BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against Richard Allan Bargen, M.D., Respondent.	**Case No. 20-5783-1**

FILED

JUN 10 2020

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this formal Complaint (Complaint) against Richard Allan Bargen, M.D. (Respondent), a physician licensed in Nevada. After investigating this matter, the IC has a reasonable basis to believe that Respondent has violated provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act). The IC alleges the following facts:

1. Respondent is a physician licensed to practice medicine in the State of Nevada (License No. 3877). He has been continuously licensed by the Board since September 15, 1979.

2. Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

3. On October 31, 2016, Patient A was seen at the Spine Nevada Institute (SNI) with a diagnosis of chronic neck and back pain with a possible reticular etiology. No opioid treatment for Patient A was indicated within Patient A's medical records.

4. On January 25, 2017, Patient A established care at the High Desert Clinic (Clinic). Medical records indicated Patient A slipped on ice and had an ankle sprain; however, these medical records do not indicate or explain Patient A's treatment plan. The Nevada Prescription

[1] The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), at the time this formal Complaint was authorized for filing, was composed of Dr. Rachakonda Prabhu, M.D., Chairman, Dr. Victor Muro, M.D., and Ms. April Mastrolucca.

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Monitoring Program (PMP) report shows that Respondent prescribed and filled a 27 MME (morphine milligram equivalents) dosage of codeine (an opioid-based cough medicine). Further, Respondent's medical records do not document any consideration or an assessment of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data for Patient A. Lastly, there is no medical justification indicated for Patient A's opioid treatment as prescribed by Respondent.

5. On February 9, 2017, Patient A visited the Clinic for foot & ankle pain, headaches and back pain. The PMP report for this date indicated Patient A obtained a prescription and filled 15 MME of hydrocodone-acetaminophen from Respondent. Respondent prescribed Lyrica (150mg). The medical record states "PMP clean," but such an entry demonstrates that Respondent failed to see that an opioid drug was prescribed along with a benzodiazepine drug (temazepam).

6. On February 23, 2017, Patient A was seen by an unidentifiable care provider at the Clinic and the medical record was unsigned for this patient encounter. The PMP report indicates Patient A was prescribed 60 MME of oxycodone by Respondent and was prescribed 15 MME of codeine by Mr. B. Such an amount of MME is a ***substantial increase*** of dosage from the previous encounter (2/9/2017). The medical record does not document any consideration or an assessment of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose escalation to using potentially excessively high doses of opioid therapy.

7. On March 7, 2017, Patient A was prescribed temazepam (30 mg) by Respondent pursuant to the PMP for this date and there are no medical records for this prescription.

8. On March 23, 2017, the PMP report indicates Patient A was prescribed 60 MME of oxycodone by Respondent. The medical records do not have any consideration or an assessment of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose escalation to using potentially excessively high dosages of opioid therapy.

9. On May 18, 2017, Patient A was seen by an unknown provider at the Clinic and was treated with an injection into the right lower back. The PMP for this date indicates Patient A

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obtained and filled a prescription of 90 MME of oxycodone, an 18 MME prescription of codeine, and a prescription for temazepam from Respondent. The medical records do not have any consideration or an assessment of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose escalation to using potentially excessively high dosages of opioid therapy.

10. On June 14, 2017, Patient A was seen by an unknown provider at the Clinic. The PMP indicates Respondent prescribed codeine (18 MME). There are no medical records for this encounter and prescription.

11. On June 20, 2017, Patient A was seen by an unknown provider at the Clinic. The medical record indicates that she was recently in the ER (Emergency Room) for possible pancreatitis. There is no provider name or signature on the medical record. The PMP for this date indicated Patient A obtained and filled a prescription of 90 MME of oxycodone as written by Respondent. The medical records do not have any consideration or an assessment of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose escalation to using potentially excessively high dosages of opioid therapy.

12. On July 14, 2017, the PMP indicates that Patient A filled a "butalbital comp codeine" prescription as written by Respondent. The medical records do not have any consideration or an assessment of the use of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data.

