oxycodone 5/325 was issued.

29. Patient B returned to care on July 11, 2011, and reported worse back pain. Patient B reported her pain as being 8 on a scale of 0 to 10. Respondent charted: "examination of the back does reveal tenderness at the lumbosacral junction and more to the right side." Respondent's plan included: "1. Back pain. I do think referral to Dr. [physiatrist] would be helpful. There are a number of modalities that would provide relief, including increased physical activity, weight loss and physical therapy. Increasing the amount of Percocet will likely not cause the greatest benefit down the road. I do think Lyrica and other agents would be very helpful. However, her mother has not responded well to Lyrica. We will also trial Butrans 5 mg weekly today to see if this is affordable. Fentanyl is likely too strong at this point." Respondent prescribed buprenorphine 5μg per hour transdermal patch (Butrans®), apply one each week, #4. Additionally, he prescribed oxycodone-acetaminophen (Endocet®) 5/325, take one every 6 hours as needed, #135.

30. Patient B telephoned Respondent's clinic on August 8, 2011, and requested a refill of her oxycodone. Respondent issued a prescription for another 135 tablets.

31. On August 29, 2011, Patient B returned to care, and reported that the pain medication had been helpful. She further reported that her mother had advised her against seeing the physiatrist, that she was having headaches 4 or 5 times per month. Patient B reported her pain as a 4 on a scale of 0 to 10. Respondent's plan included: "2. Back pain. We will continue the Endocet 4-5 tablets daily. I do think that trying fentanyl would be of benefit as well. We had tried Butrans last time, but it was not covered by insurance." Respondent then issued prescriptions: fentanyl 25 μg per hour, apply one every 3 days, #10; oxycodone 5/325, take one every 6 hours as needed, #135, refill on or after September 9, 2011.

32. On September 26, 2011, Patient B telephoned Respondent's clinic and requested a refill of her fentanyl patches. Respondent then prescribed 10 additional patches.

33. Patient B returned to care on September 29, 2011. She noted that she would meet with her psychiatrist on October 6, and that her fibromyalgia had been worse with the weather. "She has not tolerated nerve tonics well." Patient B reported continuing to take oxycodone, 4 to 5 tablets per day, as well as cyclobenzaprine. The medication list indicates that the fentanyl patches were discontinued because they would not stay on. There is no discussion in the chart about how this can be reconciled with the fact that Patient B requested a refill of these patches, 3 days previously. Patient B reported her pain as a 6 on a scale of 0 to 10 "pretty much everywhere and mostly my lower back." Respondent's plan included: "6. Fibromyalgia: we will continue her current dose of Percocet. She has not had difficulty with escalating doses or early refills. Should she need changes I do think Advanced Pain Management would be very helpful. There is also a physical therapist who specializes in fibromyalgia at the Southside Clinic which would be of significant benefit for her should she be able to arrange transportation." Respondent issued a prescription for oxycodone 5/325, take one tablet for to 5 times daily, one-month supply, #135.

34. Patient B telephoned Respondent's clinic on October 31, 2011, and requested a refill of her oxycodone. Respondent issued a prescription for another 135 tablets with the same dosage instructions. Patient B telephoned for another refill on November 28, 2011, and another prescription for 135 tablets was issued.

35. Patient B returned to care on December 20, 2011, and reported ongoing headaches. Respondent noted that amitriptyline was not helpful, and that Patient B reported being on liquid Roxicet for her pain, having been seen in the emergency department on December 19. She reported her pain as the 6 on a scale of 0 to 10 "my whole body kind of aches." Respondent's plan included: "3. Chronic low back pain. We will continue pain medication as helpful." The chart reflects that a prescription for 135 tablets of oxycodone 5/325 was issued.

36. On January 20, 2012, Patient B telephoned Respondent's clinic and requested a refill of her oxycodone. Respondent issued a prescription for 135 tablets. On February 17, 2012, Patient B telephoned the clinic and requested a refill of her oxycodone; Respondent issued a prescription for another 135 tablets, and Patient B was informed that she needed to be seen before another prescription would be issued.

37. On March 2, 2012, Patient B returned to the clinic and reported that her pain was a 6 on a 0 to 10 scale. She further reported that she had an appointment to begin physical therapy the following week, and that her headaches had resolved. Respondent's plan included: "1. Back pain. I do strongly recommend she follow up with physical therapy. This would be the most helpful thing we can try long term. Regarding long-term use of chronic opioids, this is concerning given her young age. We will see if Nucynta may be a better option. We have prescribed this as 100 mg 4 times daily. Barring that we will continue with Percocet. I do think referral to Advanced Pain Management for potential injection would be helpful." A prescription for tapentadol (Nucynta®) was issued, #120.

