

BEFORE THE BOARD OF MEDICAL EXAMINERS  
STATE OF MONTANA

IN THE MATTER OF CASE NO. 2013-MED-LIC-372 REGARDING:

THE PROPOSED DISCIPLINARY	)	Case No. 190-2014
TREATMENT OF THE LICENSE OF	)	
MARK IBSEN, M.D.,	)	<b>FINDINGS OF FACT;</b>
Medical Doctor, License No. 7378.	)	<b>CONCLUSIONS OF LAW; AND</b>
	)	<b>PROPOSED ORDER</b>

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**I. INTRODUCTION**

On July 9, 2013, the Montana Board of Medical Examiners (BOME) issued a Notice of Proposed Board Action and Opportunity for Hearing regarding the medical license of Mark Ibsen, M.D. The matter was assigned Case No. 2013-MED-LIC-372. On July 26, 2013, Dr. Ibsen requested a hearing on the proposed board action. The case was subsequently transferred to the department's Hearings Bureau (now the Office of Administrative Hearings) on July 31, 2013 and was assigned Case No. 190-2014. A notice of hearing and telephone conference was issued on August 5, 2013. On August 20, 2013, a scheduling conference occurred with Michael Fanning, agency legal counsel, representing the Department of Labor and Industry's Business Standards Division, and John Doubek, attorney at law, representing Dr. Ibsen. At that time, the hearing in the herein matter was set for January 21-22, 2014.

On December 9, 2013, the department's counsel filed a Motion to Continue and to Vacate Trial based on his belief that a settlement of the matter was probable and that additional time to complete negotiations was necessary. Subsequent negotiations were not fruitful and the parties agreed to hold a one-day hearing on June 23, 2014.

On May 29, 2014, department counsel again moved to add additional time to the hearing. After a conference with the parties, the matter was rescheduled for October 21-22, 2014. The case was also transferred to Hearing Officer David Scrimm at that time.

A contested case hearing began on October 21, 2014. Dr. Ibsen was represented by John Doubek, attorney at law, and the department was represented by Michael L. Fanning.

On October 21, 2014, the hearing officer determined that due to the late submission of some of the Licensee's exhibits, testimony relying on those exhibits would have to be taken after the department and its expert witnesses had sufficient time to review them. On October 22, 2014, the hearing officer convened a telephone conference with the parties to schedule the hearing of the remaining testimony in this matter. The parties agreed to hold the continued hearing on December 3-4, 2014.

At the October 21-22, 2014 hearing, Sarah Damm, Wendy Hall, Kathy Dunks, Natalie McGillen, Ellen Stinar, Lisa Weinreich, LaVelle Potter, Jeremy Otteson, Pharm.D., Alisha Tuss, and Robert Gardipee, Pharm.D., presented sworn testimony.

At the December 3-4, 2014 hearing, Ian Marquand, Amber Carpenter, Michael Ramirez, N. Camden Kneeland, M.D., Starla Blank, Pharm.D., Jean-Pierre Pujol, M.D., Patients No. 3, No. 4, and No. 5, Witness FR, Mark Ibsen, M.D., and Charles Anderson, M.D., presented sworn testimony.

The testimony of Sarah Damm is given less weight because her motivations for bringing the complaint against Dr. Ibsen were guided more by a personal interest than a legitimate interest in protecting the public welfare. The testimony of Jeremy Otteson, Pharm.D., is given less weight as it was primarily offered to support a contention that Dr. Ibsen had mental health issues that were never proved. Similarly, the testimony of Robert Gardipee is given less weight because it was also offered to support the contention that Dr. Ibsen had mental health issues that would require him to be treated. The testimony of Michael Ramirez is given no weight as it was offered solely for the contention that Dr. Ibsen had mental health issues that needed to be addressed by the Board. This contention was not proved. As described below, the testimony of Charles Anderson is given less weight in those instances where his opinion relied on his review of the separate records. His general opinions based on the totality of Dr. Ibsen's records and practice are given full weight. Department's Exhibits 1-9, 11-14, 15, 16-18, 19, 20, 21, 22, 23, 28-1 to 28-9, 29, 30, and 31 and Licensee's Exhibits J and L1-9 were admitted into the evidentiary record. Exhibits 1-9, 12, 13, 15, 16, 17, 18, 19, 20, 22, 23, and L1-L9 are sealed because the privacy interests in the medical records of the patients and Dr. Ibsen outweigh the public's right to know.

## II. ISSUE

The issue in this matter is whether the Montana Board of Medical Examiners should sanction the medical license of Dr. Mark Ibsen for unprofessional conduct related to his prescribing practices for opioid pain medications, his failure to provide

adequate monitoring (referrals), and his failure to meet the standard of care for patient recordkeeping.

### III. FINDINGS OF FACT

The department submitted 156 proposed findings of fact and Dr. Ibsen submitted none that were specifically enumerated. Those findings not included herein are specifically rejected as repetitive, mere citations of testimony, or irrelevant to a determination of whether Dr. Ibsen should be disciplined. Mont. Code Ann. § 2-4-623(4) does not require a separate, express ruling on each proposed finding of a party, as long as the agency's decision and order on such party's proposed findings are clear. *Montana Consumer Counsel v. Public Serv. Comm'n*, 168 Mont. 180, 192-193, 541 P.2d 770, 777 (1975) (citing *National Labor Rel. Bd. v. State Center Warehouse & C. S. Co.*, 9 Cir., 193 F.2d 156; *American President Lines, Ltd. v. N. L. R. B.*, 9 Cir., 340 F.2d 490).

In addition, some findings of fact are the same or similar to those proposed by the parties. The Montana Supreme Court has ruled that findings of fact which are "sufficiently comprehensive and pertinent to the issues to provide a basis for decision, and which are supported by the evidence," is not prejudicial merely because the court followed proposals of counsel. *Donnes v. State*, 206 Mont. 530, 538 (Mont. 1983) (citing *In Re the Marriage of Parenteau*, 204 Mont., 664 P. 2d 900, 903 (1983)).

#### A. Chronic Pain and the Use and Abuse of Opioids and Weaning

1. This case centers around Dr. Ibsen's treatment of nine patients suffering from chronic pain at his clinic called Urgent Care Plus in Helena, Montana. At all times material to this matter, and up to the present, Dr. Ibsen has been a physician licensed by the Montana Board of Medical Examiners (BOME). The Screening Panel alleges that with respect to only five of those nine patients,<sup>1</sup> Dr. Ibsen overprescribed pain medications; failed to provide adequate monitoring (referrals); and did not meet the standard of care for patient recordkeeping.

2. Chronic pain and acute pain are often distinguished by their duration, but a better definition of chronic pain is that which persists beyond the period that one would expect healing to have occurred, whereas acute pain is short-term pain. Tr. 396, 671.

3. Chronic pain treatment in the United States has evolved significantly over the last 15-20 years. Tr. 397. In 1997, Dr. Russell Portenoy published a paper

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<sup>1</sup> Which of the five patients the Screening Panel reviewed is unknown.

about a small group of patients he treated with opioid pain medications. Opioids had previously been almost entirely reserved for cancer pain. Dr. Portenoy's data demonstrated that those patients did fairly well over a short period of time. He postulated that prescription of opioid pain medication was a reasonable way to treat chronic pain. Thereafter, medical practice and thinking progressed to a much more heightened awareness of pain and actual treatment of pain. Pain became the fifth vital sign. Regulatory and accreditation agencies started advocating for patients and surveying health systems for appropriate pain management. This shifted the pendulum (or "standard of care") and pain treatment using opioids greatly increased. Tr. 661:5-22. Aggressive marketing by the manufacturers also contributed to the rise in use and acceptance of opioid pain medications. Tr. 396-97.

4. In the last ten years as the treatment of chronic pain became a specialty, there were more studies of both treatment modalities and outcomes for patients with chronic pain. The studies found that long-term treatment with opioids did not work well for the majority of people and involved significant risks. The medical community also began to see that chronic pain had a significant mental and behavioral health component. Most recently the biggest change in chronic pain research has been a focus on how the brain processes pain, how pathways of pain develop, and to address those processes and developments from a central standpoint. If pain persists, it wears a pathway in the nervous system, called the neuroplasticity system. If pain isn't addressed, then that pain itself becomes a separate problem.

5. The standard of care usually shifts over time, but can sometimes shift immediately. When a persuasive new study comes out, it can become the standard of care immediately. No such study was cited by the witnesses in this case. Chronic opioid users also face higher rates of depression, leading to decreased activity and decreased productivity compared to control groups. Tr. 662:10-16. The experience of pain in patients who have those diagnoses is very different than those without those conditions. Tr. 398:1-9. The United States consumes 75 percent of the world's opioid medications and 95 percent of its Hydrocodone. Tr. 663.

6. Common opioids include Morphine, Hydromorphone (Dilaudid), Hydrocodone (Lortab, Norco, Vicodin), Oxycodone (Percocet, Oxycontin), Morphone, and Fentanyl. Tr. 393-394.

7. Under the federal scheduling system adopted in Montana, drugs are classified based on their relative danger and their potential for diversion and abuse. Mont. Code Ann. § 50-32-201.

8. Opioid medications pose a risk to patients and to the public who may acquire them. Those risks include death, overdose, addiction, and impairment.

Studies indicate that 20 to 30 percent of patients who receive long-term opioid therapy will ultimately be diagnosed with addiction. Tr. 400:2-5, 13-17. Organ damage is not quite as common as most people think and most of these medications are relatively safe in terms of organ function. Tr. 403:1-4.

9. Montana, like the rest of the United States, has seen a rise in diversion of pharmaceuticals to abuse and to illicit trade. Tr. 216. The term drug “diversion” refers to prescription drugs falling into the hands of one other than the person to whom it was prescribed. Prescription drug “abuse” is the use of the medicine for something outside of its intended purpose. Tr. 402.

10. In response to this problem, the Attorney General’s office formed a task force with a dedicated prosecutor and has implemented a drug take-back program to prevent diversion of unused pain medications. Tr. 666. The United States Drug Enforcement Agency (DEA) created Tactical Diversion Squads to concentrate on pharmaceutical abuse. Tr. 216-17. With the leadership of then Attorney General Bullock and others, the Montana Legislature created the Montana Prescription Drug Registry (MPDR) in 2011 and it launched in late December 2012. Tr. 667:20 to 668:2. After registering and training, Dr. Ibsen and other physicians at Urgent Care Plus (UCP) began using it in February 2013. The complaint in this matter was filed just one month later.

11. The MPDR gathers records from pharmacies on all aspects of controlled substance prescriptions filled in Montana: patient’s name, prescriber’s name, type of drug and strength, quantity, days’ supply, method of payment, etc. Tr. 668:7-16. By reviewing that information, a physician or a pharmacist can see if a patient is seeking drugs from multiple doctors; if they are compliant with a treatment regimen; or if the patient’s insurance has refused payment for an early refill. Tr. 668-69.

12. Montana requires pharmacies to submit prescription data to the MPDR, but does not require doctors to study the records available to them. Tr. 669:23 to 670:11. When the complaint in this matter was filed, Dr. Ibsen had not yet become a regular user of the MPDR. In 2014, Dr. Ibsen adopted the use of the MPDR as UCP’s standard of practice. Of the 2677 pages of patient records in Exhibits L-1 to L-9, 87 percent were created prior to the adoption of the use of the MPDR.<sup>2</sup> See Attachment A. The patient with the most records created after this date, Number 5, was the one with the most urinalyses conducted.

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<sup>2</sup> The hearing officer selected the date of January 1, 2013 as the beginning date because the MPDR was activated “at the end of 2012.” Tr. 668:1-2.

13. Proper use of opioids starts with the prescribing physician who has a duty to educate the patients about the potential risks and benefits of treatment, but pharmacists, patients, law enforcement, and licensing agencies all have a role. Tr. 405. Federal law declares that a doctor prescribing opioids may only write a prescription for a legitimate medical purpose in the usual course of practice. Tr. 219-20. All of Dr. Ibsen's prescriptions were for legitimate medical purposes. Pharmacists have a corresponding duty to dispense only legitimate prescriptions. Tr. 220. There is no expressed definition of a legitimate prescription, leaving latitude for professional judgment. Tr. 220. When a doctor writes a prescription for what he believes is a legitimate medical purpose and a pharmacist questions whether it is a legitimate prescription, conflicts can arise.

14. A multidisciplinary approach to chronic pain management is extremely common and widely recommended. Tr. 410. These disciplines may include: mental and behavioral health, psychology, psychiatry, counseling, physical therapy, chiropractic, massage, interventional therapy such as injections, etc. Dr. Kneeland, the department's expert witness, operates his clinic on an interdisciplinary model with these practitioners in one location. More commonly, physicians may use a referral model with the primary physician referring out to other professionals in the locale. Tr. 410-11. There are no multidisciplinary pain clinics in Helena, Montana.

15. Dr. Ibsen's patient records indicate that he uses all these other disciplines in his practice, but he refers his patients to them as opposed to Dr. Kneeland's unique situation of having eight specialties under one roof.

16. Dr. Ibsen referred patients to Landmark Forum, a program designed to transform peoples' lives by helping them create a powerful life full of self-expression, joy, and access to power. Tr. 627. Patient 4 found the program helpful. Tr. 527. Patient 3 believed it would be beneficial "so [she] would not be on a lot of narcotics as [her] only solution." Tr. 556. Dr. Kneeland testified that it was multidisciplinary because it uses something other than traditional medical treatment, but that it was not an accepted alternative for chronic pain treatment based on published evidence. Tr. 455.

17. The medical community is hosting educational programs about swinging the pendulum back the other way in regard to the lack of effectiveness of long-term treatment of chronic pain with opioids, educating patients about the dangers of opioids, educating patients about alternatives to medications. A lot more remains to be done. Tr. 667:1-10.

18. Despite new approaches, the swing in the pendulum regarding the long-term use of opioids for chronic pain management has not resulted in their

discontinuance, even modern multi-faceted pain clinics rely heavily on them. Many physicians prescribing long-term opioids require their patients to sign a pain contract before they will be treated. These contracts call for periodic drug screenings, pill counts, single providers, and single pharmacies to prevent “doctor shopping” to secure multiple prescriptions and careful patient counseling on risks. Tr. 221-23. Dr. Ibsen’s patients testified that he formed verbal agreements to limit their prescriptions of pain medications to him and to using one pharmacy. Their MPDR records are consistent with their testimony.

