

WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY
PROCEEDINGS AGAINST

ROBERT J. FOX, R.N., A.P.N.P., L.A.C., D.O.M.,
RESPONDENT.

FINAL DECISION AND ORDER

ORDER 0007424

Division of Legal Services and Compliance Case Nos. 18 NUR 237 and 19 NUR 315

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

Robert J. Fox, R.N., A.P.N.P., L.Ac., D.O.M.
Milwaukee, WI 53212

Wisconsin Board of Nursing
P.O. Box 8366
Madison, WI 53708-8366

Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190
Madison, WI 53707-7190

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 Wisconsin Board of Nursing (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 Robert J. Fox, R.N., A.P.N.P., L.Ac., D.O.M., (DOB xx/xx/1975) is licensed in the state of Wisconsin as a registered nurse, having license number 169944-30, first issued on September 16, 2009, and current through February 28, 2022. Respondent is certified in the state of Wisconsin as an advanced practice nurse prescriber, having license number 4476-33, first issued on August 1, 2011, and current through September 30, 2022.¹ Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is located in Milwaukee, Wisconsin 53212.

¹ Respondent is also credentialed in the state of Wisconsin to practice acupuncture, having credential number 383-55, first issued on February 4, 2004, and current through June 30, 2021.

2. At all times relevant to this proceeding, Respondent practiced as an advanced practice nurse prescriber, acupuncturist, and executive director at a holistic care center (Center), located in Milwaukee, Wisconsin.

18 NUR 237

3. On March 25, 2018, the Department received an anonymous complaint that Respondent is prescribing excessive amounts of opioids to Patient A.

4. Respondent's prescriber report from Wisconsin's Prescription Drug Monitoring Program (PDMP) was reviewed for the time period between June 20, 2017, to January 26, 2018, with regard to controlled substances prescribed to Patient A. Patient A was receiving controlled substances at amounts beyond CDC and Wisconsin guidelines prior to treating with Respondent. One goal of Respondent's treatment was to reduce the amount of opioids utilized by Patient A.

5. The aforementioned PDMP prescriber report reflected the following controlled substances prescribed by Respondent to Patient A:

Medication Name	Strength	Date Prescribed	Estimated Days Supply	Quantity Dispensed	Morphine Milligram Equivalent
Amphetamine-Dextroamphetamine	30MG	6/20/17	30	60	
Fentanyl	75MCG/HR	6/20/17	30	10	180
Oxycodone HCl	30MG	6/20/17	30	240	360
Lisdexamfetamine Dimesylate	70MG	7/12/17	30	30	
Amphetamine-Dextroamphetamine	30MG	7/18/17	30	60	
Fentanyl	75MCG/HR	7/18/17	30	10	180
Oxycodone HCl	30MG	7/24/17	30	240	360
Oxycodone HCl	30MG	8/15/17	30	240	180
Fentanyl	75MCG/HR	8/15/17	30	10	360
Amphetamine-Dextroamphetamine	30MG	8/15/17	30	60	
Amphetamine-Dextroamphetamine	30MG	9/12/17	30	60	
Lisdexamfetamine Dimesylate	70MG	9/12/17	30	30	
Oxycodone HCl	30MG	9/12/17	30	270	405
Fentanyl	75MCG/HR	9/12/17	3	10	180 (assuming 30 day supply)
*Fentanyl	75MCG/HR	10/3/17	30	10	180
*Amphetamine-Dextroamphetamine	30MG	10/3/17	30	60	
Lisdexamfetamine Dimesylate	70MG	10/3/17	30	30	
Oxycodone HCl	30MG	10/6/17	30	270	405
*Oxycodone HCl	30MG	10/31/17	30	240	360
*Lisdexamfetamine Dimesylate	70MG	10/31/17	30	30	
*Amphetamine-Dextroamphetamine	30MG	10/31/17	30	60	
*Fentanyl	75MCG/HR	10/31/17	30	10	180

Fentanyl	75MCG/HR	11/28/17	30	10	180
Oxycodone HCl	30MG	11/28/17	30	240	360
Amphetamine-Dextroamphetamine	30MG	11/28/17	30	60	
Lisdexamfetamine Dimesylate	70MG	11/28/17	30	30	
Amphetamine-Dextroamphetamine	30MG	12/26/17	30	60	
Lisdexamfetamine Dimesylate	70MG	12/26/17	30	30	
Oxycodone ER	36MG	12/26/17	30	60	108
Oxycodone HCl	30MG	1/3/18	30	120	180
Amphetamine-Dextroamphetamine	30MG	1/24/18	30	60	
Lisdexamfetamine Dimesylate	70MG	1/24/18	30	30	
*Oxycodone HCl	30MG	1/24/18	30	180	270
*5 or more days early					

6. The Morphine Milligram Equivalent (MME) of the medications prescribed by Respondent to Patient A, as detailed above, exceed the levels recommended by opioid prescribing guidelines issued by both the Centers for Disease Control (CDC) and Wisconsin.

