BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE ALASKA STATE MEDICAL BOARD

In the Matter of	)	
	)	
RAYMOND ANDREASSEN, D.O.	)	OAH No. 22-0897-MED
	)	Agency No. 2018-000439/843/502

DECISION

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I. Introduction

The Division of Corporations, Business and Professional Licensing initiated this disciplinary action against Raymond Andreassen four years after becoming aware of significant concerns with his controlled substance prescribing practices. Dr. Andreassen, who has practiced family medicine in Delta Junction for forty years, surrendered his DEA registration more than a year before the Division filed its Disciplinary Accusation in this matter.

Dr. Andreassen contends that his errors in controlled substance prescribing are exaggerated, amounting largely to recordkeeping issues more than substance, and that they reflect his thoughtful albeit unconventional medical judgment in a few very difficult cases. More critically, Dr. Andreassen argues, his longstanding family medicine practice serves vastly more patients than the small segment he formerly treated with controlled substances. He contends it is vitally important to the remote and underserved area in which he practices, and should not be disturbed based on stale concerns about substances he no longer prescribes.

A two-week hearing established that Dr. Andreassen's judgment in the prescribing of controlled substances, before he surrendered his DEA certificate, was indeed deeply flawed, at least as to a subset of patients, compelling the conclusion that his practices as to that subset of patients violated Board regulations. At the same time, the evidence also confirmed that Dr. Andreassen's broader family medicine practice is beneficial to his remote community.

With Dr. Andreassen having surrendered his controlled substance prescribing authority, and with no evidence or argument that Dr. Andreassen's practice outside that arena was deficient, the Division has conceded and this decision concludes that revocation is too harsh and harmful a penalty under the totality of the circumstances. This decision concludes that the appropriate remedy is one that permits Dr. Andreassen to continue providing family medicine services, without controlled substance prescribing, but subject to additional scaffolding and accountability measures. A period of probation, a formal reprimand, and a civil fine are also imposed.

II. Background and Factual History

A. 2016-2018 Opioid Prescribing Guidelines and Regulations

In March 2016, the Centers for Disease Control (CDC) issued the "Guideline for Prescribing Opioids for Chronic Pain," setting out recommendations as to (1) when to initiate or continue opioids for chronic pain; (2) opioid selection, dosage, duration, follow-up, and discontinuation; and (3) assessing risk and addressing harms of opioid use.[1] While acknowledging the significant number of people experiencing chronic pain, the Guideline notes a lack of evidence that opioids provide long-term benefits for chronic pain. On the other hand, evidence *does* support increased risks associated with opioid use, including addiction, overdose, and death – all with dose-dependent effects. Accordingly, the Guideline advises only starting opioid therapy if "expected benefits for both pain and function are anticipated to outweigh the risks," continuing opioid therapy only "if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety," and implementing various measures to ensure patient safety.

In April 2017, the Federation of State Medical Boards promulgated Guidelines for the Chronic Use of Opioid Analgesics, intended "to provide state medical and osteopathic boards with updated guideline for assessing a clinician's management of pain, so as to determine

[1] Ex. 19.

whether opioid analgesics are used in a manner that is both medically appropriate and in compliance with applicable state and federal laws and regulations." Beginning with the premise that "[t]he diagnosis and treatment of pain is integral to the practice of medicine," the Guidelines provide detailed guidance on: (1) Patient evaluation and risk stratification, (2) Development of a treatment plan and goals, (3) Initiating an opioid trial, (4) Ongoing monitoring and adapting the treatment plan, (5) Periodic and unannounced drug testing, (6) Adapting treatment, (7) Consultation and referral, (8) Discontinuing opioid therapy, (9) Medical recordkeeping, and (10) Compliance with controlled substance laws and regulations.[2] As Dr. Andreassen correctly notes today, the Guidelines also caution that they are not intended to "create any specific standard of care, which standard must depend upon fact-specific totality of circumstances surrounding specific quality-of-care events."

In July 2018, the Board amended, 12 AAC 40.975, its Controlled Substance Prescribing regulation to adopt the FSMB 2017 Guidelines and the CDC 2016 Guideline by reference "as the standards of practice for prescribing controlled substances for pain management."[3] Dr. Andreassen admits that he was largely unaware of the details of these requirements during the period at issue in this case.

B. Dr. Andreassen practice background

Born in Alaska but raised in the Lower 48, Raymond Andreassen is an osteopathic physician who has focused his lengthy career on rural medicine in underserved communities. After beginning his medical career in the Air Force, since 1983 Dr. Andreassen has practiced family medicine in Delta Junction, a rural community 100 miles southeast of Fairbanks.

Because of its small population and geographical isolation, Delta has considerably fewer patient resources than Alaska's cities. The even smaller communities for which it serves as a regional hub – Tok (100 miles southeast of Delta), and much smaller, further afield villages such as Tetlin (20 miles southeast of Tok) and Northway (another 20 miles past Tetlin) – have even fewer patient resources.

Dr. Andreassen specifically chose Delta because of his strong desire to serve patients in a high-need rural setting. After initially working for another local provider, and then practicing out of his home for several years, he purchased the clinic building and opened the Family Medical

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2 Ex. 20, p. 2.

3 Additionally, the amendments added subparts setting out the required frequency for consulting the prescription drug monitoring program (PDMP) database when prescribing controlled substances, the maximum allowable dose for an initial opioid prescription, and practice expectations for the practice of pain management.