19. Pain contracts serve multiple purposes: to inform the patient about the risks of opioid medicines; to monitor their use of the drugs; and to prevent them from diverting the drugs to others. Certain patient behaviors can indicate abuse or diversion of pain medications including demanding early refills or claiming to have run out or to have lost their prescription. Tr. 223-24. Other such “red flags” are patients bypassing local providers and traveling great distances to see a particular physician, and multiple members of a single family with common pain complaints and demands for similar pain medications. Tr. 224-25. Under federal law, physicians have a duty to assure that a patient is not abusing or diverting a pain medication. Tr. 225.

20. Longer-acting opioids are preferred in a chronic pain setting, because the patient has fewer lows and highs resulting in more even pain management. Tr. 676:13-21. Some patients with chronic pain will require opioids on a permanent basis in order to improve their overall level of function. Doctors treating chronic pain patients want them to be able to work, to interact with their family, to have a social life, to “have a life.” Tr. 765-766.

21. At UCP, Dr. Ibsen typically prescribed opioids for the treatment of chronic pain. Dr. Ibsen often looks for alternatives to opioids such as heat, ice, elevation, other medications. Tr. 685:1-5. Sometimes he will use those alternatives in combination with an opioid. Id. Dr. Ibsen also frequently prescribed Tramadol and Ultram as non-narcotic alternatives to opioids.

## **B. Urgent Care Plus and Dr. Ibsen Treatment Standards**

22. Dr. Ibsen opened UCP on January 2nd of 2010. Adjacent to UCP and located in the same building is Natural Medicine Plus. Each business is separately owned and provides the “plus” for the other. Tr. 633:11-20. Urgent Care Plus is not a multidisciplinary pain clinic, but Dr. Ibsen is not prevented from treating patients with chronic pain.

23. UCP does not have the panoply of services offered by multidisciplinary pain clinics such as Dr. Kneeland's, but does offer on-site ultrasound imaging and chiropractic care. UPC also had Natural Care Plus and a physical therapist located in the same building to provide alternative therapies, which were prescribed for Patients 1 to 9.

24. When patients go to UCP, they are registered, taken through a vital sign station, then taken to an examination room and evaluated by one of the medical assisting staff. There are protocols to follow in each case. If somebody has a problem urinating, they'll get a urinalysis before they see Dr. Ibsen. UCP tries to keep the workflow moving because as an urgent care facility, one of the measures of patient satisfaction is how long the wait is and how long it takes to get in and out. When Dr. Ibsen reaches the room the patient is in, he introduces himself and says, "I'm Dr. Ibsen. How can I serve you?" Tr. 806:1-25.

25. UCP employs internal policies that are consistent with the Substance Abuse and Mental Health Services Administration policies. UCP frequently uses the MPDR. Tr. 808. Dr. Ibsen and his staff began using the MPDR in cases where they didn't know where someone was coming from or whether they had seen a previous practitioner. Shortly after initiating his use of the MPDR, Dr. Ibsen found it to be such a great tool that he instituted a policy requiring that he and others use it in almost every case. Tr. 809.

26. In 2013, the UCP staff wanted a systematic guide for pain patients. In response, Dr. Ibsen instituted the use of the Pain Resource Guide (PRG). The PRG is a five-page booklet of resources that are available for people in Helena who are in pain. Dr. Ibsen would go through the guide with acute pain and chronic pain patients that had not had previous discussions about pain management with other providers. Dr. Ibsen would use it as a point of his discussion about pain with the patient. Tr. 809-810, Ex. J.

27. When Dr. Ibsen begins his examination of a patient suffering from pain, he seeks to locate the pain generator; to determine how long they have had the pain; what they've previously been treated for; what are they doing already; what has worked; what hasn't; why they are there; and whether they were fired by another doctor and why. Most, if not all, of his chronic pain patients have been on pain medication before. He generally does not initiate pain medications for a chronic pain patient. Most of the nine patients at issue in this matter had seen other providers prior to seeing Dr. Ibsen for the first time. When a new patient who has been on pain medications prescribed by another doctor came into UCP, Dr. Ibsen would consult the MPDR; obtain records from the former physician; or do a urine drug screen to see if there are any opioids in their urine. Prior to the creation of the

MPDR, he would get the old records from the previous provider. Those would generally become part of the patient's records at UCP.

28. Dr. Ibsen conducts a full physical examination paired with a history. Eighty percent of his diagnosis comes from the history. A lot of these patients are upset so Dr. Ibsen spends a significant amount of time listening to address their upset, and then he conducts a physical examination of the area(s) that are the source of the patient's complaint. Sometimes a diagnostic study or a lab test would also be conducted. Patients 1 to 9 were often referred to other physicians for MRIs, CAT scans, CT scans, psychiatric issues, and physical therapy. The medical records, and to a greater degree the patient's testimony, indicate that the time Dr. Ibsen spends with his patients frequently includes counseling that other doctors might refer out.

29. After the initial visit, Dr. Ibsen continues to take a history and conduct a physical examination. The physical examination and history taking may be somewhat more abbreviated than that initial visit depending on what the patient is saying. If they state "I fell down the stairs and I injured my knee," Dr. Ibsen focuses on the knee. If they said "it's my usual neck pain," he focuses on the neck. Dr. Ibsen frequently spends a great deal of time with patients for which his staff gives him a lot of flack. At other times, when there are ten patients to be seen, Dr. Ibsen cannot spend an hour with any particular patient in order to be able to see them all.

30. Dr. Ibsen uses the standard Subjective, Objective, Analytical, and Plan (SOAP) notes. See e.g. Ex. L-1:675-685. UCP uses forms created by Practice Velocity to record general history, medication list, prior history, family history, and review of systems. Tr. 842:8-25. The UCP form will ask the patient a series of questions to determine what the main problem is; date of onset and location; what medications have been taken; when the last dose was taken; pain level and location; whether it's related to a motor vehicle injury; or whether it is work-related. The patient is also asked about other chronic active conditions; what medications they are taking; previous surgeries; allergies; family history; tobacco and alcohol use; and whether street or unprescribed drugs have been taken. Tr. 843. On the right side of the chart, boxes are checked to identify whether the patient has fevers, chills, sweats, fatigue, or weight loss. The form also allows the doctor to know whether any neurologic, eye, skin, or musculoskeletal problems might be present. If one of the boxes is not checked, it wasn't considered. If it's checked negative, it was considered and rejected as a symptom.

31. The subjective part of the form would indicate something like "33-year-old female here complaining of right lower quadrant pain with a hematoma that started on Monday." The nurse signs off on these forms before the doctor sees the patient. Tr. 844.

32. The objective part of the form contains information Dr. Ibsen or his staff find on physical examination. The vital signs are written in. Oxygen saturation is noted. Psychiatric state is indicated by checking either “normal” or “abnormal.” A patient’s mood and affect are considered as are skin conditions such as erythema, cyanosis, ecchymosis, or laceration. The form allows the doctor to write additional notes or sketch diagrams of an injury. The third page of the record indicates the assessment and plan. Tr. 844, Ex. L-6:1833.

33. Dr. Ibsen does not run a pain clinic. His patients are more generally afflicted with sprained ankles, sinus infections, pneumonia, abdominal pain, ectopic pregnancies, coughing, diarrhea, or they’re having pain. Tr. 835.

34. Dr. Ibsen understands that the law forbids doctors from using narcotics as a maintenance therapy for addicted patients. Dr. Ibsen treated the patients at issue in this case for their pain issues. Tr. 915.

35. Dr. Ibsen has prescribed medical marijuana to some of his patients. The form that allows a patient to obtain medical marijuana limits it to one year which is renewable. Dr. Ibsen believes his patients will benefit from the drug/substance for their lifetime so he indicates so on the form he signs. Dr. Ibsen understands that the authorization is only good for one year but wants to be clear that he believes that a longer-term use will be beneficial. His stating so has not resulted in any patient receiving the permit for more than one year. Dr. Ibsen believes that having the patient come back for renewal and describing its efficacy at that time fulfills his monitoring requirements. Tr. 927.

36. Some of Dr. Ibsen’s patients were suspected of fraudulently obtaining dangerous drugs. Tr. 928. Dr. Ibsen has ceased prescribing for patients who appear to be doctor shopping or will only continue if they agree that he will be their sole pain medication prescriber and that they will use only one pharmacy. Tr. 929. He also has a conversation with his patients who come in for an early refill. Depending on the circumstances, he might ask “Why did you use all those pills up in five days?” “Did you fall down the stairs?” “Did you have an increase in pain?” or “Did acute pain come in on top of chronic pain?” Tr. 930:1-25.

37. Using opioids to treat chronic pain is not Dr. Ibsen’s first choice, but some of the alternative therapies for pain are not approved by insurance or insurance wouldn’t pay for them and so opioids are a viable option. Dr. Ibsen also refers patients to Alcoholic’s Anonymous or Narcotics Anonymous as necessary.

38. Dr. Ibsen is a compassionate advocate for his patients. Tr. 233-234. It is very important that he be truthful with his patients and build trust as much as he

can. Trust in his patients is the biggest motivator in making decisions about their care.

39. Dr. Ibsen believes that there a number of “red flags” that he should consider before prescribing opioid medications to his patients. Those include: persons coming from out of town; generalized complaints of pain or muscle pain without objective findings; and evidence of doctor shopping. Tr. 235.

### **C. Patients 1 to 9**

#### Preface

It is unclear to the hearing officer how these nine patients were selected for review by the Board of Medical Examiners, but the hearing officer is concerned that they appear to be selected by Sarah Damm, a former employee of Dr. Ibsen’s, who, due to her discharge from employment, could have decided to cherry pick a group of patients whose records she thought would be most damaging to Dr. Ibsen. Whether they reflect the general standard of care that Dr. Ibsen offers is unknown. Damm worked at UCP from February 2010 to February 2013 which makes the timing of her complaint suspect. If she was so concerned about patient care or drug abuse, why did she wait until after she was discharged? Would she have filed the complaint had she not been discharged?

The hearing officer reviewed over 5000 pages of exhibits and transcripts in this case. Exhibits L1 to L9 accounted for 2677 pages of those documents and were in such disarray<sup>3</sup> it was extremely difficult to track the time line of patient care. The department’s records are in chronological order with the most recent being first.<sup>4</sup>

The hearing officer has focused his findings regarding Patients 1 to 9 on Dr. Ibsen’s prescription of opioids, primarily because the charges against Dr. Ibsen are tied to his prescribing opioids and secondarily because that was the focus of the

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<sup>3</sup> Exhibit L-1 oldest to most recent  
Exhibit L-2 most recent to 2011 then jumps to 2010 then goes to most recent  
Exhibit L-3 most recent to oldest  
Exhibit L-4 oldest to most recent  
Exhibit L-5 oldest to 2011 then jumps to 2013 and back to 2012  
Exhibit L-6 oldest to most recent  
Exhibit L-7 most recent to oldest  
Exhibits L-8 and L-9 oldest to most recent

<sup>4</sup> If the Board considers reviewing these documents, I would suggest having counsel for the doctor come into the Board’s office to put them in better order.

testimony and other evidence in this case. These patients were on other medications some of which were initially prescribed by other doctors prior to seeing Dr. Ibsen and then continued by him after his assessment of the patient. Findings regarding Patient 5 are the result of a page-by-page review of the some 800 documents that make up Patient 5's medical records. The hearing officer focused on Patient 5 because he was one of three former patients to testify and because a very detailed analysis of one patient will provide a reviewing body a better sense of what is in the actual medical records. The detailed analysis also allowed the hearing officer to compare the medical records with the MPDR records and with testimony presented at hearing, and facilitates a better understanding of the complexity of the patients' diagnoses and care.

40. All nine patients suffered from chronic pain or a series of acute episodes of pain. Most if not all of these patients had complex pain issues. Tr. 770. Counsel for the department attempted to show that certain patient treatments did not occur by questioning the patients about their medical records. Counsel had no foundation for the testimony about the patient records because the patients had never seen them before and had no idea what was or should have been in them. No negative inference arose when a witness testified about their treatment and those events were not reflected by the medical records. Their testimony is more reliable about what happened during their visits with Dr. Ibsen and with any other providers they may have seen.

41. Dr. Kneeland did not specifically criticize the care of any of these nine patients. Ms. Blank only specifically criticized the treatment of Patients 1, 3, and 4. Those criticisms are addressed in the findings for each patient. Ms. Blank may have referenced another patient but the record does not clearly establish which patient it was.

### **Patient 1**

42. Patient 1 saw Dr. Ibsen beginning on June 22, 2011 to the present. Ex. L-6. Patient 1 was prescribed Hydrocodone prior to being treated by Dr. Ibsen. Ex. 28-1. The MPDR records indicate some early refills, but her medical records indicate a correlation to her significant pain generators. Patient 1 was almost exclusively prescribed a 7.5 mg dose of Hydrocodone Ibuprofen. Almost all of Patient 1's prescriptions were filled by the Safeway pharmacy and all were paid for by insurance.

43. Patient 1's intake records show that she had eight surgeries prior to seeing Dr. Ibsen and presented with pain in the abdomen and bruising. Over the next few months, Dr. Ibsen treated Patient 1 with a variety of pain medications. She

presented a complex history with previously diagnosed bipolar disorder and lots of medications. Dr. Ibsen's medical records show the date of onset was June 20, 2011, she'd been taking ibuprofen, last dose two hours ago. Pain at a level of six out of ten. The pain radiated downwards. She had a history of MRSA which was not related to a motor vehicle injury and not work-related. Her chronic active condition is identified as bipolar disorder. Patient 1 quit tobacco in 2011. She indicated that she never used alcohol or street or unprescribed drugs. Tr. 842:8-25. Dr. Ibsen noted "ABD, abdomen, and US, ultrasound, in a.m. Check labs. 20 Lortab." Ultrasound done at UCP. Lortab is the brand name for Hydrocodone 5. Her medications included Seroquel and Klonopin. Id.

44. In August 2011, CVS pharmacy called Dr. Ibsen's office to let him know that it believed Patient 1 had been "doctor shopping." Tr. 850-851. At that time, it "would have been difficult" for a physician to detect doctor shopping. Tr. 701:1-5. There were no MPDR records to check. After that call, Dr. Ibsen discussed the issue with Patient 1 who agreed to only use one pharmacy and that Dr. Ibsen would be the only doctor prescribing pain medications. Ex. L-6:1867, Ex. 28-1. Dr. Ibsen also suggested Patient 1 attend the Landmark Forum. In October 2011, Patient 1 informed Dr. Ibsen's office that she believed her brother had stolen some of her Lortab pills. Ex. L-6:1883. Dr. Ibsen would not refill the prescription until the original time for the refill had occurred. Dr. Ibsen contacted the police with regard to the possible theft. In November 2011, Patient 1 was concerned about cholesterol so Dr. Ibsen had a lipid panel run which showed she had elevated levels. Dr. Ibsen discussed the results with Patient 1, but from the records it does not appear that he put Patient 1 on any kind of cholesterol lowering regimen or medication.