7. A review of Respondent's records for Patient A reflect that Respondent failed to consistently document the following: attempts to reduce the amount of controlled substances that Patient A was taking; and whether Respondent considered a prescribing Narcan in light of the high amounts of controlled substances prescribed to Patient A. Respondent had determined that Patient A possessed Narcan.

19 NUR 315

8. On July 5, 2019, the Department received an anonymous complaint from a source at a local hospital alleging Respondent was prescribing high doses of narcotics and steroids to Patient B.

9. Respondent's prescriber report from Wisconsin's PDMP was reviewed for the time period between January 1, 2017, to July 5, 2019, with regard to controlled substances prescribed to Patient B.

10. The aforementioned PDMP prescriber report reflected the following controlled substances prescribed by Respondent to Patient B:

Medication Name	Strength	Date Prescribed	Estimated Days Supply	Quantity Dispensed	MME Equivalent
Oxycodone HCl	15MG	2/23/2018	30	120	90
Oxycodone HCl	15MG	3/20/2018	30	120	90
Oxycodone HCl	15MG	6/19/2018	30	120	90
Oxycodone ER	27MG	6/19/2018	20	20	40.5

Oxycodone ER	27MG	8/1/2018	30	30	40.5
Oxycodone HCl	15MG	8/7/2018	30	120	90
Oxycodone HCl	15MG	10/3/2018	30	120	90
Oxycodone HCl	15MG	10/25/2018	30	120	90
Oxycodone HCl	15MG	11/20/2018	30	120	90
Oxycodone ER	27MG	12/19/2018	30	30	40.5
Oxycodone HCl	15MG	12/19/2018	30	120	90
Oxycodone HCl	15MG	2/7/2019	30	120	90
Oxycodone HCl	15MG	3/8/2019	30	120	90
Oxycodone HCl	15MG	4/9/2019	30	120	90
Oxycodone HCl	15MG	5/8/2019	30	120	90
Oxycodone HCl	15MG	6/6/2019	30	120	90

11. The MME of the medications prescribed by Respondent to Patient B, as detailed above, exceed the levels recommended by opioid prescribing guidelines issued by both the CDC and Wisconsin.

12. A review of Respondent's records for Patient B reflect that Respondent failed to consistently document the following: attempts to reduce the amount of controlled substances that Patient B was taking; and prescription of Narcan in light of the high amounts of controlled substances prescribed to Patient B.

As to Both Cases

13. On July 23, 2018, Respondent's collaborating physician, Physician C reported last speaking with Respondent on July 20, 2018, after he received a voicemail from a Department investigator. Prior to that, they last collaborated two months prior. Physician C recalled that Respondent consulted with several specialists, including an OB/GYN, regarding Patient A's care and felt comfortable with the care Respondent was providing.

14. Physician C is licensed as a medical doctor in Wisconsin with license number 26038-20. Physician C's most recent address on file with the Department is located in Brooklyn, New York.

15. In resolution of this matter, Respondent consents to the entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction to act in this matter pursuant to Wis. Stat. § 441.07, 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 violated Wis. Admin. Code § N 7.03(6)(a), by failing to perform nursing with reasonable skill and safety.

3. By the conduct described in the Findings of Fact, Respondent violated Wis. Admin. Code § N 7.03(6)(c), by departing from or failing to conform to the minimal standards of acceptable nursing practice that may create unnecessary risk or danger to a patient's life, health, or safety. Actual injury to a patient need not be established.