13. On July 19, 2017, and on July 24, 2017, the PMP indicates that Patient A received a 250 MME prescription of oxycodone written by Mr. B. Additionally, Patient A received prescriptions for zolpidem 10 tablets, #30; and another refill of 18 MME of "butalbital comp codeine" prescribed by Respondent. This 250 MME daily dosage of an opioid is another ***substantial increase*** in the opioid therapy treatment plan. The medical records do not have any consideration or an assessment of the use of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose escalation to using potentially excessively high dosages of opioid therapy.

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14. On August 14, 2017, the PMP indicates Patient A filled another codeine (18 MME) prescription as written by Respondent. The medical records do not have any consideration of or an assessment of the use of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data.

15. On August 16, 2017, Patient A was seen by an unknown provider at the Clinic. The medical records do not indicate the provider's name and the signature is illegible. The PMP report indicates Patient A received a 280 MME prescription for oxycodone written by Mr. B, plus a prescription for zolpidem 10 tablets, #30. This 280 MME daily dosage of an opioid is another ***substantial increase*** in the opioid therapy treatment plan. The medical records do not have any consideration of or an assessment of the use of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose escalation to using potentially excessively high dosages of opioid therapy.

16. On September 12, 2017, the PMP indicates Patient A filled another codeine (18 MME) prescription as written by Respondent. The medical records do not have any consideration of or an assessment of the use of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data.

17. On September 13, 2017, Patient A was seen by an unknown provider at the Clinic. The medical records do not indicate the provider's name and the signature is illegible. The PMP report indicates Patient A received a 280 MME prescription of oxycodone written by Mr. B, plus a prescription for zolpidem 10 tablets, #30. This 280 MME daily dosage of an opioid is another ***substantial increase*** in the opioid therapy treatment plan. The medical records do not have any consideration or an assessment of the use of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose escalation to using potentially excessively high dosages of opioid therapy.

18. On September 28, 2017, the PMP report indicates that Patient A filled a 360 MME prescription for oxycodone written by Mr. B. This 360 MME daily dosage of an opioid is another ***substantial increase*** in the opioid therapy treatment plan. The medical records do not have any

consideration or an assessment of the use of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose escalation to using potentially excessively high dosages of opioid therapy.

19. On October 11, 2017, Patient A was seen by an unknown provider at the Clinic. The medical records do not indicate the provider's name and the signature is illegible. The PMP report indicates Patient A received a 270 MME prescription of oxycodone written by Mr. B, plus a prescription for zolpidem 10 tablets, #30, plus 18 MME of codeine prescribed by Respondent, written on August 16, 2017. This 270 MME daily dosage of an opioid is a ***substantial decrease*** in the opioid therapy treatment plan. The medical records do not have any consideration or an assessment of use of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose de-escalation to using potentially inadequate dosages of opioid therapy.

20. On October 24, 2017, the PMP report indicates that Patient A filled a 180 MME prescription of oxycodone, written by Mr. B on this same date. There is no medical record for this encounter and the prescription of oxycodone. This 180 MME daily dosage of an opioid is ***substantial decrease*** in the opioid therapy treatment plan. The medical records do not have any consideration or an assessment of the use of non-opioid therapy, a discussion of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose de-escalation to using potentially inadequate dosages of opioid therapy.

21. On November 8, 2017, Patient A was seen by an unknown provider at the Clinic. The medical records do not indicate the provider's name and there was no signature. The PMP report indicates Patient A received a 270 MME prescription of oxycodone from Respondent, plus a prescription for zolpidem 10 tablets, #30 from Mr. B's prescription, dated October 11, 2017, plus received another 18 MME of codeine as prescribed by Respondent, written on August 16, 2017. This 270 MME daily dosage of an opioid is a ***substantial increase*** in the opioid therapy treatment plan. The medical records do not have any consideration or an assessment of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is

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no evidence of medical decision-making to justify the dose escalation to using potentially excessively high dosages of opioid therapy.