45. In early 2012, Patient 1 ran short of pills and told Dr. Ibsen's staff that she wanted to switch to another drug because of concerns about her liver. She also told one of the physician's assistants that she wanted to wean off Seroquel. In April 2012, Patient 1 again expressed a concern about weaning off Seroquel. In May, Dr. Ibsen noted that Patient 1 wanted to wean narcotics and again brought up the Landmark Forum as an alternative therapy. In June, Patient 1 got an early refill but was told to "make them last." That prescription appears to have been refilled properly. In July, Dr. Ibsen told this patient to make the next prescription last until September 1, 2012. On August 21, 2012, Patient 1 sought and was given a refill of Lortab. Tr. 684:5-25.

46. Dr. Ibsen had a conversation with this patient to address her long-term pain. Dr. Ibsen believed her bipolar disorder was her biggest issue for which she was seeing a psychiatrist. As she talked with Dr. Ibsen about her knee, it became clear to him that the surgery hadn't worked well for her and her knee was an ongoing pain generator. Dr. Ibsen gave her several options: continue the pain medication, look

forward to possibly weaning, keeping her functionality up, and taking care of anything that would cause her to fall and could result in another hematoma.

47. Dr. Ibsen did not have a written plan for Patient 1 because he had no intention that this treatment was going to last a long period of time. At the time, when Dr. Ibsen determined that a patient was experiencing chronic pain, he did not employ written pain contracts. He does now. It became clear to Dr. Ibsen that Patient 1 had an awful lot of pain for a hematoma on her abdomen and didn't tolerate pain very well and he was wondering why. Dr. Ibsen believed her opiate treatment needed to be interrupted so he talked with her at length about what would happen if she were to be off them. Tr. 847-848.

48. After the conversation with her about how he was going to address her long-term pain, he gave her a total of 60 Ultram, which is a lower level non-narcotic pain reliever. He gave her enough to last for one month and they agreed that he would be the only doctor treating her pain issues. Tr. 850.

49. Dr. Kneeland testified that Patient 1 was taking 50 percent more pain medications when compared to what Patient 1 was taking when Patient 1 first began seeing Dr. Ibsen. Dr. Kneeland failed to mention that Patient 1's increase in the amount of opioids occurred while she was not Dr. Ibsen's patient. While a patient of Dr. Ibsen, her pain medication dropped from six 7.5 mg Hydrocodone per day to three. Tr. 481:17-25.

## **Patient 2**

50. Patient 2 saw Dr. Ibsen from January 4, 2010 to September 8, 2014. Ex. L-7. Patient 2 was prescribed Hydrocodone prior to being treated by Dr. Ibsen. Ex. 28-2. The MPDR records multiple opioid prescriptions from multiple doctors until December 29, 2012. Because the MPDR was not online until late December 2012, it would be difficult for an individual doctor to discover early refills given by other doctors. Id.

51. On April 12, 2012, Patient 5 filled prescriptions for 180 10 mg Hydrocodone and 54 2 mg Hydromorphone. On May 3, 2012, Patient 2 received 180 of both medications. Kneeland testified that the amount of medication prescribed was excessive. Dr. Ibsen did not issue any of these prescriptions to Patient 2. Ex. 28-2.

52. Patient 2 presented to Dr. Ibsen with multiple issues, including stomach ulcers, depression, and anxiety. She had abdominal cancer, for which she'd had a splenectomy. She had had a hysterectomy, a hernia operation, gallbladder surgery,

two back surgeries, a gastric bypass, and had lost 100 pounds. She was having chronic back pain and planned on seeing a doctor in Los Angeles to have another back procedure. Patient 2 was in a lot of pain. Tr. 854.

53. On December 19, 2012, Dr. Ibsen received notice that St. Peter's Urgent Care considered Patient 2 to be a drug seeker. Thereafter, Dr. Ibsen did not prescribe any opiates to Patient 2 until July 7, 2014. Ex. 28-2. He wrote a total of five pain medication prescriptions for Patient 2 from July to September 2014 and has not prescribed any other medicines since that time. Id.

54. Each prescription that Dr. Ibsen writes is photocopied and faxed, so there is a copy in the chart. Dr. Ibsen does not write down all prescription information in his notes because he keeps a copy of every prescription written as part of the patient's records. Tr. 855.

55. In May 2012, Patient 2 told Dr. Ibsen her son had stolen some of her Hydrocodone. Dr. Ibsen called the police to check out her story and had a urinalysis done. Ex. L-7:2053-2055. Dr. Ibsen talked with Patient 2 at length about weaning multiple times. Patient 2 has many pain generators. Tr. 855.

56. Expert testimony was given that Patient 2 was allergic to acetaminophen but routinely got Lortab or Norco, which is a combination of Hydrocodone and acetaminophen. Tr. 691. Ms. Blank testified that Patient 2 tolerated the acetaminophen, but wondered why the record wasn't corrected. That testimony is in error. Ms. Blank's testimony was offered to show that Dr. Ibsen was prescribing medications to a patient who was allergic to it and putting the patient at risk. However, the documentary record indicates that Ibuprofen was indicated as the allergy more than 30 times and not acetaminophen. There is one record that indicates that the patient was allergic to Percocet and her prescription was changed back to Lortab. The MPDR records also indicate that this patient was prescribed Hydrocodone with acetaminophen by almost all the doctors she saw. Ibuprofen is listed as an allergy in the following parts of Exhibit L-7: 2236, 2242, 2248, 2249, 2255, 2261, 2267, 2268, 2275, 2281, 2304, 2306, and 2350. Anti-inflammatories were listed as an allergy on the following pages: 2313, 2324, 2331, 2336, 2340, 2363, 2370, 2375.

### **Patient 3**

57. Patient 3 has been a patient of Dr. Ibsen's since February 11, 2011. Patient 3 was prescribed Oxycodone prior to being treated by Dr. Ibsen. She had three injury-inducing falls during 2012. Oxycodone side effects include falls.

Dr. Ibsen changed Patient 3 from Oxycodone to Morphine Sulfate after her second fall.

58. Patient 3 initially presented with a laceration on her right fifth finger. Dr. Ibsen treated her laceration and gave her a short supply of opioids. Patient 3 had two previous neck surgeries, two thoracic outlet surgeries, rotator cuff surgery, and two lower back fusions. On May 28, 2012, Patient 3 presented having had back surgery on April 1, 2012, and back pain that radiated into her legs. Dr. Ibsen's notes indicate that she was taking Morphine, Gabapentin, Estrogen, Ambien, and had hardware in her spine. Dr. Ibsen also discovered through his discussions with her that she had had a traumatic brain injury and that she had signs and symptoms of fibromyalgia. Tr. 857. Dr. Ibsen did not put her on a pain contract as she was acutely post-op. Id. He prescribed a bolus of some Prednisone, trying to get her pain under control. Id.

59. Dr. Ibsen conducted a complete physical examination and took a complete history at every visit. Tr. 549:4-14. Dr. Ibsen took a more thorough history than any other physician. Tr. 549:14-22; 550:16-24. Patient 3 testified that Dr. Ibsen "wrote down pretty much everything." Tr. 551:2-3. Dr. Ibsen often made notes about his discussions with the patients for them to take home with them but did not duplicate that information in the patient chart.

60. Patient 3 had to end another doctor's pain contract when she began seeing Dr. Ibsen. Tr. 191. Dr. Ibsen referred her for every sort of alternative modality: "chiropractic, physical therapy, x-rays, MRIs, prolotherapy," – "Everything." Tr. 553:14-17. Dr. Ibsen also suggested swimming and massage but Patient 3's insurance would not cover those modalities. She did receive chiropractic care, physical therapy and natural medicine as referred by Dr. Ibsen and paid for by her insurance carrier. Tr. 686:6-25.

61. Patient 3 believed that Dr. Ibsen had in place a written pain contract for her care, but it was just an oral agreement. Tr. 554:18-21.

62. Patient 3 testified that Dr. Ibsen wanted her off of pain medications and they discussed weaning at every visit. Tr. 555-559. The chart notes do not indicate that weaning was a focus. The charts contain no mention of weaning until September 30, 2011 and October 23, 2011 when they "discussed" weaning and planned to wean. Ex. 3:269, 272. Patient 3 was still prescribed Oxycodone in June the following year. Ex. 3:214. Later, Patient 3 would sometimes leave her appointments upset that Dr. Ibsen would not always provide refills when she wanted. Ex. 3:191. One time she got a rash in response to one of her pain medications and Dr. Ibsen required her to return those pills to him and kept them. Id. Dr. Ibsen

conducted frequent exams and discussed risk factors for medications and read part of the Pain Resource Guide and gave her a copy.

63. Patient 3 visited the emergency department at St. Peter's and had a lab test for low calcium and recommendation from the ER physician to have a Vitamin D level taken and follow up with her primary care provider. The notes from that ER visit were in Dr. Ibsen's records but were not followed up on.

64. Dr. Ibsen helped get Patient 3 off all opioid medications from December 14, 2012 until a recent event required pain medication. Tr. 856.

65. The fact that a patient has decreased their pain medication down to zero and substituted other modalities for taking care of their pain generators does not mean they won't need an opioid pain medication at some other time. Tr. 859. Patient 3 had a tremendous amount of pain generators. Dr. Ibsen considered it a triumph and was proud of her for the work she did to get off pain medications.

#### **Patient 4**

66. Patient 4 saw Dr. Ibsen from June 21, 2010 to March 27, 2013. Other than a psychiatrist Dr. Ibsen recommended, no other doctors prescribed pain medications for Patient 4. Dr. Ibsen's last pain medication, Hydrocodone Acetaminophen 10-325, was issued on February 2, 2013. The MPDR records indicate no early refills. All Patient 4's prescriptions were filled by one of two pharmacies.

67. On cross-examination, Patient 4 repeatedly stated he could not "confirm or deny" the simplest fact. Tr. 529:6; 529:9; 512:15-16; 535:18; 530:8. Patient 4's testimony was uncontrolled and he could not be contained by either attorney or the hearing officer. Tr. 532. Patient 4's testimony is given less weight than that of the other witnesses with regard to his treatment.

68. Patient 4 was on pain medication when he first came to see Dr. Ibsen but over time and with the help of doctors he referred him to was able to minimize the neck pain Patient 4 was having as well as addressing his psychological issues. He also successfully treated him for ADHD. Once Patient 4's psychiatric issues were under control, then his pain issues came to the forefront. Tr. 863. Dr. Ibsen talked with the psychiatrists but did not chart those conversations in Patient 4's medical records. Tr. 864.

69. Patient 4 testified he was taking no pain medications when he first saw Dr. Ibsen for care around June 2010, and did not start pain medications until about

six months later, approximately January 2011. Tr. 536:7-18. Dr. Ibsen first diagnosed him with depression and prescribed antidepressants (Tr. 509:20, 24) and later diagnosed him bipolar. Tr. 510:5-7. Only later did Dr. Ibsen begin prescribing medications for Patient 4's migraine headaches. Tr. 511:1-6.

70. Patient 4's testimony regarding partying and self-medication were some time prior to seeing Dr. Ibsen. Tr. 509:14-16. Patient 4 took no pain medication before seeing Dr. Ibsen, but Patient 4 was later addicted to pain medications and Dr. Ibsen referred him to Dr. Ellis for outpatient addiction care. Tr. 540:12-16. Dr. Ellis believed that Patient 4 should be in a drug rehabilitation facility. Tr. 542:17 to 543:2. Later, Dr. Ellis expelled him from his clinic on suspicion of fraudulently obtaining drugs. Tr. 541-42; Ex. L2 at 857. That suspicion was never proven.

71. After establishing care with Dr. Ibsen, Patient 4's typical visits for psychological and pain issues were typically one hour in duration, during which time Dr. Ibsen would spend a lot of time counseling him. Tr. 515. Other than the fact they occurred, there is very little detail in the documentation of those visits in Patient 4's medical records. See Ex. L-2.

72. Ms. Blank was critical of Dr. Ibsen's treatment of Patient 4 with respect to his prescription of sleep medications. Patient 4 was getting multiple benzodiazepines and chloral hydrate, which is another sedative hypnotic and a controlled substance. Patient 4 was also getting a drug called Zyprexa for sleep. Blank was concerned that while Patient 4 had a diagnosis of bipolar disorder, the prescription would specifically say Zyprexa 10 mg at bedtime as needed for sleep which she found to be an unusual medication to use for sleep. Dr. Ibsen referred Patient 4 to a number of other physicians who worked to stabilize him resulting in a number of prescriptions to help him with his anxiety, bi-polar syndrome, sleep, and other psychological disorders.

73. Blank further opined that benzodiazepine is an appropriate medication to help someone sleep, but taking it and chloral hydrate, another sedative, that's a duplication which can be hazardous and was not effective in this case. Dr. Ibsen referred Patient 4 to several psychiatrists which helped his sleep improve. Tr. 689:1-25.

74. Dr. Ibsen consulted with Dr. Tolleson about Patient 4's psychological issues on July 13, 2010. He initially prescribed chloral hydrate for sleep. Dr. Ibsen referred Patient 4 to a local psychiatrist who diagnosed him as bipolar. Ex. 5:403. Patient 4 followed up with both these doctors. Tr. 383. After a prolotherapy session, Dr. Roush contacted Dr. Ibsen and asked him to change Patient 4's pain medication to Oxycodone. Ex. L-2:334.

75. Patient 4 was diagnosed with ADHD and given amphetamines as a treatment. Ms. Blank did not criticize this prescription.

76. Dr. Ibsen planned to wean Patient 4 off of pain medications but he had a neck-generated headache. Patient 4 also had degenerative changes in his neck and did not want to have surgery. Dr. Ibsen prescribed medical marijuana for him. Dr. Ibsen also sent him to Dr. Roush for prolotherapy. Prolotherapy involves injecting an irritant which becomes its own pain generator. The body's anti-inflammatory cascade kicks in and the ligaments actually tighten up. A significant amount of short-term pain is generated by the inflammatory injection. Once that pain creates an anti-inflammatory response in tightening up the ligaments, they're better. Patient 4 performed exactly as Dr. Ibsen hoped and Patient 4's neck pain issues were resolved and he was able to get off the pain medications. During the months of prolotherapy (May through August 2012), the MPDR records indicate that Dr. Ibsen prescribed more pain medications than he had previously, likely due to the pain caused by the prolotherapy. See L-2:876. The records further indicate that Dr. Ibsen prescribed 90 days worth of Hydrocodone or Oxycodone from March 27, 2012 through August 29, 2012. This does not indicate that Dr. Ibsen was overprescribing opioids to Patient 4. What sticks out more in Patient 4's MPDR records is the 25-day - 300 pill prescription that Dr. Ellis wrote on September 28, 2012. In August 2012, Patient 4 reinjured his back moving furniture in his office. At this same time, Dr. Ibsen began prescribing Fentanyl patches in an attempt to wean the patient off of higher doses of opioids. Tr. 805.

