WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
KWESI K. GRANT-ACQUAH, M.D., RESPONDENT.	:	ORDER 0008308

Division of Legal Services and Compliance Case Nos. 20 MED 171 and 20 MED 415

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

Kwesi K. Grant-Acquah, M.D.
Wauwatosa, WI 53222

Wisconsin Medical Examining Board
P.O. Box 8366
Madison, WI 53708-f8366

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 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. Kwesi K. Grant-Acquah, M.D. (Respondent), (Year of Birth 1977) is licensed in the state of Wisconsin to practice medicine and surgery, having license number 64548-20, first issued on September 9, 2015 with registration current through October 31, 2023. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is in Wauwatosa, Wisconsin 53222.

2. Respondent was previously ordered remedial education by the Board (Order No. 0005962) on November 14, 2018 for failing to appropriately document patient diagnoses and prescriptions for controlled substances.

3. At all times relevant to this proceeding, Respondent practiced as a physician with a specialty in internal medicine at a clinic he owned located in Milwaukee, Wisconsin (Clinic).

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4. Respondent was identified by an insurance carrier (Carrier) as excessively using the Medicaid current procedural terminology (CPT) evaluation and management code 99215.[1] Further data review revealed a disproportionate submission of claims by Respondent with the diagnoses of "Chronic Pain Syndrome" and "Unspecified Arthritis, Unspecified Site."

5. The Carrier reported concerns with Respondent's treatment and documentation which included:

a. Documentation did not support the level of care being billed by Respondent who used CPT codes 99214[2] and 99215 for medication refills or random pill counting.

b. Documentation did not indicate which staff member completed patients' pill counts.

c. Documentation lacked notation of patients' pain location and level of pain.

d. Deficiencies in documentation for patient exams.

e. No documentation of other treatment options completed prior to prescribing opioids and other controlled substances to patients.

f. Questionable prescribing practice involving opioids and other controlled substances.

6. During the course of the investigation, patient records were obtained and reviewed in light of the Carrier's concerns and Respondent's previous conduct as addressed in Order 0005962.[3]

7. Patient A was being treated long-term by Respondent with applicable diagnoses including pain in right leg, chronic pain syndrome, chronic pain due to trauma, other chronic postprocedural pain, traumatic arthropathy of right hip, unspecified arthropathy, other intervertebral disc degeneration of the lumbar region, long term (current) use of opiate analgesic, and unspecified, uncomplicated opioid use. Respondent prescribed oxycodone 15mg to Patient A on a monthly basis.

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[1] Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; or medical decision making of high complexity. Physicians typically spend 40 minutes face to face with the patient.

[2] Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; or medical decision making of moderate complexity. Physicians typically spend 25 minutes face to face with the patient.

[3] Documentation and practices occurring *after* the date of Order 0005962 (November 14, 2018) were evaluated.

a. Despite subjective complaints of back and knee pain, numerous visit notes indicate Patient A's back examination was within normal limits with no documentation that a knee examination was performed. Yet Respondent continued to prescribe oxycodone and other pain medications.

b. From the end of 2018 through 2021, several visit notes include subjective entries which appear to be copied/pasted from visit to visit. These entries include, "Was scheduled for labs but had brief syncopal event during draw," and, "+Pain in left knee x 1-2 months, worsening, worse w/prolonged sitting."

8. Patient B was being treated long-term by Respondent with applicable diagnoses including lumbago with sciatica, lumbosacral intervertebral disc degeneration and displacement, chronic pain syndrome, and opioid use/abuse. Respondent prescribed Percocet 5-325mg, tramadol 50mg, and Lyrica 50mg to Patient B on a monthly basis.

a. On December 5, 2018, Respondent documented Patient B's back examination as unremarkable with normal range of motion of spine with no paraspinal muscle tenderness. Respondent prescribed Percocet, tramadol, and Lyrica to Patient B.

b. On January 2, 2019, Patient B provided oral fluid for a drug screen. Tested panels included illicit drugs, opiates, other drugs, sedatives, synthetic opioids, and antidepressants. At this visit, Respondent documented a back examination indicating decreased passive and active range of motion, bilateral negative straight leg raises, and positive paraspinal tenderness. In the subjective medication list, the only notation is tramadol 50mg every four hours. Respondent prescribed Percocet, tramadol, and Lyrica to Patient B.