4. As a result of the above conduct, Respondent is subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b) and (d).

ORDER

1. The attached Stipulation is accepted.
2. Respondent is **REPRIMANDED**.
3. The registered nurse license and advanced practice nurse prescriber certificate issued to Respondent (credential numbers 169944-30 and 4476-33, respectively) are **LIMITED** as follows:
 - a. Within ninety (90) days of the date of this Order, Respondent shall at his own expense, successfully complete twelve (12) hours of education on the topic of responsible opioid prescribing offered by a provider pre-approved by the Board's monitoring liaison, including taking and passing any exam offered for the courses.
 - i. Respondent shall submit proof of successful completion of the education in the form of verification from the institution providing the education to the Department Monitor at the address stated below. None of the education completed pursuant to this requirement may be used to satisfy any continuing education requirements that have been or may be instituted by the Board or Department, and also may not be used in future attempts to upgrade a credential in Wisconsin.
 - ii. The Board's monitoring liaison may change the number of credit hours and/or education topics in response to a request from Respondent. The monitoring liaison may consider the topic availability and/or hours of education when determining if a change to the ordered education should occur.
 - iii. This limitation shall be removed from Respondent's license and certificate after satisfying the Board or its designee that Respondent has successfully completed all of the ordered education.
 - b. Every ninety (90) days for a period of no less than one (1) year from the date of this Order, Respondent shall submit his Wisconsin PDMP Prescriber Metrics Report (PMR) on any patient he has prescribed opioids reflecting his prescribing for the preceding quarter.

- i. Respondent shall submit each PMR under an affidavit attesting that it accurately and completely reflects his PDMP-eligible prescribing for the preceding quarter.
 - ii. No PMR Respondent submits shall contain any patient health information but shall otherwise be submitted in the exact form generated by the PDMP.
- c. Within 120 days, Respondent shall engage the services of a collaborating physician located in Wisconsin and provide the collaborating physicians contact information to the Department Monitor.
 - d. Within 14 days of entering into a collaborative agreement, Respondent shall provide the Department Monitor with written acknowledgment from each collaborating physician that a copy of this Order and any subsequent order modifying this Order has been received.
 - e. Respondent shall provide his collaborating physician with a copy of this Order. For a period of one (1) year, that physician shall conduct patient file reviews of all patients to whom Respondent has prescribed opioids and submit quarterly reports to the Department Monitor.
 - f. Respondent shall review PDMP every time he issues a prescription for opioids and retain a printout of that review in the patient's file. This will be done for one (1) year so the collaborating physician can ensure PDMP is being reviewed with every prescription issued.
 - g. For a period of one (1) year, anytime Respondent issues or refills a prescription for opioids, Respondent must determine whether the patient presents a risk of overdose and whether a prescription for Narcan is medically indicated. Respondent must document whether or not a Narcan prescription is issued and the reasoning in the patient's medical chart. The collaborating physician will then review this information and report any concerns to the Department Monitor.
 - h. Respondent shall document all alternative methods of treatment he tried with each patient before prescribing any opioids.
 - i. The Board may issue additional limitations based on concerns reported by the collaborating physician.

4. After satisfying the Board or its designee that Respondent has successfully completed of the terms in paragraph 3 of this Order, these limitations shall be removed from Respondent's license and certificate.

5. Pursuant to the Compact, Respondent may not practice in a Compact state, other than Wisconsin, while Respondent's license and certificate are encumbered by any terms of this Order.

6. Within 120 days from the date of this Order, Respondent shall pay COSTS of this matter in the amount of \$2,609.00.

7. Request for approval of courses, 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) 266-2112; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov


Respondent may also submit this information online at: <https://dspsmonitoring.wi.gov>

8. In the event Respondent violates any term of this Order, Respondent's license and certificate (nos. 169944-30 and 4476-33, respectively), or Respondent's right to renew his license or certificate, may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of the Order. The Board may, in addition and/or in the alternative refer any violation of this Order to the Division of Legal Services and Compliance for further investigation and action.

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

WISCONSIN BOARD OF NURSING

by:



A Member of the Board

10 June 2021

Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY
PROCEEDINGS AGAINST

ROBERT J. FOX, R.N., A.P.N.P., L.AC., D.O.M.,
RESPONDENT.

STIPULATION

ORDER 0007424

Division of Legal Services and Compliance Case Nos. 18 NUR 237 and 19 NUR 315

Respondent Robert J. Fox, R.N., A.P.N.P., L.Ac., D.O.M., 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 Attorney Samuel J. Leib.
4. Respondent agrees to the adoption of the attached Final Decision and Order by the Wisconsin Board of Nursing (Board) (see Exhibit A and B). 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.
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.