77. Patient 4 was last prescribed Hydrocodone from Dr. Ibsen on February 14, 2013. Tr. 483:1-18. Dr. Ibsen considered getting Patient 4 off of Hydrocodone a success. Tr. 862.

### **Patient 5**

78. Patient 5 saw Dr. Ibsen from February 5, 2011 to April 1, 2013. Patient 5 was prescribed Hydrocodone and Oxycodone prior to being treated by Dr. Ibsen. The MPDR records indicate some early refills, especially between July 24, 2013 and August 30, 2014, a period of time during which she was not being treated by Dr. Ibsen.

79. Patient 5 arguably had the most complicated medical history of these nine patients, and suffered from a number of painful maladies and had a number of surgeries for which she was given pain medications that sometimes overlapped those given by another physician. Most of her prescriptions for pain medication were issued for a period of time of three to six days which may have been related to the fact that she was in the UCP office frequently addressing her clotting issues related to

the embolism she suffered. There is only one instance of a 30-day pain prescription. Ex. 28-5.

80. Patient 5 first presented at UCP on February 5, 2011 with tooth and jaw pain related to recent tooth removal. Ex. L-1:191. On February 27, 2011, Patient 5 returned with similar complaints. Id.:200. On that same date, the pharmacist at Osco contacted UCP to let them know that they believed Patient 5 was a drug seeker as she had been filling pain pills at other pharmacies. Id.:207.

81. On April 3, 2011, Patient 5 saw Dr. Ibsen due to pain related to another recent tooth removal. The MPDR records indicate that Dr. Ibsen prescribed a five-day supply of 7.5-500 mg Hydrocodone. Ex. 28-5. On August 11, 2011, Patient 5 reported with back spasms. Dr. Ibsen ordered X-rays and a urinalysis. On October 12, 2011, Patient 5 reported her back pain continued and that she believed she had a sinus infection. Dr. Mohr prescribed an antibiotic and Flexeril.

82. On January 31, 2012, Patient 5 reported pain and bleeding four days after having had gynecological surgery in Missoula. Id.:231. Dr. Ibsen ordered a number of tests and referred her to Dr. McMahon for follow-up as he was the surgeon. Id.:232-233. She was prescribed Percocet for the pain. Id. UPC notified the patient of the lab results on February 2, 2012.

83. On March 6, 2012, Patient 5 reported with a broken tooth which apparently was the result of some dental surgery. Id.:241. Dr. Ibsen referred her back to the dentist and prescribed an antibiotic and Norco. Id.:242. On March 15, 2012, Patient 5 returned after having had follow-up oral surgery where the broken tooth was removed. Id.:248. During the surgery, Patient 5's sinus was damaged and repaired. Id.:253. John Dea, an FNP at UCP, prescribed an antibiotic and Percocet and referred the patient to her dentist. Id.:249.

84. On April 3, 2012, Patient 5 reported back to UCP with continued pain in her mouth and indicated that she had been through three courses of antibiotics. Id.:255. John Dea again prescribed an antibiotic and Tramadol and referred her to Dr. Dickson. Id.:262. On April 7, 2012, Dr. Ibsen saw Patient 5 who reported with pain in her sinus. Id.:268. Dr. Ibsen identified a dental fistula and prescribed a series of Rocephin injections, Lortab, yogurt, and probiotics. Patient 5 was referred for a CT scan. Id.:269-270. On April 10, 2012, Patient 5 reported back to UCP with continuing tenderness in her mouth and sinus pain for which she was prescribed Cleocin and Percocet. Id.:278. Patient 5 was also referred to Dr. Pargot, an ENT. Id. The CT scan indicated that healing was starting. Id.:280. UCP reported those results to Patient 5 on April 10, 2012. Id.:283. On April 15, 2012, Patient 5 received another Rocephin injection from Dr. Weinrich, but reported that she had

flushing on her chest, neck, and back and still had pain from the tooth removal. Id.:291. On April 14, 2012, Patient 5 reported back to UCP with continuing pain and to follow up on the CT scan. Id.:284. Dr. Ibsen gave Patient 5 another Rocephin injection and gave her a prescription for Lortab. Id.:285 and 288.

85. On April 14, 2012, St. Peter's Hospital reported that Patient 5 had been seeing them on the days she was not visiting UCP. St. Peter's requested that UCP not prescribe any more narcotics since Patient 5 had been getting them from both clinics. Id.:297-298. Dr. Ibsen did not prescribe any more pain medications to Patient 5 until September 2012. Patient 5 testified that she had a verbal agreement with Dr. Ibsen that only he would prescribe pain medication. The MPDR records support that testimony. Tr. 586, Ex. 28-5. On April 17, 2012, Patient 5 called the UCP office to report that she was "feeling better, Rocephin worked." Id.:289.

86. In May 2012, Patient 5 reported sacro-ileal joint and leg problems. Id.:299. Dr. Ibsen prescribed Prednisone and ice. Id.:301. Dr. Ibsen also prescribed Tramadol which is not a narcotic. Id.:303.

87. On July 10, 2012, Patient 5 reported to UCP with left foot pain after slipping on stairs. Id.:311. Patient 5's foot and toes were X-rayed and she was told to wear hard-soled shoes for a period of time. Id.:313. On July 12, 2012, the county attorney's office served a subpoena for Patient 5's records apparently in connection with the St. Peter's incident. Id.:319-321. At this point in Patient 5's records is a letter dated "May 2012" from an insurance company alerting Dr. Ibsen to the fact that many doctors were prescribing opioids to this patient. Id.:323-325. It is not clear from the record when this letter was received. Patient 5's records do not indicate that Dr. Ibsen had a discussion with his patient about this information. Many of the other doctors prescribing pain medication to Patient 5 were emergency room doctors and dentists and oral surgeons who treated her during this time. The MPDR records (Ex. 28-5) indicate that all Patient 5's pain medications were prescribed in small amounts making it difficult to determine, despite St. Peter's Hospital's letter to the contrary, whether Patient 5 was abusing painkillers or simply in a lot of pain for which the medications were insufficient so she took more per day than originally prescribed.

88. On August 20, 2012, Patient 5 reported right hip and lower back pain and was diagnosed with piriformis syndrome. Id.:326. Dr. Ibsen prescribed physical therapy. Id.:330. On September 4, 2012, Patient 5 reported that she had been unable to see a physical therapist because she was between insurance coverage, as her husband, whose insurance coverage she relied upon, had switched jobs and his new insurance was not yet in effect. Id.:333. Another UCP provider referred Patient 5 to a pain specialist, Dr. Martini. Id.:335. This page of the records also indicates that

NSAIDS were not a good alternative for pain treatment because of her bleeding disorder and that steroids were not a good option either because of mental side effects.

89. On September 7, 2012, Patient 5 reported with stress from the pain. Id.:340. Patient 5 was crying because of the pain and stress. Id.:342. Dr. Pujols prescribed Paxil. On September 14, 2012, Patient 5 sought a stress consult and wanted a liver function panel run because she had recently had an ovarian cyst removed and had had a kidney infection. Dr. Ibsen ordered a number of tests run, including urinalysis. Id.:346-350. The results of those tests are included in the record and were discussed with Patient 5. Id.:353. On September 21, 2012, Patient 5 reported in severe pain and indicated she would be having surgery in October. Id.:358-360. Patient 5 had a hysterectomy on October 4, a few days later she went to St. Peter's Hospital with extreme pain in her chest. St. Peter's attributed the pain to gas. Subsequently, she went to Missoula where it was determined that she was suffering a pulmonary embolism and was hospitalized for two days. Id.:364. On October 16, 2012, Dr. Ibsen ordered a number of tests including a CBC, CHM 14, and urinalysis. Id.:365-371. The urinalysis reported that she had opiates in her urine. Dr. Ibsen prescribed Z-Pak (azithromycin), a powerful antibiotic, and started a series of INR tests related to her embolism and the fact that she was now taking Coumadin designed to address her bleeding issues. Id. At this visit Patient 5 also stated she wanted narcotics without Tylenol. Id.:366. That same patient record appears to indicate that her liver function tests were "ok." Id.

90. At this point in time, Patient 5 was going to UCP several times a week primarily to check her INR levels and testings. At each visit the nurse would inquire as to why she was there. The frequent visits could be misread to indicate some ulterior motive. On October 18, 2012, Patient 5 reported that she wanted to use "lesser Rx" and to change from Percocet to Lortab, which Dr. Ibsen changed. During an October 18, 2012 appointment with Dr. Ibsen, Patient 5 wanted Percocet (Oxycodone) instead of Lortab (Hydrocodone) because the Lortab was not working as well to control her pain. At this time Patient 5 was taking up to seven 5/325 mg Hydrocodone tablets each day. Ex. 29-5.

91. Because Patient 5 had significant gynecological surgery, Dr. Ibsen worked with her and other providers to develop hormone replacement options. In October, Dr. Ibsen also had a discussion with her about the risks of other thromboses, her treatment, risks to her heart, and the INR testing.

92. On October 23, 2012, Patient 5 reported to UCP that she had been admitted to St. Peter's Hospital with abdominal bleeding. She also requested to return to Percocet instead of Lortab. Dr. Ibsen did so after visiting with the patient.

Ex. L-1:389. Dr. Ibsen ran a number of tests on her including the INR. While at St. Peter's, her liver function was tested and reported normal. Id.:392. Patient 5 received Rocephin shots on October 23, 24, 25, 26, and 27. Id.:404-411. On October 23, 2012, Dr. Ibsen wrote a prescription for a 12-day supply of Percocet that allowed Patient 5 to take up to four pills a day. Ex. L-1:389.

93. On October 28, 2012, Patient 5 reported bleeding and Dr. Ibsen ordered several tests including urinalysis. Dr. Ibsen also followed up on the lab reports that indicated that her kidneys and liver were "ok." Id.:413. He noted a hematoma on her abdomen and performed an ultrasound. Id. He recommended she see Dr. Garrest (sp.) in Missoula the next day. Patient 5 was seen again the next day reporting poor sleep and severe pain. The notes indicate that the pain was post-operative. Id.:421. The notes on page 423 appear to indicate that the patient returned some pain medication and exchanged it for a different prescription.

94. During the next few months, Patient 5 reported to UCP frequently related to her INR levels and for blood draws. On November 1, 2012, Dr. Ibsen indicated the results were perfect. Id.:427. On November 2, 2012, Dr. Ibsen noted that he will provide Patient 5 with Percocet or Lortab and then wean gradually after this prescription. Patient 5's notes indicate that Dr. Ibsen approved her taking her pain medication every four hours instead of six if needed to control pain. Id.:441. Doing so would require early refills. On November 9 and 11, 2012, Patient 5 reported increased abdominal pain, insomnia, depression, and anxiety. Dr. Ibsen prescribed a lower dose Percocet and Lortab at this point. Ex. L-1:462. He also prescribed Provera and Ambien for sleep. On November 27, 2012, Patient 5 talked with another provider at UCP about her low INR levels and her risk for recurrent pulmonary embolisms. He recommended a P.E. study but the patient refused to go to St. Peter's ER. A CT scan of the chest was set up instead at Helena Imaging. The next day Patient 5 reported pain all over including her right hip. She was physically examined and a number of lab tests were administered. Id.:503. By November 28, 2012, Dr. Ibsen reduced Patient 5's prescription to six tablets of the 5/325 mg dosage of the less potent Hydrocodone Acetaminophen. On November 30, 2012, Dr. Ibsen noted that Patient 5 "requests more narcs." Id.:511. Dr. Ibsen increased her dose of Lortab to 10 mg.

95. On December 4, 2012, Patient 5 reported to UCP with abdominal pain and back spasms. Id.:516. The provider suggested she go to the ER for an appendicitis evaluation. On December 5, 2012, Patient 5 returned to UCP reporting that she had not gone to the ER and that in addition to the symptoms from the previous day she had "waves of nausea." Id.:522. She also requested Percocet. Id. She received Ultram. Ex. L-1:327. A CBC and urinalysis was ordered by another provider. On December 17, 2012, Patient 5 reported with elevated INR and liver

function levels. Dr. Ibsen ran quite a few tests including a Tylenol level and urinalysis. He also noted he was going to get the patient's records from St. Peter's Hospital. Those records were either not obtained or not placed in the patient's file. Id.:545-548. Patient 5's ALP, ALT, and AST levels were quite high. Patient 5 was prescribed Amoxicillin, Biaxin, and Omeprazole and Lovenax. Id.:551-554. On December 21, 2012, Patient 5 reported with exhaustion, nausea, and with sores on her face and head and lumps on her skull. Dr. Ibsen ran another set of tests and prescribed Septra, Zoltran, and an echocardiogram. Her liver function levels were still elevated, but her Tylenol level was a 10 with the reference level 10-25. Id.:568-580. On December 24, 2012, Dr. Ibsen prescribed a topical treatment for her skin issues. On December 31, 2012, Patient 5 reported with congestion, nausea, and vomiting. Dr. Ibsen ran some additional tests, had her stop some of the other antibiotics, and suggested Pepto-Bismol for the nausea. Id.:595-599. The tests showed her liver function level had improved but were still elevated and that she was positive for H-Pylori.

96. In 2012, Patient 5 had six gynecological surgeries, two failed dental procedures, a pulmonary embolism, and significant infections from two of those surgeries. Dr. Garnaas performed a number of the gynecological surgeries and regularly communicated with Dr. Ibsen regarding her care. Tr. 580. In 2012, Patient 5 may have briefly been off pain medications but given the number of surgeries and the supplies of medications it is difficult to discern. See Ex. 28-5.