c. The "History of Present Illness" sections of the December 5 and January 2 notes read identical, "30-year-old male returns to clinic. He reports a history of low back pain for several years. Patient states earlier in April 2018 he could not get out of bed due to excruciating acute low-back pain with distribution radiation to his back leg, gluteal area. Denied any trauma or injuries. MRI completed JUNE 2018, results dw pt, facet arthropathy DDD and foraminal stenosis.

d. For the December 5 and January 2 notes, Respondent documented in the plan, "Contd tramadol, one tab Q6hrs, prn, IBUPROFEN 800mg TID prn, MRI of L spine results d/w pt, L-5 DDLyrica,D w/foraminal stenosis. Still reported pain on tramadol, Lyrica and IBU, added Percocet 5s TID and monitor, contd PT. Start random pill cts, drug tox at fu.

e. On January 7, 2019, Respondent received the results of Patient B's oral drug screen. The results were negative for all tested substances.

f. On January 29, 2019, Respondent documented Patient B's back examination as unremarkable with normal range of motion of spine with no

paraspinal muscle tenderness. Respondent documented review of Patient B's oral drug screen, noted it was "NQ," ordered additional testing, and documented warning Patient B against inappropriate use of narcotic medications. Respondent prescribed Percocet, tramadol, and Lyrica to Patient B. Patient B provided oral fluid for a drug screen. Tested panels included illicit drugs, opiates, other drugs, sedatives, synthetic opioids, and antidepressants.

g. The "History of Present Illness" section of the January 29 note is wholly identical to the previous December and January notes with the exception of the addition of, "No MRI greater than 2 years."

h. In the January 29 note, the plan language included is identical to the December 5 and January 2 notes with the addition of the noted negative drug screens and narcotic use warning.

i. On February 7, 2019, Respondent received the results of Patient B's oral drug screen. The results were negative for all tested substances.

j. On February 13, 2019, Respondent noted that Patient B has been prescribed medications for chronic pain, that both his January and February drug screens were "NQ," and that Patient B is reporting compliance. Respondent documented Patient B's back examination as unremarkable with normal range of motion of spine with no paraspinal muscle tenderness. Respondent adds, "Noncompliant w/rx, discharged, DRUG TOX NQ X 2, JAN+FEB 2019, pt reported compliance. Pain mgmt referral 2/13/19.

9. Patient C was being treated long-term by Respondent with applicable diagnoses including chronic pain syndrome, unspecified kidney failure, and pain in right knee. Respondent prescribed Percocet 10-325mg Patient C on a monthly basis. In May 2018, the dispensed quantity of the Percocet indicated that Respondent increased Patient C's Percocet from three times a day to four times a day.

a. On December 5, 2018, Patient C's presenting chief complaint is "Pain re-eval." Respondent notes that "Pain is controlled, rated 4/10 after meds, 7/10 prior. Pain is controlled on current rx." Notes related to an objective knee examination include, "chronic pain to right knee Hx of osteophytes," and an extremity exam which reads, "EXT: no edema, some medial right knee peripatellar TTP, ROM intact. EXT: no edema, some medial right knee peripatellar TTP, ROM intact." This notation is duplicated immediately following the first notation. Current medications in this visit note continue to list Percocet at TID while Respondent writes, "Continue with current treatment. Stable on every 6 hour dosing, continue Percocet tens every 6 hours."

b. Since Patient C's April 25, 2018 visit, the notes include an assessment of, "Encounter for screening for malignant neoplasm of colon – Z12.11." The

plan related to this in the December 5 note reads, "referred to GI for colonoscopy earlier in 2018, ROI requested to review med records."

c. On January 28, 2019, the plan for the colon cancer screening reads, "referred to GI for colonoscopy. PSA results pending."

d. On February 12, 2019, Patient C presented for a random pill count. Respondent noted, "Patient has been taking pain meds as per prescription, compliant on pill count today per med monitoring – off 2 pills."

e. On March 6, 2019, Patient C presented with continued complaint of persistent cough. Respondent notes opacities in x-ray obtained two days prior to visit. No abnormalities noted in Respondent's objective examination, yet his assessment indicates localized swelling, mass, and lump of trunk as well as localized enlarged lymph nodes. Respondent to order chest CT scan.

f. On March 25, 2019, Respondent noted that Patient C's chest CT revealed a large right lung mass and adenopathy, and that Patient C needs a bronchoscopy. Pulmonary follow-up scheduled for the following month. Colon screening plan repeats, "referred to GI for colonoscopy. PSA results pending."