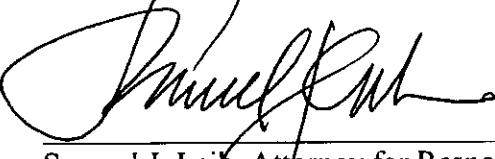
7. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

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.




Robert J. Fox, R.N., A.P.N.P., L.Ac., D.O.M., Respondent
Milwaukee, WI 53212
License Nos. 169944-30 and 4476-33

5/7/21
Date



Samuel J. Leib, Attorney for Respondent
Leib Knott Gaynor LLC
219 N. Milwaukee Street, Suite 710
Milwaukee, WI 53202

5/7/2021
Date



Alicia M. Kennedy, Prosecuting Attorney
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison WI 53707-7190

5/10/21
Date

EXHIBIT A

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY :
PROCEEDINGS AGAINST :
 : FINAL DECISION AND ORDER
ROBERT J. FOX, R.N., A.P.N.P., L.AC., D.O.M., :
RESPONDENT. :

Division of Legal Services and Compliance Case Nos. 18 NUR 237 and 19 NUR 315

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

Robert J. Fox, R.N., A.P.N.P., L.Ac., D.O.M.
Milwaukee, WI 53212

Wisconsin Board of Nursing
P.O. Box 8366
Madison, WI 53708-8366

Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190
Madison, WI 53707-7190

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 Wisconsin Board of Nursing (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 Robert J. Fox, R.N., A.P.N.P., L.Ac., D.O.M., (DOB xx/xx/1975) is licensed in the state of Wisconsin as a registered nurse, having license number 169944-30, first issued on September 16, 2009, and current through February 28, 2022. Respondent is certified in the state of Wisconsin as an advanced practice nurse prescriber, having license number 4476-33, first issued on August 1, 2011, and current through September 30, 2022.¹ Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is located in Milwaukee, Wisconsin 53212.

¹ Respondent is also credentialed in the state of Wisconsin to practice acupuncture, having credential number 383-55, first issued on February 4, 2004, and current through June 30, 2021.

2. At all times relevant to this proceeding, Respondent practiced as an advanced practice nurse prescriber, acupuncturist, and executive director at a holistic care center (Center), located in Milwaukee, Wisconsin.

18 NUR 237

3. On March 25, 2018, the Department received an anonymous complaint that Respondent is prescribing excessive amounts of opioids to Patient A.

4. Respondent's prescriber report from Wisconsin's Prescription Drug Monitoring Program (PDMP) was reviewed for the time period between June 20, 2017, to January 26, 2018, with regard to controlled substances prescribed to Patient A. Patient A was receiving controlled substances at amounts beyond CDC and Wisconsin guidelines prior to treating with Respondent. One goal of Respondent's treatment was to reduce the amount of opioids utilized by Patient A.

5. The aforementioned PDMP prescriber report reflected the following controlled substances prescribed by Respondent to Patient A:

Medication Name	Strength	Date Prescribed	Estimated Days Supply	Quantity Dispensed	Morphine Milligram Equivalent
Amphetamine-Dextroamphetamine	30MG	6/20/17	30	60	
Fentanyl	75MCG/HR	6/20/17	30	10	180
Oxycodone HCl	30MG	6/20/17	30	240	360
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Amphetamine-Dextroamphetamine	30MG	8/15/17	30	60	
Amphetamine-Dextroamphetamine	30MG	9/12/17	30	60	
Lisdexamfetamine Dimesylate	70MG	9/12/17	30	30	
Oxycodone HCl	30MG	9/12/17	30	270	405
Fentanyl	75MCG/HR	9/12/17	3	10	180 (assuming 30 day supply)
*Fentanyl	75MCG/HR	10/3/17	30	10	180
*Amphetamine-Dextroamphetamine	30MG	10/3/17	30	60	
Lisdexamfetamine Dimesylate	70MG	10/3/17	30	30	
Oxycodone HCl	30MG	10/6/17	30	270	405
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*Lisdexamfetamine Dimesylate	70MG	10/31/17	30	30	
*Amphetamine-Dextroamphetamine	30MG	10/31/17	30	60	
*Fentanyl	75MCG/HR	10/31/17	30	10	180

Fentanyl	75MCG/HR	11/28/17	30	10	180
Oxycodone HCl	30MG	11/28/17	30	240	360
Amphetamine-Dextroamphetamine	30MG	11/28/17	30	60	
Lisdexamfetamine Dimesylate	70MG	11/28/17	30	30	
Amphetamine-Dextroamphetamine	30MG	12/26/17	30	60	
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Oxycodone HCl	30MG	1/3/18	30	120	180
Amphetamine-Dextroamphetamine	30MG	1/24/18	30	60	
Lisdexamfetamine Dimesylate	70MG	1/24/18	30	30	
*Oxycodone HCl	30MG	1/24/18	30	180	270
*5 or more days early					

6. The Morphine Milligram Equivalent (MME) of the medications prescribed by Respondent to Patient A, as detailed above, exceed the levels recommended by opioid prescribing guidelines issued by both the Centers for Disease Control (CDC) and Wisconsin.