38. Patient B returned to clinic on March 13, 2012, reporting that she had fallen at home on March 8, and experienced the significant pain. She went to the emergency room four days later, and received a ketorolac injection, which was not effective. She reported her pain as a 10 on a scale of 0 to 10. Respondent's plan included: 1. Acute or chronic pain exacerbation. I do think the timing for the injury and the subsequent ER visit our concerning. I do think this is an exacerbation of underlying fibromyalgia. There may be a degree of ankle sprain though she is able to walk without much difficulty. I would recommend that she continue with an Ace wrap as helpful. One is provided to date. I do think physical therapy would be of benefit tomorrow though she is recommended to go easy as she did have this recent fall. I do think fibromyalgia is the primary cause of most of her pain. We discussed other non-narcotic options for treatment of pain though she is not interested at this time given difficulty her mother has had with such treatments. She is most interested in continuing with Percocet. I did discuss that this will likely not be the best long-term intervention as it will become less effective over time. At this time we will continue with this medication though I would be very much interested in trying Savella, Lyrica or Cymbalta again in the future." Respondent then issued a prescription for oxycodone 5/325, #135. There was no charted discussion of the tapentadol.

39. On April 9, 2012, Patient B telephoned Respondent's clinic for a refill of her oxycodone. Respondent issued another prescription for 135 tablets. On May 4, 2012, Patient B called for a refill of her oxycodone, and Respondent issued another prescription for 135 tablets. There is a note that Patient B should have enough medication to last through May 8, 2012, and that the prescription would not be issued until May 7, 2012.

40. Patient B returned to care on May 21, 2012, and stated that her back pain had been getting worse for the past 2 months, and that she had been taking 8 to 10 tablets of oxycodone per day. She had not undertaken physical therapy: no explanation for this was charted. Patient B's chart does not reflect a pain level. Respondent noted that Patient B appeared very fatigued and unhappy. His plan included: "1. Back pain. I do discuss with [patient] that taking her pain medication more than prescribed is dangerous and illegal. I do think this is more a symptom of pseudoaddiction in the sense that her pain is incompletely controlled. I do want to give her the benefit of the doubt. We will change to oxycodone 10 mg immediate release, a two-week supply to take up to 4 times daily. I do strongly recommend physical therapy. MRI of the back is reassuring. It does not show any significant red flags for which surgery would be indicated. I would also be very interested in trying Cymbalta as she is having some dysphoria. I do discuss with [patient] that she needs to take these medications as prescribed; otherwise I cannot continue to prescribe them." Respondent issued a prescription for oxycodone 10 mg QID, #60; duloxetine (Cymbalta®) 30 mg, delayed release, take one daily for one week, and then twice daily thereafter.

41. Patient B telephoned Respondent's clinic on June 4, 2012, and requested a refill of the "original" formulation. Respondent then prescribed oxycodone 5/325, #135.

42. Patient B returned to care on June 29, 2012. Respondent charted, in part: "at the previous visit she had been using Percocet inappropriately and we instead tried oxycodone 10 mg. She states that oxycodone 20 mg is equivalent to Percocet 5/325. She is interested in continuing the Percocet, though she would like to increase the dose. She did try the Cymbalta, however, she states that after 4 days this caused some confusion and she is not interested in taking more of it." There is no pain level charted. Respondent's plan included: "chronic pain. We will continue the Percocet, however, we will increase to 7.5/325 with the same dosing #135 months late. I do strongly recommend physical therapy. There are other agents I would like to use again in the future. I am concerned that at her young age of 30, should she continue with these medications that will bode a very poor quality of life in the future." Respondent issued a prescription for oxycodone-acetaminophen 7.5/325mg, #135.

43. Patient B returned to care on July 28, 2012. Respondent charted: "she states her chronic pain remains fairly well controlled with the Percocet, however, she has had worsening bilateral hand pain for the past 10 days. She had been given splints in the past for carpal tunnel syndrome though she has recently moved and does not know where they are. She states the 3rd and 4th digit of both hands are affected. The right-hand is more affected than the left. She continues to have difficulty with neck pain for which cyclobenzaprine has been helpful at night." There is no record of Patient B's pain level. Respondents plan included: "1. Chronic pain. We will continue with the Percocet for tablets daily, #135. 2. Bilateral hand pain. At present this does appear to be carpal tunnel syndrome. I would recommend she used the splints again. She does not have much difficulty further up the forearm, in the elbow or the upper arm. I do not detect a significant abnormality in the neck aside from muscle tightness. Use of tizanidine may be of benefit which cyclobenzaprine causes too much sedation." Respondent issued prescriptions for oxycodone 7.5/325, #135; and tizanidine 4 mg, TID, #90, one refill.