g. On April 8, 2019, Patient C presented for a random pill count. Despite being included in several notes before, the subjective history states, "[R]eports a four-day history of right knee pain. He thinks his knee hurts while he was cleaning the floor, was on knees. No history of chronic right knee pain." As noted two months prior, Respondent reported, "Patient has been taking pain meds as per prescription, compliant on pill count today per med monitoring – off 2 pills."

h. In a fasting labs note, dated April 10, 2019, Respondent reported that Patient C's PSA testing had been completed and Patient C would return to the clinic in two weeks to discuss the results.

i. On April 22, 2019, Respondent repeated "referred to GI for colonoscopy. PSA results pending." Contrary to the note from April 10, no PSA results are noted despite the inclusion of other lab results. For "Localized swelling, mass and lump, trunk," Respondent repeats, "LUNG MASS CT CHEST WC MARCH 2019 @ MDI-PULMONARY REFERRAL-already placed fu APRIL 2019, needs bronchoscopy."

j. At Patient C's "Gen Med" appointment with Respondent on May 29, 2019, Respondent repeats, "referred to GI for colonoscopy. PSA results pending."

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10. Patient D (male born in 1977) received long-term treatment from Respondent for chronic pain syndrome due to discogenic back problems. Respondent's treatment included prescribing Patient D oxycodone and other monitored medications for pain management. Patient D was required to submit urine drug screen (UDS) tests.

11. On July 15, 2020, Respondent had a telemedicine visit with Patient D. Respondent documented that Patient D's February 2020 drug testing was reviewed as well as his June 5, 2020 results and that Patient D was compliant with treatment. Respondent ordered monthly UDS testing and random pill counts to continue, scheduled Patient D for a repeat UDS, and counseled Patient D regarding his narcotic medications. Respondent renewed Patient D's 30-day prescriptions for oxycodone and pregabalin.

12. On July 27, 2020, Respondent received Patient D's July 16, 2020 UDS results which were negative for oxycodone and metabolites and pregabalin.

13. On August 17, 2020, Respondent had a telemedicine visit with Patient D. Respondent again notes that Patient D's February 2020 drug testing was reviewed and notes that the July 2020 UDS results were nonquantifiable, and that Patient D did not have an explanation for the negative results. Respondent ordered a repeat UDS test and discussed with Patient D that he would be discharged if repeat UDS results demonstrated continued noncompliance with medications and gave Patient D two-week prescriptions for oxycodone and pregabalin.

14. On August 24, 2020, Respondent received Patient D's August 17, 2020 UDS results which were positive for pregabalin but negative for oxycodone and metabolites. A second sample was collected and sent out for testing on August 27, 2020. Respondent received the results from the second sample on August 31, 2020 which were positive for oxycodone and metabolites and pregabalin as well as carboxy-THC and norfentanyl.

15. On September 1 and 29, 2020, Respondent had telemedicine visits with Patient D. Respondent's notes regarding Patient D's chronic pain syndrome, documented drug compliance for treatment, and drug counseling were the same as reflected in the July 15, 2020 records despite the fact that August 17 and 24, 2020 UDS results were inconsistent with Patient D's prescribed medications. Respondent did not discuss the inconsistent UDS results at either visit with Patient D and resumed his monthly pain treatment prescriptions due to his "compliance" with treatment. Respondent renewed Patient D's 30-day oxycodone prescription.

16. On October 6, 2020, Respondent received Patient D's September 29, 2020 UDS results which were negative for oxycodone and metabolites and pregabalin.

17. On October 9, 2020, Respondent had a telemedicine visit with Patient D. Respondent's notes for that visit were identical to the July 15, 2020 records and appear to have been copied and pasted for the previous four visits. Respondent did not document a review of the inconsistent UDS results from September 29, 2020 with Patient D and prescribed a 90-day supply of pregabalin.

18. In sum, UDS results from July 16, 2020, August 17, 2020, August 27, 2020, and September 29, 2020 were inconsistent with Patient D's prescribed medications as either negative for the controlled substances that he was prescribed, or positive for illicit drugs. Yet on July 15, 2020, September 1, 2020, September 28, 2020, and October 28, 2020, Respondent prescribed Patient D 30-day supplies of oxycodone 15mg. On August 17, 2020, Respondent prescribed Patient D a 15-day supply of oxycodone 15mg. On July 16, 2020, August 17, 2020, and September 1, 2020 Respondent prescribed Patient D 30-day supplies of pregabalin. On October 9, 2020, Respondent prescribed Patient D a 90-day supply of pregabalin.