7. A review of Respondent's records for Patient A reflect that Respondent failed to consistently document the following: attempts to reduce the amount of controlled substances that Patient A was taking; and whether Respondent considered a prescribing Narcan in light of the high amounts of controlled substances prescribed to Patient A. Respondent had determined that Patient A possessed Narcan.

19 NUR 315

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9. Respondent's prescriber report from Wisconsin's PDMP was reviewed for the time period between January 1, 2017, to July 5, 2019, with regard to controlled substances prescribed to Patient B.

10. The aforementioned PDMP prescriber report reflected the following controlled substances prescribed by Respondent to Patient B:

Medication Name	Strength	Date Prescribed	Estimated Days Supply	Quantity Dispensed	MME Equivalent
Oxycodone HCl	15MG	2/23/2018	30	120	90
Oxycodone HCl	15MG	3/20/2018	30	120	90
Oxycodone HCl	15MG	6/19/2018	30	120	90
Oxycodone ER	27MG	6/19/2018	20	20	40.5

Oxycodone ER	27MG	8/1/2018	30	30	40.5
Oxycodone HCl	15MG	8/7/2018	30	120	90
Oxycodone HCl	15MG	10/3/2018	30	120	90
Oxycodone HCl	15MG	10/25/2018	30	120	90
Oxycodone HCl	15MG	11/20/2018	30	120	90
Oxycodone ER	27MG	12/19/2018	30	30	40.5
Oxycodone HCl	15MG	12/19/2018	30	120	90
Oxycodone HCl	15MG	2/7/2019	30	120	90
Oxycodone HCl	15MG	3/8/2019	30	120	90
Oxycodone HCl	15MG	4/9/2019	30	120	90
Oxycodone HCl	15MG	5/8/2019	30	120	90
Oxycodone HCl	15MG	6/6/2019	30	120	90

11. The MME of the medications prescribed by Respondent to Patient B, as detailed above, exceed the levels recommended by opioid prescribing guidelines issued by both the CDC and Wisconsin.

12. A review of Respondent's records for Patient B reflect that Respondent failed to consistently document the following: attempts to reduce the amount of controlled substances that Patient B was taking; and prescription of Narcan in light of the high amounts of controlled substances prescribed to Patient B.

As to Both Cases

13. On July 23, 2018, Respondent's collaborating physician, Physician C reported last speaking with Respondent on July 20, 2018, after he received a voicemail from a Department investigator. Prior to that, they last collaborated two months prior. Physician C recalled that Respondent consulted with several specialists, including an OB/GYN, regarding Patient A's care and felt comfortable with the care Respondent was providing.

14. Physician C is licensed as a medical doctor in Wisconsin with license number 26038-20. Physician C's most recent address on file with the Department is located in Brooklyn, New York.

15. In resolution of this matter, Respondent consents to the entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction to act in this matter pursuant to Wis. Stat. § 441.07, 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 violated Wis. Admin. Code § N 7.03(6)(a), by failing to perform nursing with reasonable skill and safety.

3. By the conduct described in the Findings of Fact, Respondent violated Wis. Admin. Code § N 7.03(6)(c), by departing from or failing to conform to the minimal standards of acceptable nursing practice that may create unnecessary risk or danger to a patient's life, health, or safety. Actual injury to a patient need not be established.