44. Patient B returned to care on August 24, 2012. Respondent charted: "she reports her Percocet is not as effective as it had been previously. She is having difficulty with the way

the prescription was written before as they will not provided as a one-month supply and she has run out to days early. She describes ongoing bilateral hand pain, particularly affecting the right, with numbness and tingling. 2 of the other fingers on the right-hand have also been affect it. She has been having significant pain in the right hip which does radiate around to the front. She has not yet done physical therapy but is looking into options in her new home in Delavan. She describes difficulty sleeping at night secondary to her pain. Tizanadine has been very effective." There is no record of Patient B's pain level. Respondent's plan included: "1. Fibromyalgia. I do think very strongly that Lyrica in addition to her current medications could be very helpful to prevent progression of her disease. I would like to do this again in the future; however, she is not interested at this time. Improved sleep as well as physical therapy would also be strongly recommended. 2. Chronic pain. We will continue the tizanidine. I very much recommend not trying few trans patches though she is not interested at this time. We will increase the Percocet up to 10/325 to take for tablets daily #120. [...] 5 right hip pain. This appears to be trochanteric bursitis which I do think could benefit significantly from injection. She is not interested at this time." There is no explanation for why Patient B rejects Respondent's recommendations. Respondent issued prescriptions for oxycodone/APAP 10/325, take one every 6 hours PRN, #120; and tizanidine 4 mg, TID, #90, 11 refills.

45. Patient B then returned to care on September 17, 2012. Respondent charted, in part: "regarding her chronic pain, she does think the increase in Percocet has been helping. She states that this will help for approximately 4 hours. She has had significant difficulty with sleep at night secondary to her pain. She is not using the new trans patch. She does continue to take tizanidine which has been helpful. She will be following up with her psychiatrist again later this month. She continues to have difficulty with right hip pain but declines injection." Respondent's plan included: "1. Chronic pain. We will refill the Percocet #120 to take 4 times daily. I do think Butrans would be very helpful though she is not interested in taking it. I do again think that Lyrica could be helpful as well. I do strongly recommend follow up with physical therapy. [...] 3. Right hip pain. I do think that trochanteric bursitis injection would be very helpful. She is not interested." No reason is charted for Patient B's rejection of Respondent's recommendations. Respondent issued prescriptions for oxycodone 10/325, take one every 6 hours as needed, #120; and diazepam 10 mg, take one nightly as needed for anxiety, #30.

46. The Board finds that at no time did Respondent require Patient B to sign a medication agreement, conduct a urine drug screen, conduct a pill count, consult with collateral sources, or take any recognized steps to avoid diversion. Respondent's chart is inadequate to support this level of opioid prescribing, fails to establish functional goals and monitor progress towards such goals, and fails to demonstrate that alternatives to opioid therapy were adequately tried.

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. By the conduct described in the Findings of Fact, Respondent Brigg W. Barsness, M.D., engaged in unprofessional conduct pursuant to Wis. Admin. Code § Med 10.02(2)(h) by

engaging in practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

3. By the conduct described in the Findings of Fact, Respondent Brigg W. Barsness, M.D., engaged in unprofessional conduct pursuant to Wis. Admin. Code § Med 10.02(2)(a) by failing to chart the dispensing of sample medications, as required by Wis. Admin. Code § Med 17.05(1)(b).

4. As a result of the above conduct, Brigg W. Barsness, M.D., is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

1. The attached Stipulation is accepted.

2. Respondent Brigg W. Barsness, M.D., is REPRIMANDED.

3. The medicine and surgery license issued to Brigg W. Barsness, M.D., (license number 51515-20) is LIMITED as follows:

a. Within nine (9) months of the date of this Order, Respondent shall successfully complete:

- a significant course of continuing medical education on the topic of prescribing psychotropic medications;
- a significant course of continuing medical education on the topic of prescribing controlled substances;
- a significant course of continuing medical education in documentation; and
- five (5) hours of continuing medical education in informed consent, including its documentation.

b. Respondent shall be responsible for obtaining the course(s) required under this Order, for providing adequate course(s) descriptions to the Department Monitor, and for obtaining pre-approval of the course(s) from the Wisconsin Medical Examining Board, or it designee, prior to commencement of the course(s). The following courses are preapproved on the topic of prescribing controlled substances:

- Intensive Course in Controlled Substance Prescribing, Case Western Reserve University School of Medicine.
- Physician Prescribing Course, University of California, San Diego, School of Medicine.

- Prescribing Controlled Drugs: Critical Issues & Common Pitfalls of Misprescribing, University of Florida College of Medicine, Department of Psychiatry.

- Prescribing Controlled Drugs, Vanderbilt University School of Medicine and the Center for Professional Health.

The following courses are preapproved on the topic of prescribing psychotropic medications:

- Essential Psychopharmacology, Harvard Medical School Winter Seminar.

- Psychopharmacology 2014, Massachusetts General Hospital Academy.