97. On January 2, 2013, Patient 5 reported with abdominal pain. Dr. Ibsen ordered a Chem 14, CBC, and urinalysis. At this point her liver function levels were normal except for ALT which was at 53. Dr. Ibsen also ordered a CT scan of her abdomen and pelvis. Id.:612-622. The CT scan indicated all her organs were unremarkable. Id.:624. On January 7, 2013, Patient 5 reported that the pain was better. Id.:626. On January 9, 2013, she reported that she was not feeling well and Dr. Ibsen ran the CBC, Chem 14, INR, D-Dimer, and urinalysis. Id.:632-636. On that same date, Dr. Ibsen noted "Lortab 10 ? Was not working ? What next WEAN." Id.:636. The liver function tests indicated only her AST was high at a level of 40. Id.:639. On January 9, 2013, the results of Patient 5's echocardiogram were reported as showing a dilated right heart. Dr. Ibsen noted "discuss next visit." Id.:649-650. On January 18, 2013, Dr. Ibsen noted "Nice" on a report of Patient 5's INR level that indicated it was at 2.2. On that same date, the UPC staff contacted Patient 5 with the results of her tests and learned that she was feeling better. On January 23, 2013, Patient 5 reported with a panic attack and constant abdominal pain. Dr. Dea ordered a CBC, Chem 14, and urinalysis and to follow up with Dr. Ibsen. He also prescribed Ativan for anxiety. Id.:673. On January 24, 2013, Patient 5 reported with a severe headache. Dr. Ibsen would not refill the Ativan, provided a prescription for Tramadol, and recommended Landmark Forum and Al-Anon/Narc-Anon.

Ex. L-1:676. On January 28, 2013, Patient 5 reported with pain in the abdomen. Dr. Ibsen discussed weaning, seeing Leah Lambert and Phil Robinson. Id.:681. He also mentioned Al-Anon again, although her chart indicates she does not drink alcohol. Id.:680. Dr. Ibsen also noted “want to wean.” Id.:682. He prescribed 5 mg and 10 mg Lortab and noted on the prescription that Patient 5 was to alternate between them in an effort to wean. Id.:685.

98. On February 1, 2013, Patient 5 reported that she wanted to alternate Hydrocodone 7.5 with Ultram, a non-narcotic painkiller also known as Tramadol, and noted that she has been on pain meds more than one year. Id.:688. Patient 5 was prescribed one day’s worth of 7.5 Norco and Ultram. Id.:692. On February 2, 2013, Patient 5 reported for medicine refills and reported traumatic events in her family life. Id.:698. Dr. Ibsen prescribed Tramadol and 10 mg Lortab. On February 5, 2013, Patient 5 reported that she hurt all over, that it hurt to breathe, and that her pain was 8 on a scale of 1 to 10. She was tested for the flu and given a prescription allowing her to take up to four Lortab per day. She had generally been taking two a day previously. Id.:705, Ex. 28-5. On February 8, 2013, Patient 5 reported with dental pain after having had a root canal four days earlier. Id.:715. On February 6, 2013, Dr. Ibsen wrote a prescription for 10 mg Lortab that noted she was to start taking them on February 10, 2013. The prescription was filled on February 8, 2013.

99. On February 7, 2013, Patient 5 called UCP seeking a refill of the 5 mg Lortab to supplement with the 10 mg version. Id.:730. Dr. Ibsen denied the request. Id. On February 11, 2013, Patient 5 called to say the 10 mg Lortab was upsetting her stomach and asked whether she could cut them in half and get a prescription for Tramadol or could another UCP provider give her 7.5 Lortab with low dose of Tylenol. Id.:731. Another provider denied her request because she already had pain medications. Id. On February 13, 2013, Patient 5 reported severe abdominal pain, back pain, sciatica, and for a medication refill. Another provider’s examination noted a good range of motion for her back and heel to toe walk was normal. Id.:733. Dr. Oser refilled her Tramadol. Id.:737. On February 14, 2013, Patient 5 returned with dizziness and for a medicine check. There are no notes other than the intake form. Dr. Ibsen refilled her prescription for 10 mg Lortab. Id.:743. On February 15, 2013, Patient 5 returned and reported that she was concerned about her liver enzymes and “wants to reverify plans.” Id.:744. Dr. Ibsen ordered a Chem 14 panel and apparently ordered a liver panel that Patient 5 cancelled when she went for her INR blood draw at St. Peter’s. Id.:746. He also refilled Lortab at the 7.5 mg dosage effective February 20, 2013. Patient 5 requested four pills per day then to wean to Tramadol. Id.:747. This prescription was filled as ordered. Ex. 28-5. On February 24, 2013, Patient 5 reported pain in her upper right molar and requested

antibiotics. Dr. Ibsen prescribed Z-Pak and filled a six-day supply of Lortab 10 mg for the dental pain.

100. On March 5, 2013, while in for her INR draw, Dr. Ibsen discussed weaning the 10 mg Lortab with her. Id.:774. On March 7, 2013, Patient 5 reported with low back pain. Id.:779. Another provider gave her Prednisone and recommended stretches. Id.:781. On March 8, 2013, Patient 5 called UPC informing them that the Prednisone was making her agitated and mean. She was not provided any other medications. On March 11, 2013, Patient 5 reported with back and abdominal pain. Id.:787. Dr. Ibsen ordered a number of tests including urinalysis. Dr. Ibsen noted he had a long discussion with Patient 5 regarding Narcotics Anonymous, weaning, or 30-day treatment. Id.:789. He also noted “she is not desperate enough to go” and “need for relief is her soul speaking.” Id. The lab results indicated her INR levels had changed dramatically and also that one of her liver enzymes was slightly elevated. Id.:793. On March 14, 2013, Patient 5 was in for her blood draw and spoke to Dr. Ibsen about wanting “relief” from her “discomfort.” Id.:799. Dr. Ibsen again suggested Narcotics Anonymous, Alanon, and Landmark Forum. Id.:800. He also discussed her seeing Phil Robinson and weaning. Id. On March 29, 2013, Dr. Ibsen had another long discussion with Patient 5 about her anxiety, pain management, and weaning. Id.:808. He also noted that he would prescribe Lortab and Tramadol and wean by April 13, 2013. Id.:809. At the same time, Patient 5 had completed her round of Coumadin and INR tests so Dr. Ibsen’s treatment ended at this point. Dr. Ibsen wrote just one more prescription for Patient 5 on April 4, 2014. Since that time, Patient 5 has seen a number of other doctors, none of whom have weaned her from opioids. On April 1, 2013, Dr. Ibsen issued his last pain medication for Patient 5, a four-day supply of 5/325 mg Hydrocodone. Since that time, there has been some fluctuation in the dosage of Hydrocodone Patient 5 received but there has been only one prescription for the more potent Oxycodone, all prescribed by other physicians. Walgreens filled most of Patient 5’s prescriptions and none were ever more than a 10 mg dose.

101. Dr. Ibsen was not able to wean Patient 5 off of pain medications because she wasn’t really in chronic pain, she had a stacked-up series of acute pains. For each surgical procedure she would have post-operative pain that resulted in her surgeon prescribing pain medications as appropriate.

102. Patient 5 obtained in many instances early refills on her Hydrocodone. Dr. Ibsen did not consider them to be early refills because she had a series of acute pains and needed enough pain medication to get relief. Tr. 868. When the prescription was insufficient, the pain was not being relieved. During the month Patient 5 had the pulmonary embolism, she was also recovering from pelvic surgery and she used up over 100 Hydrocodone without getting pain relief and eventually

received Percocet and Hydrocodone in the same month, as an attempt to get her acute pain under control.

103. Patient 5 had pain in her pelvis, pain in her abdomen, pain in her chest, emotional upsets, and was worried about having several life-threatening events in such a short time. Due to these issues, Patient 5 was both in pain and anxious. Dr. Ibsen knew it was important to listen to Patient 5's concerns because every time she had something, she actually had something. She was sick every time she said she was sick.

104. Patient 5 testified, without conflicting evidence, that typical visits lasted one hour or sometimes longer. Tr. 584:13-17. Dr. Ibsen routinely took a history and conducted a physical examination. Tr. 585:6-9. Dr. Ibsen implemented a verbal pain contract with Patient 5. Tr. 586:16-21. The MPDR records support this testimony, as during the time period September 2012 to April 2013, Dr. Ibsen was the only doctor writing pain prescriptions for Patient 5 other than one OB-GYN doctor and one ER doctor.

105. Dr. Ibsen attempted multiple alternative modalities for Patient 5 without success. Tr. 588:12-25.

106. At the trial in December 2014, Patient 5 testified she is not currently on any pain medications. Tr. 590:14-16.

107. After not seeing results with the initial rounds of antibiotics, Dr. Ibsen tried a more broad based antibiotic and Patient 5 got better. Ms. Blank testified that in her opinion the patient got better due to the earlier antibiotics and not due to the later one Dr. Ibsen prescribed. Tr. 712-713.

108. Dr. Kneeland initially testified that based on his calculations from the beginning of treatment to the last MPDR record reviewed, Patient 5's doses of opioids had increased ten percent. However, on cross-examination he did not disagree that when Dr. Ibsen last prescribed Hydrocodone, it was at about half of what he had prescribed over the course of the previous year for that patient. Dr. Kneeland also testified that he noticed that other physicians prescribed more Hydrocodone for Patient 5 than Dr. Ibsen had.

109. Patient 5 had been getting small quantities of pain medications from many other doctors and filling them at different pharmacies but she had so many surgeries and follow-ups to those surgeries that it cannot be found by a preponderance of the evidence that she was doctor shopping.

## **Patient 6**

110. Patient 6 saw Dr. Ibsen from March 31, 2012 to April 16, 2013. Patient 6 was prescribed Oxycodone prior to being treated by Dr. Ibsen. The MPDR records indicate only marginally early refills in March and April 2013, shortly before Dr. Ibsen discontinued Patient 6's treatment. Dr. Ibsen wrote three prescriptions of Oxycodone for Patient 6 in 2012. The highest dose was 10 mg Oxycodone. In 2013, Dr. Ibsen wrote four prescriptions for Patient 6, all for 10 mg Hydrocodone.

111. Dr. Ibsen only saw this patient a few times. Patient 6 had been under the care of Dr. Weinert, who prescribed him as much or more pain medication than Dr. Ibsen. Patient 6 had pain in his low back and needed a medication refill. He was lifting and pushing on heavy objects. He had low back pain, shoulder pain, neuropathy, high blood pressure, hypothyroidism, anxiety, five previous knee surgeries on the right, two previous knee surgeries on the left, and two previous shoulder surgeries. Tr. 871:1-25. Patient 6 was also in the process of having a third shoulder surgery and hernia and sinus surgery. Accordingly, he was under a lot of medications including Gabapentin and Cymbalta. Tr. 871-872.

## **Patient 7**

112. Patient 7 saw Dr. Ibsen from June 24, 2011 to February 21, 2013. Patient 7 was prescribed Hydrocodone prior to being treated by Dr. Ibsen. The MPDR records indicate some early refills. All of Patient 7's prescriptions were filled by CVS pharmacy and all but one was paid for by insurance. Patient 7 reported with pneumonia. He had also recently had a microdiscectomy, but six weeks after surgery, he herniated a disc above it. He was also in a lot of financial difficulty. Tr. 872.

113. Patient 7's MPDR records indicate that at the beginning of his treatment, he was receiving up to four 10 mg Oxycodone tablets per day and at the end of his treatment he was reduced to six 5 mg tablets. Ex. 28-7.

114. Dr. Kneeland opined that Patient 7 weaned 20 percent from the time he started with Dr. Ibsen to the last record he reviewed.

## **Patient 8**

115. Patient 8 saw Dr. Ibsen from February 2011 to May 2014. Patient 8 was prescribed Hydrocodone prior to being treated by Dr. Ibsen. The MPDR records indicate no early refills. Those same records indicate that most of Patient 8's prescriptions were filled by Walgreens pharmacy and all but one were paid for by insurance or Medicare. Patient 8's MPDR records indicate a regular monthly prescription of 10 mg Hydrocodone.

116. Dr. Kneeland opined that other physicians who had treated Patient 8 prescribed at the same or higher levels of Hydrocodone as Dr. Ibsen had.

117. Patient 8 initially had a urinary tract infection. She started coming to UCP because her gastroenterologists would refuse to treat her pain associated with her Crohn's disease. Tr. 873:1-25. None of these gastroenterologists were comfortable giving her ongoing opioids for her pain. Dr. Ibsen tried using Fentanyl patches but it didn't relieve her pain and she felt that it was not lasting the three days. Dr. Ibsen was unwilling to prescribe a higher dosage of Fentanyl. Patient 8 has been maintained as somewhat functional, but is largely disabled by her Crohn's disease. Dr. Ibsen was not able to get her off any opiates, but did not increase her opiates. Tr. 874:1-25.

### **Patient 9**

118. Patient 9 has been a patient of Dr. Ibsen's since November 2010. Patient 9 was prescribed Oxycodone prior to being treated by Dr. Ibsen. The MPDR records indicate no pattern of early refills. All Patient 9's prescriptions were filled by the Kmart pharmacy and all were paid for by insurance or Medicare. Patient 9's MPDR records indicate a regular monthly prescription of 10 mg Hydrocodone.

119. Patient 9's medical records indicate she had two implantable pain pumps removed because of problems with the wiring and decided to go the oral medication route. Her previous doctor had recently died. Patient 9 had a number of complex issues including reflex sympathetic dystrophy, spinal cord stimulator, depression, and ulcers. Patient 9's prescriptions included Percocet, four a day, Cymbalta, the spinal cord stimulator that had stopped functioning, Clonazepam, Ambien, and Flexeril. Tr. 875:1-25. Patient 9 has never been off pain medications due to multiple painful maladies.

120. The MPDR records indicate that Patient 9 has been prescribed primarily 10 mg Oxycodone on a monthly basis since September 2012. Since that same date, with one exception, Dr. Ibsen has been the only doctor prescribing opioids to this patient.

### **D. The Former Christensen Patients, the DEA, and Pharmacists**

121. The department offered testimony regarding an incident involving Dr. Ibsen, one of Dr. Ibsen's patients, the Western Montana Health Center, and an attempt to transfer a medication to the patient. This matter was considered by the BOME and dismissed. Tr. 186. This incident was not offered to show that Dr. Ibsen was overprescribing, inadequately monitored treatment, or that his recordkeeping did not meet the standard of care. It could therefore only have been offered to show that

Dr. Ibsen was mentally unstable and should be sanctioned accordingly. The hearing officer finds no substantial evidence or expert testimony upon which to find that Dr. Ibsen is suffering from a mental illness. Therefore, this testimony and any other evidence of this incident is irrelevant to the recommended decision.

122. The hearing officer also allowed testimony regarding Dr. Ibsen's interaction with two pharmacists after the time the Screening Panel issued its Notice of Proposed Board Action on the basis that testimony about their interactions with Dr. Ibsen might be relevant to a sanction in this matter. Because the hearing officer is not finding that Dr. Ibsen's conduct was so egregious to warrant a sanction related to his communication skills, the hearing officer finds Otteson's testimony irrelevant and has not relied upon it in making his decision.