4. As a result of the above conduct, Respondent is subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b) and (d).

ORDER

1. The attached Stipulation is accepted.
2. Respondent is REPRIMANDED.
3. The registered nurse license and advanced practice nurse prescriber certificate issued to Respondent (credential numbers 169944-30 and 4476-33, respectively) are LIMITED as follows:
 - a. Within ninety (90) days of the date of this Order, Respondent shall at his own expense, successfully complete twelve (12) hours of education on the topic of responsible opioid prescribing offered by a provider pre-approved by the Board's monitoring liaison, including taking and passing any exam offered for the courses.
 - i. Respondent shall submit proof of successful completion of the education in the form of verification from the institution providing the education to the Department Monitor at the address stated below. None of the education completed pursuant to this requirement may be used to satisfy any continuing education requirements that have been or may be instituted by the Board or Department, and also may not be used in future attempts to upgrade a credential in Wisconsin.
 - ii. The Board's monitoring liaison may change the number of credit hours and/or education topics in response to a request from Respondent. The monitoring liaison may consider the topic availability and/or hours of education when determining if a change to the ordered education should occur.
 - iii. This limitation shall be removed from Respondent's license and certificate after satisfying the Board or its designee that Respondent has successfully completed all of the ordered education.
 - b. Every ninety (90) days for a period of no less than one (1) year from the date of this Order, Respondent shall submit his Wisconsin PDMP Prescriber Metrics Report (PMR) on any patient he has prescribed opioids reflecting his prescribing for the preceding quarter.

- i. Respondent shall submit each PMR under an affidavit attesting that it accurately and completely reflects his PDMP-eligible prescribing for the preceding quarter.
 - ii. No PMR Respondent submits shall contain any patient health information but shall otherwise be submitted in the exact form generated by the PDMP.
 - c. Within 120 days, Respondent shall engage the services of a collaborating physician located in Wisconsin and provide the collaborating physicians contact information to the Department Monitor.
 - d. Within 14 days of entering into a collaborative agreement, Respondent shall provide the Department Monitor with written acknowledgment from each collaborating physician that a copy of this Order and any subsequent order modifying this Order has been received.
 - e. Respondent shall provide his collaborating physician with a copy of this Order. For a period of one (1) year, that physician shall conduct patient file reviews of all patients to whom Respondent has prescribed opioids and submit quarterly reports to the Department Monitor.
 - f. Respondent shall review PDMP every time he issues a prescription for opioids and retain a printout of that review in the patient's file. This will be done for one (1) year so the collaborating physician can ensure PDMP is being reviewed with every prescription issued.
 - g. For a period of one (1) year, anytime Respondent issues or refills a prescription for opioids, Respondent must determine whether the patient presents a risk of overdose and whether a prescription for Narcan is medically indicated. Respondent must document whether or not a Narcan prescription is issued and the reasoning in the patient's medical chart. The collaborating physician will then review this information and report any concerns to the Department Monitor.
 - h. Respondent shall document all alternative methods of treatment he tried with each patient before prescribing any opioids.
 - i. The Board may issue additional limitations based on concerns reported by the collaborating physician.
4. After satisfying the Board or its designee that Respondent has successfully completed of the terms in paragraph 3 of this Order, these limitations shall be removed from Respondent's license and certificate.
5. Pursuant to the Compact, Respondent may not practice in a Compact state, other than Wisconsin, while Respondent's license and certificate are encumbered by any terms of this Order.

6. Within 120 days from the date of this Order, Respondent shall pay COSTS of this matter in the amount of \$2,609.00.

7. Request for approval of courses, 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) 266-2112; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

Respondent may also submit this information online at: <https://dspsmonitoring.wi.gov>

8. In the event Respondent violates any term of this Order, Respondent's license and certificate (nos. 169944-30 and 4476-33, respectively), or Respondent's right to renew his license or certificate, may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of the Order. The Board may, in addition and/or in the alternative refer any violation of this Order to the Division of Legal Services and Compliance for further investigation and action.

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

WISCONSIN BOARD OF NURSING

by: _____
A Member of the Board

_____ Date

EXHIBIT B

STATE OF WISCONSIN
BEFORE THE DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

IN THE MATTER OF DISCIPLINARY :
PROCEEDINGS AGAINST :
 : FINAL DECISION AND ORDER
ROBERT J. FOX, L.AC., D.O.M., R.N., A.P.N.P. :
RESPONDENT. :

Division of Legal Services and Compliance Case Nos. 18 RLA 002 and 19 RLA 002

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

Robert J. Fox, L.Ac., D.O.M., R.N., A.P.N.P.
Milwaukee, WI 53212

Wisconsin Department of Safety and Professional Services
P.O. Box 8368
Madison, WI 53708-8368

Division of Legal Services and Compliance
Wisconsin Department of Safety and Professional Services
P.O. Box 7190
Madison, WI 53707-7190

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 Wisconsin Department of Safety and Professional Services (Department). The Department has reviewed this Stipulation and considers it acceptable.