22. On November 21, 2017, the PMP report indicates that Patient A filled a 180 MME prescription of oxycodone, written by Mr. B on this same date. There is no medical record for this encounter and the prescription of oxycodone. There is no medical record for this encounter and prescription. This 180 MME daily dosage of an opioid is a ***substantial decrease*** in the opioid therapy treatment plan. The medical records do not have any consideration or an assessment of non-opioid therapy, a discussion or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose de-escalation to using potentially inadequate dosages of opioid therapy.

23. On December 6, 2017, Patient A is seen by Respondent on her final visit to the Clinic. The PMP report indicates Patient A received a 270 MME prescription of oxycodone written by Mr. B, plus a prescription for zolpidem 10 tablets, #30 from Mr. B's prescription, dated October 11, 2017, plus 18 MME of codeine prescribed by Dr. B on August 16, 2017. This 270 MME daily dosage of an opioid is a ***substantial increase*** in the opioid therapy treatment plan. The medical records do not have any consideration or an assessment of non-opioid therapy, a discussion of or an assessment of risks and benefits, or a review of the PMP data. There is no evidence of medical decision-making to justify the dose escalation to using potentially excessively high dosages of opioid therapy.

24. On December 11, 2017, Patient A died. The Churchill County Sheriff/Coroner certificate states that "based upon the considerations of the circumstances surrounding death, review of available medical history/records, autopsy examination, toxicological analysis, and other ancillary testing, the death of [Patient A] is ascribed to multiple drug toxicity (venlafaxine, amitriptyline, oxycodone and zolpidem). Based upon the circumstances of death as currently known, there is insufficient evidence to suggest suicidal intent; hence, the manner of death is best classified as accident." The Churchill County Sheriff's Office Report (Form 42) Supplement indicates that there was a bottle of controlled substances (venlafaxine) prescribed by Respondent found at the residence of Patient A and such inspection indicated the following:

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Rx Date	Name of Med.	Rx#	Rx#	Dose	Physician
11/8/17	Venlafaxine	90	65	(1) 3x day	Dr. Bargen

COUNT I

NRS 630.301(4) (Malpractice)

25. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

26. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

27. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

28. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he provided medical services to Patient A, who had a several encounters at the Clinic.

The Respondent's specific acts of malpractice are as follows, but not limited to:

1) prescribing excessively high doses of opioid therapy over 90 MME in violation of the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,* July 2013; 2) failing to justify the use and increase, decrease, and then increase of dosages of opioid medication; 3) prescribing a combination of benzodiazepines and opioids without documenting the medical justification; 4) failing to review the PMP prior to, during, and after the encounters with Patient A; 5) failing to assess Patient A for an alternative for non-opioid treatments; 6) failing to assess and discuss with Patient A with the risks versus benefits of opioid therapy; 7) failing to assess Patient A's concurrent medications interactions with the opioid therapy; 8) failing to assess Patient A for possible drug abuse, drug diversion or any other non-medical related activity; 9) failing to review the PMP data; and, 10) failing to assess Patient A for possible drug screens on a consistent basis.

29. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

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COUNT II

NRS 630.306(1)(b)(2) (Violation of Standards of Practice)

30. All of the allegations in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

31. Violation of a standard of practice adopted by the Board is grounds for initiating disciplinary action against a licensee pursuant to NRS 630.306(1)(b)(2).

32. The Board adopted by reference the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,* July 2013, published Federation of State Medical Boards of the United States, Inc. (Model Policy).

33. NAC 630.187 sets forth the professional standards for the prescription of opioid analgesics.

34. Respondent prescribed to Patient A in a manner that violated the professional standards for the prescription of opioid analgesics.

35. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT III

NRS 630.3062(1)(a) (Failure to Maintain Complete Medical Records)

36. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

37. NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating disciplinary action against a licensee.

38. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A.

39. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

40. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

5. That the Board take such other and further action as may be just and proper in these premises.

DATED this 4 day of June, 2020.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

Robert Kilroy, Esq., General Counsel
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Richakonda D. Prabhu, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 4th day of June, 2020.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

D Prabhu Richakonda MD

Richakonda D. Prabhu, M.D., Chairman

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