123. The hearing officer also allowed testimony regarding Dr. Ibsen's treatment of 21 former patients of Dr. Christensen. Because the treatment of those patients is based on a set of unique circumstances described below and unrelated to Dr. Ibsen's normal practice, the hearing officer now finds that testimony irrelevant to the issues in this matter and has not relied upon it for making his recommendation.

124. The tension between Dr. Ibsen and two pharmacists, Gardipee and Otteson, is reflective of national tension between doctors and pharmacists across the country created by the higher scrutiny brought to bear on the relationship, the use of opioid prescriptions, and the fear of prosecution by a licensing board or the DEA. Tr. 267.

125. In April 2014, Dr. Chris Christensen's pain and addiction clinic in Florence, Montana, was shut down by the BOME and the DEA. All of his patient records were seized by state and federal agents. His former patients who had been receiving Methadone and 30 mg doses of Oxycodone, or both, were left without a doctor to care for them. Twenty-one of perhaps 1000 of those patients found their way to Urgent Care Plus and Dr. Ibsen. Tr. 257 and 811.

126. Within a few days of the first former Christensen patient arriving at UCP, the DEA came to visit Dr. Ibsen who was not then available. Ultimately, on May 6, 2014, Dr. Ibsen and his office manager, Ellen Stinar, met with Agent Tuss and Agent Addis to discuss Dr. Ibsen's prescribing practices. The DEA had received reports from local pharmacists that Dr. Ibsen had been prescribing large amounts of opioids to some of Christensen's former patients and had heard that the BOME may be investigating Dr. Ibsen as well.

127. The DEA agents asked about UCP's usual practice style. Tr. 231, 818. Dr. Ibsen told them how people come through the door, how they get processed, how they deal with the varied complaints. Tr. 234. He informed them that he sometimes

refers to other doctors when it's appropriate. *Id.* Dr. Ibsen gave them a tour of UCP and of Natural Medicine Plus so they could see he had an open relationship with a multidisciplinary practice. *Tr.* 232. Dr. Ibsen did not know if the agents went over to see the physical therapy area or not. *Tr.* 814. During the hour and a half meeting, the DEA did not express any criticism of Dr. Ibsen's practice. *Id.* The DEA did not review any records, they didn't ask to see any records, they didn't carry any subpoenas. *Id.* Dr. Ibsen told the agents that he was seeing a few of the Christensen patients. The DEA agents told Dr. Ibsen "you must be careful not to prescribe medications to people who might divert them." *Tr.* 239-240, 816:21, 23. Dr. Ibsen wondered how he would know and the agents responded there are "red flags," and they pointed out the various red flags: traveling a long distance; traveling in a pod or group; having had multiple previous physicians before; asking for particular medications by name; gaming, such as not being able to give a urinalysis if asked; and having beady eyes. *Tr.* 819-820. Dr. Ibsen told the DEA agents that he ensured the patients were not just drug seekers by using the MPDR to see if they were using multiple doctors; that patients had previous medical records; whether they were traveling from out of town; and whether they had subjective pain complaints that could not be confirmed. *Tr.* 236-7. Dr. Ibsen also asked "how should I be managing this, if you have some advice for me" and the [agents] said, "We can't advise you. We're not physicians." *Tr.* 821. The DEA agents also told Dr. Ibsen that the fact he gave them advance notice did not give him "open prescribing for anything that you want, you still have to prescribe within normal limits." *Tr.* 320. The DEA also counseled Dr. Ibsen to "polic[e] his patients." *Tr.* 239.

128. Dr. Ibsen told them about a group of family members who were former Christensen patients who had recently begun seeing him. It concerned Dr. Ibsen due to the possibility that these people could be diverting and he suggested that the DEA might want to look into it. *Tr.* 236-238.

129. At the end of May, Dr. Ibsen called DEA Agent Tuss to let her know about a patient that was apparently doctor shopping and trying to obtain additional pain medication. *Tr.* 240-241. Dr. Ibsen cancelled the prescription he had written. *Id.*

130. The first Christensen patient who sought treatment at UCP was pale and sweaty and started telling Dr. Ibsen his story. *Tr.* 812. He stated that he went to Christensen's office, encountered a closed office with crime scene tape up, tried to make some phone calls and there was no one answering the phones. *Id.* He was out of his medications and having pain and symptoms of withdrawal, including abdominal pain, cramping, sweating, restless legs, and goose flesh. *Id.* Dr. Ibsen felt that his ethical duties required him to see these patients. *Tr.* 813.

131. Each of these patients presented a different condition and each was on a mix of large dosages of short-acting and long-acting opiate, Oxycodone, and Methadone. Tr. 813, Ex. 29. Dr. Ibsen looked up each patient's prescription history on the MPDR. Id.

132. Dr. Ibsen took a history and conducted a physical examination of each of these patients. Tr. 822. Dr. Ibsen was not comfortable prescribing Methadone for chronic pain, so he prescribed the amount of Oxycodone they'd been receiving (30 mg in most cases) and then once he figured out what their needs were, he planned on tapering them. Tr. 823. He told the UCP team "we're going to take some patients on here that are going to be challenging" and asked if they saw another option and they all agreed. Id.

133. Dr. Ibsen was so moved by the situation that he tried to contact the TV stations about the problem to no avail. Tr. 814. The Helena Independent Record ran a series of stories on chronic pain in mid-May and Dr. Ibsen was quoted in one of the stories as weaning patients off opioids. Tr. 296, 300.

#### **E. Robert Gardipee**

134. Bob Gardipee, Pharm.D., is a community pharmacist who has practiced in Helena for 14 years. Tr. 276. Apart from his professional responsibility to assure safe prescribing, Mr. Gardipee is personally concerned by increasing prescription drug abuse and its harm on the local community. Tr. 277. Mr. Gardipee takes seriously his professional and legal duty as the "gatekeeper" to assure that prescriptions are for legitimate medical purposes. Tr. 278-79. Dr. Kneeland testified that all of Dr. Ibsen's prescribed pain medications were for legitimate medical reasons. Tr. 477. DEA standards will not allow a pharmacist to escape culpability for an illegitimate prescription by simply blaming the prescribing doctor and, as the pharmacist in charge at his pharmacy, Mr. Gardipee is responsible for any professional errors. Tr. 280-81. Gardipee is not a physician and was not qualified as an expert regarding physician conduct.

135. Gardipee represents his pharmacy at the Board of Pharmacy meetings. At one meeting, he learned that the DEA had started auditing pharmacies that have increased use of controlled substances, and that the audits took four to six hours to complete. The audits would include looking through invoices and prescription histories to make sure prescribing was legitimate and that there was not possible diversion. Tr. 280. If Walgreens was audited, Gardipee would be the responsible party for his pharmacy. Any allegations of unprofessional conduct or any questions by the DEA would fall on Gardipee's shoulders. Tr. 281.

136. Gardipee read the articles on chronic pain in the newspaper and saw that Dr. Ibsen was quoted as wanting to wean his patients but he believed that Dr. Ibsen was actually increasing doses and granting early refills of pain medications. Tr. 296. Gardipee decided it was his mission to see that Dr. Ibsen's patients were weaned off their medication despite the fact that he was not a doctor and did not understand their needs. Gardipee took it upon himself to contact the other pharmacies in town to tell them that he was no longer going to fill prescriptions that were increased dosages or early refills. Tr. 297. After contacting the pharmacies, he contacted Dr. Ibsen's office and stated that he would only fill prescriptions that were going to be decreases in doses, which he believed was consistent with Dr. Ibsen's statements made in the Independent Record. Id.

137. Gardipee talked to Ellen Stinar and said he would not fill 30 mg Oxycodone prescriptions anymore. Tr. 297, 824. Dr. Ibsen was upset that a pharmacist would involve himself in how he planned to treat a patient and did not hesitate to let Gardipee know that he thought Gardipee should fill the prescription as written. Tr. 821. Dr. Ibsen had talked with other pharmacists over the years when they would ask "Is this the medication you intend to prescribe?" Dr. Ibsen's response was routinely "Yes." Tr. 824. So he didn't hear much from Bob until he said "no" to the 30 mg Oxycodone. Dr. Ibsen was concerned that the patients needed the 30 mg dosage because they were not going to get the Methadone which carried most of the pain relief. For that reason, he allowed some patients to get early refills because the Oxycodone by itself was not initially sufficient. Tr. 824.

138. Dr. Ibsen prescribed the large doses of Oxycodone for a legitimate medical reason - these patients had been receiving a similar dosage of Oxycodone and Methadone from Dr. Christensen. Tr. 476. Without these prescriptions, their pain had returned and Dr. Ibsen provided them with the medication he thought would alleviate their pain.

139. Dr. Ibsen decided to have a meeting with Gardipee and the DEA on June 27, 2014 because: (a) he realized that his communications with Gardipee had not been very professional; (b) Gardipee still wanted to know why Dr. Ibsen was prescribing the high doses of Oxycodone; (c) the DEA was interested in him; and (d) he was in the middle of the investigation that led to this proceeding. Tr. 825-826.

140. Dr. Ibsen wanted to demonstrate that he was actually interested in being proactive about this. Dr. Ibsen understood Gardipee was under pressure from his corporate office because he dispensed more 30 mg Oxycodone than he ever had. Tr. 827. Dr. Ibsen had never written prescriptions for that high a dose of Oxycodone before April 14, 2014, so he thought he, Gardipee, and the DEA should all talk about

it and see if there wasn't some way to come to some agreement that would help address the situation.

141. Gardipee is not an expert or specialist in pain medications or weaning off of them. Tr. 282-283. Gardipee understood that during the weaning process a patient's pain can fluctuate - that it was not necessarily a straight slide down on the weaning scale. Tr. 312. Gardipee knew the effects of taking a patient suffering from chronic pain off of Methadone would be withdrawal and an increase in their pain. Tr. 314.

142. At the June meeting, Gardipee told Dr. Ibsen to have his patients sign a pain contract and that part of the pain contract would be that they need to set up an appointment with a pain specialist and that Dr. Ibsen could treat them until that appointment occurred. Tr. 299-300 (emphasis added). Gardipee further "recommended" that Dr. Ibsen would prescribe decreasing doses consistent with what Gardipee felt was Dr. Ibsen's stated goal in the Independent Record. *Id.* Gardipee found it unusual for patients to be going to an urgent care for chronic pain issues on a weekly to every ten-day basis. Tr. 300.

143. Dr. Ibsen did not institute pain contracts with the former Christensen patients because he did not believe that he would be seeing these patients long-term. The MPDR records confirm that his belief was correct.<sup>5</sup>

144. Gardipee's complaints about not weaning the Christensen patients were premature based on the testimony offered by the state's experts. Dr. Ibsen had not prescribed more than a month's worth of medications before Gardipee believed they should begin weaning. Nonetheless, to alleviate Gardipee's concerns about his own licensure and job, Dr. Ibsen stopped prescribing the 30 mg Oxycodone and substituted 10 mg tablets of Oxycodone albeit with more total pills.

145. Gardipee testified that by September 2014, Dr. Ibsen was prescribing more tablets per day of the lower dosage causing Gardipee again to refuse to fill those prescriptions as announced at the June meeting. Tr. 303-04. If Gardipee was referring to the former Christensen patients, he was mistaken because the MPDR records show otherwise. See Ex. 29. Most of the Christensen patients were not long-term patients of Dr. Ibsen's. Tr. 297-98. Gardipee also testified that many of the former Christensen patients "usually paid by cash." Tr. 292. However, only 20 percent of these patients' prescriptions were paid for with cash, the other nearly

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<sup>5</sup> The MPDR records for three of the 21 patients do not indicate that Christensen prescribed medications for them and only a handful were seeing Dr. Ibsen in November 2014 when Exhibit 29 was created.

80 percent of the prescriptions written by Dr. Ibsen to these patients were paid for by some form of insurance. Ex. 29. Even if Gardipee's testimony was limited to the suspect group from the Great Falls area, the number paying with cash is 23 percent and with insurance is 77 percent (67 out of 87 prescriptions). Ex. 29. Gardipee is not credible in this area of his testimony and it undermines his other testimony.

146. Toward the end of the June 27 meeting, the DEA told Dr. Ibsen "you are not only risking your DEA license by prescribing to these folks, you are risking your freedom." Tr. 829:12-14. This got Dr. Ibsen's attention so he asked "All right. I want to do this right. How can I do it?" Tr. 829:18. The DEA agent responded "I can't tell you. We're not doctors." Id.

147. On July 22, 2014, Dr. Ibsen called Agent Tuss to report that two of his patients had altered pain medication prescriptions to acquire more than ordered. Tr. 248. One had been caught by the pharmacy, the other was not. Dr. Ibsen faxes a copy of the prescription to the pharmacy so that they can compare it to the original given to the patient. Apparently the pharmacy did not compare the prescriptions of the other person. Tr. 249. The DEA appreciated the information, but ultimately the conversation turned negative due to Dr. Ibsen's frustration with DEA's request that he change what he does without any specifics because they were not doctors.

148. Some of these 21 patients presented red flags to Dr. Ibsen so he reported some of them to the Missouri River Task Force. Tr. 816. Others were questioned about possible diversion of their prescriptions. Id. Two of those patients altered their prescriptions. One was filled by Osco and the other person was stopped and the prescription not filled. They were caught because of Dr. Ibsen's fax practice. Tr. 816.

149.<sup>6</sup> All these patients had different diagnoses and not all of the 21 were clearly former Christensen patients. At the time Exhibit 29 was created, it indicates that 14 of these patients reduced the amount of Oxycodone they were taking from the time they first saw Dr. Ibsen until the date of their most recent record that

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<sup>6</sup> In this finding the hearing officer summarizes the treatment of the former Christensen patients for several reasons: first because their treatment was presented at hearing in general terms; and for brevity. Should the BOME find it helpful, the hearing officer did, in the course of drafting this recommended decision, develop findings on each patient that he later determined were unnecessary.

identified him as the prescribing physician.<sup>7</sup> The MPDR records also show that seven stayed on the same dosage for the time Dr. Ibsen treated them. Some of that is due to the fact that Dr. Ibsen saw some of these patients only one time. Based on the records provided and the testimony received, there is a strong correlation between (1) the reduction in total level of opioids taken, (2) longer-term treatment with Dr. Ibsen or another doctor, and (3) the patient possessing commercial insurance. Patients 13, 20, and 21 appear to be doctor shopping. Ultimately, it appears to the hearing officer that based on the very low percentage of successful tapering or weaning that the experts reported - 73 percent being able to reduce their opioid dosage and ten percent who were able to completely eliminate opioid usage - that Dr. Ibsen was doing well with most of these patients. Tr. 496. Reducing a patient's daily opioid use from six 30 mg Oxycodone pills to four 10 mg Oxycodone pills a day is significant.