Accordingly, the Department adopts the attached Stipulation and makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Respondent Robert J. Fox, L.Ac, D.O.M., R.N., A.P.N.P., (DOB xx/xx/1975) is credentialed in the state of Wisconsin to practice acupuncture, having credential number 383-55, first issued on February 4, 2004, and current through June 30, 2021.¹ Respondent's most recent address on file with the Department is located in Milwaukee, Wisconsin 53212.

¹ Respondent is licensed in the state of Wisconsin as a registered nurse, having license number 169944-30, first issued on September 16, 2009, and current through February 28, 2022. Respondent is certified in the state of Wisconsin as an advanced practice nurse prescriber, having license number 4476-33, first issued on August 1, 2011, and current through September 30, 2022.

2. At all times relevant to this proceeding, Respondent practiced as an advanced practice nurse prescriber, acupuncturist, and executive director at a holistic care center (Center), located in Milwaukee, Wisconsin.

18 RLA 002

3. On March 25, 2018, the Department received an anonymous complaint that Respondent is prescribing excessive amounts of opioids to Patient A.

4. Respondent's prescriber report from Wisconsin's Prescription Drug Monitoring Program (PDMP) was reviewed for the time period between June 20, 2017, to January 26, 2018, with regard to controlled substances prescribed to Patient A. Patient A was receiving controlled substances at amounts beyond CDC and Wisconsin guidelines prior to treating with Respondent. One goal of Respondent's treatment was to reduce the amount of opioids utilized by Patient A.

5. The aforementioned PDMP prescriber report reflected the following controlled substances prescribed by Respondent to Patient A:

Medication Name	Strength	Date Prescribed	Estimated Days Supply	Quantity Dispensed	Morphine Milligram Equivalent
Amphetamine-Dextroamphetamine	30MG	6/20/17	30	60	
Fentanyl	75MCG/HR	6/20/17	30	10	180
Oxycodone HCl	30MG	6/20/17	30	240	360
Lisdexamfetamine Dimesylate	70MG	7/12/17	30	30	
Amphetamine-Dextroamphetamine	30MG	7/18/17	30	60	
Fentanyl	75MCG/HR	7/18/17	30	10	180
Oxycodone HCl	30MG	7/24/17	30	240	360
Oxycodone HCl	30MG	8/15/17	30	240	180
Fentanyl	75MCG/HR	8/15/17	30	10	360
Amphetamine-Dextroamphetamine	30MG	8/15/17	30	60	
Amphetamine-Dextroamphetamine	30MG	9/12/17	30	60	
Lisdexamfetamine Dimesylate	70MG	9/12/17	30	30	
Oxycodone HCl	30MG	9/12/17	30	270	405
Fentanyl	75MCG/HR	9/12/17	3	10	180 (assuming 30 day supply)
*Fentanyl	75MCG/HR	10/3/17	30	10	180
*Amphetamine-Dextroamphetamine	30MG	10/3/17	30	60	
Lisdexamfetamine Dimesylate	70MG	10/3/17	30	30	
Oxycodone HCl	30MG	10/6/17	30	270	405
*Oxycodone HCl	30MG	10/31/17	30	240	360
*Lisdexamfetamine Dimesylate	70MG	10/31/17	30	30	
*Amphetamine-Dextroamphetamine	30MG	10/31/17	30	60	
*Fentanyl	75MCG/HR	10/31/17	30	10	180

Fentanyl	75MCG/HR	11/28/17	30	10	180
Oxycodone HCl	30MG	11/28/17	30	240	360
Amphetamine-Dextroamphetamine	30MG	11/28/17	30	60	
Lisdexamfetamine Dimesylate	70MG	11/28/17	30	30	
Amphetamine-Dextroamphetamine	30MG	12/26/17	30	60	
Lisdexamfetamine Dimesylate	70MG	12/26/17	30	30	
Oxycodone ER	36MG	12/26/17	30	60	108
Oxycodone HCl	30MG	1/3/18	30	120	180
Amphetamine-Dextroamphetamine	30MG	1/24/18	30	60	
Lisdexamfetamine Dimesylate	70MG	1/24/18	30	30	
*Oxycodone HCl	30MG	1/24/18	30	180	270
*5 or more days early					

6. The Morphine Milligram Equivalent (MME) of the medications prescribed by Respondent to Patient A, as detailed above, exceed the levels recommended by opioid prescribing guidelines issued by both the Centers for Disease Control (CDC) and Wisconsin.