19. On October 28, 2020, Respondent reviewed Patient D's past four inconsistent UDS results with him during a telemedicine visit. Respondent informed Patient D that he was noncompliant with treatment in August and September 2020 and was positive for norfentanyl. Respondent alleged that Patient D became "aggressive, loud, and belligerent" when informed of the UDS results while an unidentified third party on Patient D's end of the call threatened Respondent. At the conclusion of the call, Respondent banned Patient D from his clinic and provided him with prescriptions for a 30-day supply of oxycodone, a 90-day supply for pregabalin, a prescription for lucemyra, and a referral for pain management.

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

CONCLUSIONS OF LAW

1. The 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 engaged in unprofessional conduct including direct patient care violations by failing to conform to the standard of minimally competent medical practice which creates an unacceptable risk of harm to a patient or the public whether or not the act or omission resulted in actual harm to any person within the meaning of Wis. Admin. Code § Med 10.03(2)(b).

3. By the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct including direct patient care violations by prescribing, ordering, dispensing, administering, supplying, selling, giving, or obtaining any prescription medication in any manner that is inconsistent with the standard of minimal competence within the meaning of Wis. Admin. Code § Med 10.03(2)(c).

4. By the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct by failing to establish and maintain timely patient health care records, including records of prescription orders, within the meaning of Wis. Admin. Code § Med 10.03(3)(e).

5. As a result of the above conduct, Respondent is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

1. The attached Stipulation is accepted.

2. Respondent is REPRIMANDED.

3. Respondent's license and registration to practice medicine and surgery in the state of Wisconsin (license no. 64548-20), is LIMITED as follows:

   a. Within ninety (90) days of the date of this Order, Respondent shall, at his own expense, successfully complete twenty (20) hours of education on the topic of responsible opioid prescribing and eight (8) hours of education on the topic of evaluation and treatment documentation offered by a provider pre-approved by the Board's monitoring liaison, including taking and passing any exam offered for the courses.

   b. 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.

   c. 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.

   d. This limitation shall be removed from Respondent's license and registration after satisfying the Board or its designee that Respondent has successfully completed all the ordered education.

4. Within ninety (90) days from the date of this Order, Respondent shall pay COSTS of this matter in the amount of $3,334.00.

5. Any requests, petitions, payments of costs (made payable to Department of Safety and Professional Services), and other information required by this Order shall be submitted to:

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.

6. In the event Respondent violates any term of this Order, Respondent's license and registration (no. 64548-20), or Respondent's right to renew his license and registration, 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.

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

WISCONSIN MEDICAL EXAMINING BOARD

By: Sheldon A. Wasserman, MD — 12/21/22

A Member of the Board — Date

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
KWESI K. GRANT-ACQUAH, M.D., RESPONDENT.	:	ORDER 0008308

Division of Legal Services and Compliance Case Nos. 20 MED 171 and 20 MED 415

Kwesi K. Grant-Acquah, M.D. (Respondent) 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 James H. Hall, Jr.

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.

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 or Respondent's attorney, 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. Respondent is further informed that should the Board adopt this Stipulation, the Board's Final Decision and Order will be reported as required by the National Practitioner Databank (NPDB) Guidebook and as otherwise required by any licensure compact or any other state or federal law.

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

_____ _____

Kwesi K. Grant-Acquah, M.D., Respondent
Wauwatosa, WI 53222
License No. 64548-20

Date

_____ _____

James H. Hall, Jr., Attorney for Respondent
Hall Burce & Olson, S.C.
759 N. Milwaukee St., Ste. 410
Milwaukee, WI 53202-3795

Date

_____ _____

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

Date

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 or Respondent's attorney, 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. Respondent is further informed that should the Board adopt this Stipulation, the Board's Final Decision and Order will be reported as required by the National Practitioner Databank (NPDB) Guidebook and as otherwise required by any licensure compact or any other state or federal law.

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

Kwesi K. Grant-Acquah, M.D., Respondent — Date: 11/25/22
Wauwatosa, WI 53222
License No. 64548-20

James H. Hall, Jr., Attorney for Respondent — Date: 11/25/22
Hall Burce & Olson, S.C.
759 N. Milwaukee St., Ste. 410
Milwaukee, WI 53202-3795

Lesley McKinney, Prosecuting Attorney — Date: 11/28/2022
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190