150. The Screening Panel concluded that with respect to five patients Dr. Ibsen committed unprofessional conduct by prescribing excessive quantities of narcotics, failing to adequately monitor patients with complicated medical conditions requiring follow-up, and failing to properly document patient charts. Since that time, the complaint against Dr. Ibsen has transformed into one involving the treatment of 30 or more patients; much broader allegations of misconduct - general treatment of chronic pain patients; medical marijuana issues; Dr. Ibsen's interactions with other professionals; and his interactions with the Drug Enforcement Agency.

## **F. Expert Witness Testimony and the Standard of Care**

### **A. Expert Witnesses**

151. Ned Camden Kneeland, M.D., testified for the department and was qualified as an physician expert in pain management. Dr. Kneeland is the medical

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<sup>7</sup> Dr. Kneeland's calculation for determining whether Dr. Ibsen's patients had reduced or increased their opioid usage was "from the prescription where it became clear that it was going to be a long-term thing." Tr. 483. Dr. Kneeland did not specifically note when any of these patients reached that beginning point for his calculation. He also at this point in his testimony failed to identify any endpoint for his calculation of what percent of Dr. Ibsen's patients were successfully weaned. He later stated that "I was just comparing when they started with when they finished." Tr. 484. Therefore, the hearing officer gives little weight to Kneeland's testimony on the subject of weaning. The aim of weaning is not necessarily to get a patient to zero opioids but rather "an acceptable level." Tr. 449. Kneeland also testified that three of the nine reduced their total opioid usage and six of the nine increased their total opioid usage from the time chronic opioid therapy was initiated to the final record that I had available in the drug registry. Tr. 451. The difficulty with regard to Dr. Kneeland's testimony on this issue is that the hearing officer does not know when Dr. Kneeland started his comparison or when he ended it. Many of the more recent MPDR records for a particular patient indicate treatment by someone other than Dr. Ibsen.

director for an interdisciplinary pain clinic in Kalispell, Montana. His practice consists primarily of the treatment of chronic pain utilizing multiple modalities. Tr. 389:25 to 390:3. Dr. Kneeland is board certified in both anesthesiology and subspecialty board certified in pain medicine through the American Board of Anesthesiology (Tr. 390:25 to 391:2) and is a member of three physicians' societies focused on pain management. Tr. 391:5-8. Dr. Kneeland is a leader in pain treatment in Montana, serving on the Montana Pain Initiative and the Montana Medical Association's panel on responsible prescribing and prescription drug abuse. Tr. 392. Dr. Kneeland did not offer any specific criticism regarding the treatment of Patients 1 to 9 or the Christensen patients. On cross-examination he did offer opinions on whether Patients 1 to 9 had weaned their opioid usage. As described above, his calculations on weaning were so significantly opaque as to give them no weight. Kneeland's primary testimony concerned the standard of care and changing thinking about the treatment of pain.

152. Starla Blank, Pharm.D., testified as an expert witness in drug therapy management, including pain management and drug therapy for chronic diseases. Tr. 653:17-20, 655:3-4. Ms. Blank has 28 years of experience as a Montana pharmacist, including leadership positions such as serving as the executive director of the Montana Board of Pharmacy and president of the Montana Pharmacy Association where she championed bills that created the Montana Prescription Drug Registry and strengthened the criminal law on fraudulently obtaining dangerous drugs. Tr. 648-50. Ms. Blank was named by then Attorney General Bullock to sit on an advisory group to counsel the Board of Pharmacy regarding the MPDR and was elected chair of that group. Tr. 650. Ms. Blank's professional experience includes serving on a multidisciplinary group at St. Peter's Hospital in Helena that makes recommendations for chronic pain management and tapering medications. Tr. 651. Ms. Blank is a board certified pharmacotherapy specialist. Tr. 652:12-13. Counsel for the department questioned Ms. Blank in a significant number of instances that were outside the scope of her expert qualification.<sup>8</sup> That testimony is given no weight. Ms. Blank was not qualified to render opinions on the standard of care for a medical practice so no weight was given to her testimony about Dr. Ibsen's charting.

153. Charles Anderson, M.D., was qualified as an expert in chronic pain management, charting, and overprescribing and testified as an expert for Dr. Ibsen. Dr. Anderson, a recently retired neurologist (2012), graduated from Dartmouth

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<sup>8</sup> On pages 681, 685, 689, 692, 693, 696, 697, 698, 706, and 707 of the official transcript of these proceedings, counsel for the department repeatedly asked the witness questions not about Dr. Ibsen's prescribing of opioids or other medications, but about the quality of his recordkeeping or about his interactions with other medical professionals. The latter two topics are not within the scope of her expertise as established for this matter. To the extent that the hearing officer overruled objections to this testimony, those rulings are reversed.

College in 1969, attended Dartmouth Medical School for two years, and then transferred to the University of Minnesota where he received his M.D. in 1972. He followed that with an internship at Emanuel Hospital in Portland, Oregon. He did his residency in neurology at the University of Minnesota from July 1974 to 1977. He was in the private practice of neurology in Fargo, North Dakota, and in that capacity he was the neurologist on a chronic pain management team. In 1988, he moved to the Northeast Arkansas Internal Medicine Clinic. Since 1991 he was in the private practice of neurology at St. Peter's Hospital. He is board certified in neurology. From 2000 to 2002 he was the chairman of the credentialing committee at St. Peter's, and from 2002 to 2004 he was the chief of staff at St. Peter's. During those years, he had many opportunities to review other doctors' charts. Tr. 733-738. Based on his 30 years of practice and his experience in managing patients with chronic pain, he was found to be competent to render an opinion as to whether the standard of care was or was not met by Dr. Ibsen in caring for patients who were receiving pain medications for their chronic pain. Tr. 760. There was considerable debate about Dr. Anderson's qualifications as an expert with regard to treatment of chronic pain management, however, his testimony increased the hearing officer's confidence in Dr. Anderson's qualifications.

#### B. Standard of Care

154. In Montana a "non-board certified general practitioner is held to the standard of care in the same or similar community in the United States in the same or similar circumstances." *Chapel v. Allison*, 241 Mont. 83, 92-93, 785 P.2d 204, 207 (1990).

155. There is considerable confusion in the record from the expert witnesses about what the effect of a standard of care is - an individual standard practice or a statewide practice. There was also dispute about whether a standard of care was mandatory. In Montana it is unclear as to whether a board certified professional can provide expert testimony regarding a general practitioner when the expert has never practiced as a general practitioner. The hearing officer has also been unable to determine if something is "a standard of care" as opposed to "the standard of care" and whether a physician is required to comply with the former. The following testimony from Ms. Blank is illustrative.

Q. So does the standard of care change depending upon the facility?

A. Well, there are recommendations in the instance of responsible opioid prescribing and pain management. And I guess the standard of care, given those recommendations, different places will adopt different parts of those recommendations.

Q. So the practice in one facility may be different than the practice in another facility and it doesn't mean that either facility is necessarily violating standard of care, true?

A. True. As long as some -- there is some certain basic things that are a part of the standard of care.

Tr. 709:10-23.

156. Blank later stated that the basic things for a pain management contract were that the patient only see one doctor for pain treatment, use only one pharmacy, and that the patient may be subject to urine drug screening. Tr. 722:9-18. Dr. Ibsen instituted a number of these agreements with Patients 1 to 9 but did not put them in writing.

157. The standard of care when assuming prescribing responsibility for controlled substances requires documentation that safer modalities have been tried and failed. The standard of care requires documentation of a patient's response to ongoing alternative modalities or interventions attempted. Tr. 442. All but one of the nine patients and all of the Christensen patients were on opioids before Dr. Ibsen began treating them. No evidence was offered to indicate that a doctor has to retry safer modalities when another doctor has already made the decision to treat with opioids. Dr. Ibsen had discussions with these patients about previous treatment but it is not always recorded in the patient records. Dr. Ibsen did not breach this standard of care.

158. The standard of care for treatment of patients with chronic pain is not to rely exclusively on opioids. Dr. Ibsen did not breach this standard of care. Dr. Ibsen provided pain medications to all the patients at issue in this case. Some he was able to wean off medications, and with most he used other therapies and prescriptions to resolve their issues.

159. Dr. Ibsen is accused of violating the standard of care for the prescription of too many opioids in the treatment of his patients' chronic pain. There was no expert testimony that Dr. Ibsen's prescribing practices led to any harm to his patients. The record shows that some patients refilled their prescriptions earlier than the previous prescription anticipated. Dr. Ibsen explained that many of those patients were experiencing greater pain than their current dosage ameliorated. The patient would contact Dr. Ibsen's office and he would write a prescription for additional, stronger, or a different type of medication after he or another practitioner discussed the reasons for doing so with the patient.

160. It is a breach of the standard of care to offer early refills without documentation of the rationale for the early refill. Tr. 426:4-10. While he testified

that he had reasons for allowing the early refills that are shown in the MPDR, the patient records did not reflect his reasoning. There may be legitimate reasons for early refills including that the patient is experiencing greater pain than their current prescription ameliorated. Other reasons could include insurance denials or travel requiring special consideration. Tr. 419-20. Dr. Ibsen discussed early refills with his patients and in most cases it was because some intervening pain generator had come into play or the prescribed pain medication was simply inadequate to control the pain. Dr. Ibsen did not regularly identify his reasons for prescribing early refills in the patients' records. Dr. Ibsen breached the recordkeeping standard of care by failing to document his reasons for allowing early refills. Tr. 437:1-6.

161. It may be the standard of care to clearly document physical examinations, to document interactions and collaborations with other professionals treating the patient. Dr. Ibsen has not been meeting this putative standard of care. Dr. Ibsen has begun using more modern forms but they still lack the detailed information necessary to meet this putative standard of care. However, because this failure has to be proved by expert medical opinion, the department has failed to prove that Dr. Ibsen violated this standard. Dr. Kneeland was asked whether Dr. Ibsen's documentation met the standard of care for a family practice or urgent care physician. Under Chapel, *supra*, Kneeland was not qualified to render that opinion.

162. It is the standard of care to assess pain outcomes beyond simply a numeric rating scale. Dr. Ibsen uses this scale but delves further into the sources and causes of the patient's pain during his lengthy appointments with them. Dr. Ibsen did not breach this particular standard of care but his documentation of that assessment is insufficient.

163. Dr. Ibsen is also charged with failing to follow up with patients he sent for evaluations and treatments from other doctors or medical providers. The evidence clearly indicates that Dr. Ibsen or UCP office staff conveyed the results to his patients but his notes are not very detailed about what was said. Dr. Kneeland testified that he found "rare instances of referrals to other specialists and rare communication from that specialist about their findings." Tr. 461:16-22. The hearing officer's review of all the patient records found a considerable number of reports from specialists and notations that the results were communicated to the patient. Dr. Ibsen met this standard of care.

164. Regular assessment of a patient is the standard of care. Dr. Ibsen did not violate this standard.

165. Dr. Kneeland testified as follows:

A fair number. There is a -- I would say the minority in Kalispell, the minority of people who treat chronic pain with opioids, the minority do not use a controlled substance agreement. In fact, many hospital organizations now mandate them.

Tr. 470:1-5.

The hearing officer does not find that the use of pain contracts is the standard of care in treating chronic pain patients or that Dr. Ibsen violated it.

166. There is no evidence that pain contracts achieve a better result for the patient. Tr. 469. Dr. Kneeland agreed that the generally accepted practice is to rely upon the patient's history in treating the patient's pain. Tr. 469.

167. The following colloquy between Dr. Ibsen's counsel and Dr. Kneeland further illustrates the hearing officer's reluctance to find the use of pain contracts to be the standard of care at this time in this case.

Q. In a recent article in the New England Journal, they posited that still the generally accepted practice is to rely upon the patient's history in treating patient's pain.

A. Absolutely.

Q. And they've already suggested that pain contracts are suggested but not at this point in time mandatory.

A. That particular author may have suggested that. And are they mandatory? No, they are a standard of care in the treatment of chronic pain.

Q. Well, if something is standard of care, doesn't it mean that it's mandatory?

A. No. A mandate is a legal -- my understanding of a mandate is a legal issue.

Q. But aren't doctors supposed to follow standard of care?

A. Absolutely. So you can think of it as a clinical mandate that you feel like you should follow, but just because that particular author didn't feel like it was recommended doesn't mean that it's not.

Q. Is there a fair number of physicians, even in Kalispell, who treat pain who don't employ written pain contracts?

A. A fair number. There is a -- I would say the minority in Kalispell, the minority of people who treat chronic pain with opioids, the minority do not use a controlled substance agreement. In fact, many hospital organizations now mandate them.

Q. And your hospital does?

A. I don't know, to be honest with you.

Tr. 469:1-25 to 470:8.

168. The key elements of a pain contract include: only one doctor is going to be prescribing pain medications; the patient will only use one pharmacy to fill their pain medications; and that patient may be subject to urine drug screening. Dr. Ibsen included these elements in the treatment of his patients without a written agreement. See Ex. L-1, L-2, and L-3. Pill counts would not be required. Tr. 722.

169. The use of a pain contract is not the standard of care. While Dr. Kneeland testified that the use of a pain contract is a standard of care, Ms. Blank testified that the use of pain contracts at Helena's leading medical facility, St. Peter's Hospital, had, just days before hearing, adopted their use in its care of chronic pain patients. Dr. Anderson testified he did not use pain contracts and expressed concern that their use could negatively impact the doctor-patient relationship. Dr. Ibsen's decision not to employ written pain contracts cannot be a basis for a finding of misconduct when Helena's largest medical facility did not adopt them until well after the time period when all the conduct at issue in this matter occurred.

170. Dr. Ibsen had one patient who was doctor shopping. However, once he discovered that fact he quit prescribing pain medications for that patient. At the time of some of those refills, Dr. Ibsen did not have access to the MPDR or it was just getting started and had not yet become the tool that it is now. He has adopted a practice of using it universally today.

171. It is not the standard of care to conduct urinalysis on chronic pain patients. Kneeland in his testimony about pain contracts discussed that urinalysis was the standard of care. Because the hearing officer has concluded that the use of pain contracts is not yet the standard of care for all physicians treating chronic pain, he cannot conclude that an element of a pain contract is the standard of care. Nonetheless, Dr. Ibsen has used urinalysis when he has had concerns about prescribing opiates to a particular patient. Tr. 438.