- 5th Annual Master Psychopharmacology Conference (online version), American Physician Institute for Advanced Professional Studies, Oak Brook, IL

The following courses are preapproved for documentation:

- Intensive Course in Medical Record Keeping with Individual Preceptorships, Case Western Reserve University School of Medicine.

- Medical Record Keeping Seminar, with Personalized Implementation Program, Center for Personalized Education for Physicians, Denver, Colorado.

- Medical Record Keeping Course, University of California, San Diego, School of Medicine.

The following course is preapproved for informed consent:

- Risk Management Consult: Informed Consent, Second Edition; Medical Risk Management, Inc., Houston, Texas

c. The Board or its designee may reject any course(s) and may accept a course(s) for less than the number of hours for which Respondent seeks approval.

d. Within thirty (30) days of completion of each educational component, Respondent shall file an affidavit with the Department Monitor stating under oath that he has attended, in its entirety, the course(s) approved for satisfaction of this requirement along with supporting documentation of attendance from the sponsoring organizations.

e. Respondent is responsible for all costs associated with compliance with this educational requirement.

f. None of the education completed pursuant to this requirement may be used to satisfy any other continuing education requirements that have been or may be instituted by the Board or Department.

4. Within 6 months from the date of this Order, Brigg W. Barsness, M.D., shall pay COSTS of this matter in the amount of $4,150.

5. Proof of successful course completion and payment of costs (made payable to the Wisconsin Department of Safety and Professional Services) shall be sent by Respondent to the Department Monitor at the address below:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190, Madison, WI 53707-7190
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

6. Violation of any of the 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 costs as ordered or fails to submit proof of successful completion of the ordered education as set forth above, Respondent's license (no. 51515-20) 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 education.

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

WISCONSIN MEDICAL EXAMINING BOARD

by: Kenneth B. Simon, MD
A Member of the Board

April 16, 2014
Date

akt

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	**STIPULATION**
BRIGG W. BARSNESS, M.D., RESPONDENT.	:	ORDER 0003163

Division of Legal Services and Compliance[1] Case No. 12 MED 242

Respondent Brigg W. Barsness, M.D., and the Division of Legal Services and Compliance, Department of Safety and Professional Services stipulate as follows:

1. This Stipulation is entered into as a result of a pending investigation by the Division of Legal Services and Compliance. Respondent consents to the resolution of this investigation by Stipulation.

2. Respondent understands that by signing this Stipulation, Respondent voluntarily and knowingly waives the following rights:

- the right to a hearing on the allegations against Respondent, at which time the State has the burden of proving those allegations by a preponderance of the evidence;
- the right to confront and cross-examine the witnesses against Respondent;
- the right to call witnesses on Respondent's behalf and to compel their attendance by subpoena;
- the right to testify on Respondent's own behalf;
- the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision;
- the right to petition for rehearing; and
- all other applicable rights afforded to Respondent under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and other provisions of state or federal law.

3. Respondent is aware of Respondent's right to seek legal representation and has been provided an opportunity to obtain legal counsel before signing this Stipulation. Respondent is represented by Gutglass, Erickson, Bonville & Larson, S.C.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Wisconsin Medical Examining Board (Board). The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's order, if adopted in the form as attached.

[1] The Division of Legal Services and Compliance was formerly known as the Division of Enforcement.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall then be returned to the Division of Legal Services and Compliance for further proceedings. In the event that the Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. The parties to this Stipulation agree that the attorney or other agent for the Division of Legal Services and Compliance and any member of the Board ever assigned as an advisor in this investigation may appear before the Board in open or closed session, without the presence of Respondent, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with deliberations on the Stipulation. Additionally, any such advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

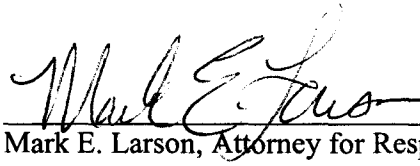
7. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

8. The Division of Legal Services and Compliance joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.

3-6-2014

Brigg W. Barsness, M.D., Respondent
1120 Main Street
Union Grove, Wisconsin 53182
License no. 51515-20

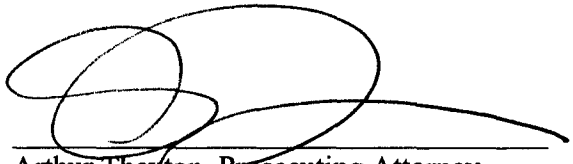
Date



3/10/14

Mark E. Larson, Attorney for Respondent
Gutglass, Erickson, Bonville & Larson, S.C.
735 North Water Street, Suite 1400
Milwaukee, WI 53202

Date



3/12/14

Arthur Thexton, Prosecuting Attorney
Division of Legal Services and Compliance
P.O. Box 8935
Madison, WI 53708-8935

Date