7. A review of Respondent's records for Patient A reflect that Respondent failed to consistently document the following: attempts to reduce the amount of controlled substances that Patient A was taking; and whether Respondent considered a prescribing Narcan in light of the high amounts of controlled substances prescribed to Patient A. Respondent had determined that Patient A possessed Narcan.

19 RLA 002

8. On July 5, 2019, the Department received an anonymous complaint from a source at a local hospital alleging Respondent was prescribing high doses of narcotics and steroids to Patient B.

9. Respondent's prescriber report from Wisconsin's PDMP was reviewed for the time period between January 1, 2017, to July 5, 2019, with regard to controlled substances prescribed to Patient B.

10. The aforementioned PDMP prescriber report reflected the following controlled substances prescribed by Respondent to Patient B:

Medication Name	Strength	Date Prescribed	Estimated Days Supply	Quantity Dispensed	MME Equivalent
Oxycodone HCl	15MG	2/23/2018	30	120	90
Oxycodone HCl	15MG	3/20/2018	30	120	90

Oxycodone HCl	15MG	6/19/2018	30	120	90
Oxycodone ER	27MG	6/19/2018	20	20	40.5
Oxycodone ER	27MG	8/1/2018	30	30	40.5
Oxycodone HCl	15MG	8/7/2018	30	120	90
Oxycodone HCl	15MG	10/3/2018	30	120	90
Oxycodone HCl	15MG	10/25/2018	30	120	90
Oxycodone HCl	15MG	11/20/2018	30	120	90
Oxycodone ER	27MG	12/19/2018	30	30	40.5
Oxycodone HCl	15MG	12/19/2018	30	120	90
Oxycodone HCl	15MG	2/7/2019	30	120	90
Oxycodone HCl	15MG	3/8/2019	30	120	90
Oxycodone HCl	15MG	4/9/2019	30	120	90
Oxycodone HCl	15MG	5/8/2019	30	120	90
Oxycodone HCl	15MG	6/6/2019	30	120	90

11. The MME of the medications prescribed by Respondent to Patient B, as detailed above, exceed the levels recommended by opioid prescribing guidelines issued by both the CDC and Wisconsin.

12. A review of Respondent's records for Patient B reflect that Respondent failed to consistently document the following: attempts to reduce the amount of controlled substances that Patient B was taking; and prescription of Narcan in light of the high amounts of controlled substances prescribed to Patient B.

13. In resolution of this matter, Respondent consents to the entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Department of Safety and Professional Services has jurisdiction to act in this matter pursuant to Wis. Stat. § 451.14, 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 engaged in unprofessional conduct as defined by Wis. Admin. Code § SPS 73.01(2), by violating, or aiding or abetting violation of any law, the circumstances of which substantially relate to the practice of acupuncture or other healing art.

3. As a result of the violations noted in the Conclusions of Law, Respondent is subject to discipline pursuant to Wis. Stat. § 451.14(2)(g).

ORDER

1. The attached Stipulation is accepted.

2. Respondent is REPRIMANDED.
3. The credential to practice as an acupuncturist issued to Respondent (credential no. 383-55) is LIMITED as follows:
 - a. Respondent must comply with all of the requirements of the Final Decision and Order entered in the Division of Legal Services and Compliance Case Number 18 NUR 237 and 19 NUR 315.
 - b. This limitation shall be removed from Respondent's license after satisfying the Department that Respondent has successfully completed the terms of the Final Decision and Order entered in the Division of Legal Services and Compliance Case Number 18 NUR 237 and 19 NUR 315.
4. Within 120 days from the date of this Order, Respondent shall pay COSTS of this matter in the amount of \$1,069.00.
5. Request for approval of courses, 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) 266-2112; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

Respondent may also submit this information online at: <https://dpsmonitoring.wi.gov>

6. In the event that Respondent violates any term of this Order, Respondent's credential (no. 383-55) to practice acupuncture in the state of Wisconsin may, in the discretion of the Department or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of the Order. The Department may, in addition and/or in the alternative refer any violation of this Order to the Division of Legal Services and Compliance for further investigation and action.
7. This Order is effective on the date of its signing.

WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

By: _____
Aloysius Rohmeyer, Chief Counsel
On Behalf of the Department

_____ Date