172. Conducting pill counts is not the standard of care.

173. It is not a standard of care to consider and rely upon the Prescription Drug Registry. Dr. Ibsen used the MPDR in his treatment of Patients 29-1 through 29-21. Tr. 716. Dr. Ibsen began treating Patients 1 to 9 before the MPDR was up and running and several years before it was widely in use and cannot therefore be sanctioned for failing to employ it. Dr. Ibsen now relies on the MPDR in treating almost all of his patients.

174. It was not established that weaning a patient to a lower amount of opioids is the standard of care. If it were the standard of care, the hearing officer would find that Dr. Ibsen met the standard of care as his results with weaning were at least as good as, if not better than, those of Dr. Kneeland's. Dr. Kneeland's opinions

with regard to the success of Dr. Ibsen in weaning his patients is given little weight as there is no determinable beginning or end point to his comparisons. Dr. Anderson's opinions are given similar weight. The hearing officer finds that if weaning were the standard of care, that based on the date of first prescription to the date of Dr. Ibsen's last prescription to his patient, he was more successful than not. The amount or dosage of pain medication prescribed by a subsequent physician is not relevant to whether Dr. Ibsen was successful at weaning the patients identified in this matter.

175. Dr. Kneeland's success rate for weaning as defined by reducing his patient's total dose in his practice is about 73 percent. Tr. 497. The success rate for completely eliminating the use of medications is roughly ten percent. Id. Dr. Ibsen's rate of successful weaning was better than Dr. Kneeland's. Tr. 766.

176. No expert testimony was offered that established that weaning a patient off of opioids is the standard of care to which doctors must adhere. It was established that weaning may be a part of a pain contract but as stated above those are not the standard of care.

177. Dr. Ibsen did not have written weaning plans but he discussed it with the nine patients and was relatively successful. Kneeland found single words such as wean or needs to wean and then a concomitant change in either the numbers or the dosage of medication going forward. Tr. 450:1-5, 14-25.

178. There was no evidence offered that any of the nine patients diverted their pain medications. Tr. 467.

179. Dr. Ibsen prescribed pain medications to the patients at issue in this matter for legitimate medical reasons. Tr. 470.

180. Dr. Kneeland testified that his practice has policies regarding care plans and separate policies regarding controlled substances, however, his testimony did not establish that those plans are the standard of care for all physicians treating chronic pain.

181. Dr. Ibsen was able to show through his patients' and his own testimony that he is not overprescribing pain medications or inadequately monitoring his patients. However, his recordkeeping failed to meet the applicable standard of care. His records failed to provide adequate histories, adequate physical examinations, or detailed pain complaints. Tr. 439. What is found in his patient charts is frequently illegible.

This is where Dr. Ibsen needs improvement. He has adopted a new recordkeeping system that may help but his own subjective evaluations and his plan

for the patients needs to be better detailed and understandable. He is not the only one at UCP that reads his notes so better recordkeeping is essential for the safe and effective treatment of his patients.

182. The patients whose records are at issue in this matter represent a very small sample of the patients Dr. Ibsen has treated over the last three years. The fact that these records were selected by a former employee with an interest in seeing Dr. Ibsen punished for terminating her employment weighs against a significant sanction in this matter. However, those records, however selected, do prove that Dr. Ibsen's recordkeeping does not meet the standard of care and needs improvement.

183. There are too few doctors willing to treat chronic pain patients. The risk-benefit analysis of long-term opioid therapy is shifting towards the risk that most non-pain specialists don't want to deal with it. It's that simple. Tr. 434. Chronic pain is an extremely difficult disease to treat. The patients can be very difficult to deal with because they're frustrated and they've had bad experiences. It's not a patient population that most physicians want to treat. That's unfortunate, because there are millions more people affected by chronic pain than by virtually any other chronic diagnosis in the world. Tr. 435:1, 7-17, 23-25. Dr. Kneeland was not aware of any other doctor in Helena that provides ongoing pain management. Tr. 477. Dr. Anderson, a long-time Helena physician, agreed that there was a trend in the Helena community of shying away from treating chronic pain patients. Tr. 766.

184. Dr. Ibsen's treatment of approximately 20 former patients of Dr. Chris Christensen's patients was brought into this proceeding for the apparent purpose of showing that Dr. Ibsen was overprescribing pain medications to these patients as well as Patients 1 to 9; that he had a bad relationship with a pharmacist who put his foot down with regard to Dr. Ibsen's alleged overprescribing and alleged failure to wean these patients; and that his conduct was so out of compliance with proper prescribing practice that the DEA had to step in. The hearing officer finds that Dr. Ibsen's treatment of these patients as a whole did not involve overprescribing; his treatment showed clear evidence of tapering of opioid prescriptions among the majority of these patients; and rather than being at odds with the DEA, demonstrated that while he is a doctor that places his patients' needs first, he understands concerns about possible diversion and has aided law enforcement with its separate duty to protect the public from the dangers of diverted prescription drugs.

185. The department failed to prove that Dr. Ibsen suffers from any psychological malady that affects his ability to safely practice medicine. The department attempted to show that Dr. Ibsen's personal conduct somehow indicated that he was unstable or had anger management issues that prevented him from safely practicing medicine. However, it offered no expert testimony to support such a

medical conclusion. As stated above, the changing dynamic between pharmacists and doctors as the result of increased scrutiny of both professions by the DEA and other drug enforcement entities has brought new pressures to bear upon the doctor/pharmacist relationship. Dr. Ibsen did not handle some of his interactions as well as he could, but the situations raised fail to prove sanctionable conduct.

186. The department failed to prove that Dr. Ibsen's monitoring of his patients violated the standard of care. The department failed to prove that Dr. Ibsen overprescribed opioid pain medications. The department never defined what overprescribing was, although based on the evidence it introduced the allegation seems based on early refills and weaning, but the department's own experts testified that no dosage of medication that Dr. Ibsen prescribed was out of the proper range for that particular drug.

#### IV. CONCLUSIONS OF LAW<sup>9</sup>

1. The Board of Medical Examiners has jurisdiction over this matter. Mont. Code Ann. § 37-3-203.

2. The department bears the burden of proof in this matter to demonstrate by a preponderance of the evidence that the licensee committed an act of unprofessional conduct. Mont. Code Ann. § 37-3-311; *Ulrich v. State ex rel. Board of Funeral Service*, 1998 MT 196, ¶8, 289 Mont. 407, 961 P.2d 126.

3. To establish that Dr. Ibsen's prescription of opioid pain medications, monitoring of referred doctors, and recordkeeping did not meet professional standards, the agency must demonstrate both the proper standard of care and the manner in which the licensee deviated from that standard of care. Mont. Code Ann. § 37-1-316(18). Cf. *Montana Deaconess Hosp. V. Gratton*, 169 Mont. 185, 545 P.2d 670 (1976) (holding that in a medical malpractice case, the medical standard of care must be established by expert medical testimony unless the conduct complained of is readily ascertainable by a layman, citing *Evans v. Bernhard*, 23 Ariz. App. 413, 533 P.2d 721 (1975)). See also, *Webb v. Board of Medical Ex.*, 202 Ariz. 555, 48 P.3d 505 (App. 2002) (holding that due process in an

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<sup>9</sup> Statements of fact in the conclusions of law are incorporated by reference to supplement the findings of fact. *Coffman v. Niece* (1940), 110 Mont. 541, 105 P.2d 661.

administrative licensing proceeding requires that both the standard of care and the deviation from that standard must be established in the record).<sup>10</sup>

4. Mont. Code Ann. § 37-1-316 provides in pertinent part:

The following is unprofessional conduct for a licensee . . .  
governed by this chapter:

\* \* \*

(18) conduct that does not meet the generally accepted standards of practice.

5. The department did not meet its burden of proof with respect to the issue of whether Dr. Ibsen was overprescribing pain medications or whether he failed to meet the standard of care with respect to patient monitoring.

6. Rule 702, M.R.Evid., provides that “if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.” The party presenting a witness as an expert must establish, to the satisfaction of the trial court, that the witness possesses the requisite knowledge, skill, experience, training, or education to testify as to the diagnosis and treatment in question as to the standard of care applicable to the physician charged. *Glover v. Ballhagen* (1988), 232 Mont. 427, 756 P.2d 1166, 1168.

7. The changes in treatment of chronic pain with opioids was compared multiple times by multiple witnesses as the swing of a pendulum. A pendulum swings from its maximum angular displacement through the equilibrium point and then proceeds to its maximum negative angular displacement. What the experts described was the end of the first swing of the pendulum (maximum angular displacement) somewhere around 1997 with the publication of Dr. Portenoy’s paper on use of opioids to treat chronic pain. After that point, the pendulum began

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<sup>10</sup> In light of the statutory language in Mont. Code Ann. § 37-1-316(18), Webb’s utility in this case is clear. The rule in Webb derives from the requirement in medical malpractice cases that a plaintiff establish both the standard of care and that the physician deviated from that standard of care. *Webb*, supra, 202 Ariz. at 510, 48 P.3d at 560, citing *Croft v. Arizona Board of Dental Examiners*, 157 Ariz. 203, 755 P.2d 1191 (App. 1988) (recognizing that a doctor is not liable in negligence for mere mistakes in judgment, but is liable only where the treatment falls below the recognized standard of care for good medical practice). The terms of Mont. Code Ann. § 37-1-316(18) require a showing that the licensee “has not met the generally accepted standards of practice” in order to prove unprofessional conduct. Obviously, in order to make a case under this statute, the agency must demonstrate both the standard of care and the licensee’s deviation from that standard, the very requirements set out in Webb.

swinging back as the use of opioids for chronic pain exploded. Now they argue that at some unknown date within the last ten years the pendulum reached its original starting point as further study of opioid use suggested that there were significant risks associated with long-term use of opioids. Dr. Kneeland testified this was not a sudden shift and perhaps is why he and others used the pendulum analogy in the first place. Assuming that is true, how far has the pendulum swung since this latest turning point? Assuming that it took some time for the advocates for widespread use of opioids to educate policymakers and doctors and additional time for the pharmaceutical companies to ramp up production of existing and new drugs to the point where we use 75 percent of the world's opioid medication supply, the pendulum could not again have started swinging back any sooner than the last three or four years. The Montana Legislature declined to pass the MPDR legislation in 2007 or 2009 which suggests that it as the state policymaker was not seeing the same urgency in the issue that some thought leaders held. The MPDR legislation did pass in 2011 and Ms. Blank referred to a paper on opioid use published that same year. Without any evidence to inform the hearing officer about when the pendulum started its third swing, it is logical to assume it was around 2011. In other words, the pendulum of thought has just begun to change and the weight at the end has not yet reached equilibrium - the point at which more than 50 percent of physicians have adopted the new theory regarding the treatment of chronic pain. The fact that St. Peter's Hospital just days before the December hearing in this case decided to require pain contracts for the long-term treatment of chronic pain, the fact that some, perhaps a minority of physicians in Kalispell, Dr. Kneeland's home base, don't employ the tools that Dr. Kneeland stated were the standard of care, and the fact that education for doctors on the changes in thought in chronic pain therapy is just beginning, strongly suggest that Dr. Kneeland's view and Ms. Blank's view that the medical community has passed the equilibrium point (the place where what they espouse is the standard of care) is simply the belief of those at the vanguard of thought and not yet the majority view. Those same facts do indicate that we may be passing the equilibrium point in the not too distant future and their views will be the standard of care. Until then, it is premature to sanction a doctor for not meeting a standard of care which is really just the latest theory, and not necessarily the prevailing view. It is similar to flunking the student before the first exam. Until the pendulum has swung past equilibrium, many tests of that theory will occur making the application of the theory to patient treatment standards more sound. Put another way, a standard of care will become the standard of care.

8. The department has met its burden of proof with respect to the issue of Dr. Ibsen's failure to maintain patient records that meet the standard of care. A violation of Montana Code Annotated § 37-1-316(18) has been preponderantly established.

9. Upon a finding that a licensee has committed unprofessional conduct, the regulatory board may impose any or all of a wide variety of sanctions including imposition of probation, restriction or limitation of practice, satisfactory completion of a program of education or treatment, and compliance with conditions of probation for a designated period of time. Mont. Code Ann. § 37-1-312(c), (d) and (g). To determine which sanctions are appropriate, a regulatory board must first consider sanctions that are necessary to protect the public, and only after that determination has been made can the board then consider remedies designed to rehabilitate the licensee. Mont. Code Ann. § 37-1-312(2).

10. The protection of the public, therefore, requires imposition of sanctions upon Dr. Ibsen including probation, monitoring of his practice, and other restrictions upon his conduct.

## **V. RECOMMENDED ORDER**

Based upon the foregoing findings of fact and conclusions of law and the totality of the circumstances, the hearing officer recommends to the Board of Medical Examiners that Dr. Ibsen's license be placed on probation for a period of 180 days with the following terms:

1. Within 60 days of the date of the final order in this matter, that Dr. Ibsen attend a seminar on proper recordkeeping.

2. Dr. Ibsen shall maintain a peer supervisor/mentor (who must be a general practitioner) who shall be approved by the Board of Medical Examiners. The peer supervisor/mentor's duties must be approved by the Board of Medical Examiners. The peer supervisor/mentor must also submit monthly reports on Dr. Ibsen.

3. After 30 days have elapsed from the day of Dr. Ibsen's recordkeeping seminar and during the remainder of his probation, the Board of Medical Examiners or its designee may, in the sole discretion of the Board, perform peer reviews on any patient records generated after the seminar. The costs of the first two such reviews shall be borne by Dr. Ibsen.

4. Dr. Ibsen shall obey all provisions of Montana Code Annotated Title 37, Chapters 1 and 3, and Montana Administrative Rules Title 24, Chapter 156.

5. In the event Dr. Ibsen fails to abide by any terms of this probation, his license may be suspended. Mont. Code Ann. § 2-4-631.

DATED this 12th day of June, 2015.

DEPARTMENT OF LABOR & INDUSTRY  
OFFICE OF ADMINISTRATIVE HEARINGS

By: /s/ DAVID A. SCRIMM  
DAVID A. SCRIMM  
Hearing Officer

Mont. Code Ann. § 2-4-621 provides that the proposed order in this matter, being adverse to the licensee, may not be made final by the regulatory board until this proposed order is served upon each of the parties and the party adversely affected by the proposed order is given an opportunity to file exceptions and present briefs and oral argument to the regulatory board.