Center in 1990. At the time of the hearing in this case, Dr. Andreassen's Family Medical Center was one of two medical clinics operating in Delta Junction.

The patient care issues giving rise to this case involve controlled substance prescribing, mostly for the treatment of chronic pain. Dr. Andreassen's overall practice, however, has never been a specialty pain management practice. Rather, his practice has been in family medicine, with management of chronic pain never reaching even ten percent of his overall practice before he surrendered his DEA certification.

Two notable features of Dr. Andreassen's practice are his near-constant availability and his holistic approach to his patients' wellbeing. Dr. Andreassen holds full days of clinic appointments throughout the workweek, typically seeing 18-20 patients per day. In addition to the scheduled appointments, Dr. Andreassen provides afterhours care whenever possible. As he describes it: "I'll get you in, I'll stay open, I'll see you in the middle of the night. I believe I do better medical care by being available." The clinic phone is forwarded directly to his personal phone after hours. Dr. Andreassen takes his patients' after-hours calls, sometimes seeing them in the clinic, sometimes providing advice by phone, and sometimes advising them to head to the hospital 100 miles away. Letters of support from current patients note the value provided by Dr. Andreassen's "commitment to being available 24/7," calling it "a lifeline for many."[4]

Hearing witnesses included adults who have seen Dr. Andreassen for their medical care since childhood, including at least one whose parents were also treated by him and whose children, in turn, are now also his patients.[5] Dr. Andreassen and the patients who testified describe a deeply personal level of involvement in his patients' well-being, not just from a physical health perspective but from a broader perspective that considers the patient's physical, emotional, spiritual, and even financial well-being.[6]

Dr. Andreassen views his medical practice as one aspect of a broader ministry of caring for those around him, and he is broadly involved in a number of acts of service on multiple

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[4] Ex. N ("In our rural setting, where medical resources can be limited, Dr. Andreassen's commitment to being available 24/7 has been a lifeline for many"); Ex. R (noting "the distance of 100 miles that separate[s] our community from other doctors" as well as "the quality of care that Dr. Andreassen always give to his patients"); Ex. H ("Dr. A has been a faithful caregiver serving night, day, weekends, holidays (he once met me at his clinic door after hours to sew up a cut-off toe)."); Ex. J ("Out of necessity we have called him 'off hours' and he has always taken the time to see us or give advice.").

[5] Test. of Patient 5. *See also, e.g.,* Ex. L.

[6] Letters of support from current patients tell a similar story. Ex. H ("gifted" and "compassionate"; "combines medical rigor with compassionate care"); Ex. J (a "capable, conscientious, and caring doctor who takes a whole-person approach to treatment."); Ex. M ("the most considerate, competent, and conscientious doctor I have ever had the opportunity to work with"); Ex. N ("Empathetic").

fronts, both medical and otherwise. He goes on mission trips, and has served as an official physician sponsor for remote area EMS/rescue squads. Outside of medical care, Dr. Andreassen organizes and provides space and funding for a weekly Narcotics Anonymous meeting. Also a licensed professional counselor, he organizes and runs what he calls the "Tuesday night get-ahead program" – essentially group education and empowerment meetings focused on goal-setting and accountability. His reason for doing so, he testified, is that, "these people need help and won't get it until someone steps up." He also provides periodic financial or other assistance to participants and others – including patients – in urgent need of rent, food, diapers, car repair, or other support. In explaining his nontraditional, broad-reaching support to community members, including patients, Dr. Andreassen describes: "the need that is driving me is that I am here to serve, to work on your behalf, and whatever it is I see you have a need and I have a capacity to help, I think I'm here to help you."[7] One patient (not a pain patient) described him as "the cornerstone of Delta Junction."[8]

C. Dr. Andreassen's treatment of "chronic pain" patients

Dr. Andreassen testified credibly that he was a late adapter of what became the pain management aspect of his practice, explaining that he "initially believed almost no one required pain management," but that his views changed as he "encountered people over and over again who wouldn't be able to function without pain medications." He found himself gradually doing more opioid prescribing, although he never really saw himself as "running a pain clinic." In his view, he was a family practitioner who was "just taking care of whatever shows up."

By the time period at issue in this case, however – roughly 2019 to 2021 – Dr. Andreassen's practice of family medicine involved a high volume of controlled substance prescribing relative to other family medicine providers.[9] In the six-month period beginning April 1, 2019, Dr. Andreassen wrote a total of 96 opioid prescriptions to 73 different patients, whereas Alaska family medicine physicians on average wrote just 19 opioid prescriptions to just

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[7] Andreassen test. Letters of support from current patients likewise emphasize this breadth of support. *See* Ex. H ("He supports the community in many ways, supporting EMT's, helping the Ukrainian refugee program, extending a helping hand to the homeless, alcoholics (AA), and destitute"); Ex. J ("a community leader who cares deeply about people who have needs, and often he helps those who are in need in his own time."); Ex. N ("deep-rooted commitment to our [community's] well-being")

[8] Ex. M.

[9] Ex. 13; Ex. 21.

14 different patients during this time.[10] Dr. Andreassen's volume of controlled anti-anxiety and sedative prescribing was also significantly higher than that of peers, both in terms of the raw number of prescriptions written and in terms of "dosage units."[11]

During this same period, Dr. Andreassen also prescribed a significantly greater total volume of morphine milligram equivalents (MMEs) than was typical amongst family practice providers. His average monthly "prescription volume" of total MMEs prescribed was more than five times greater than his family medicine physician cohort for oxycodone, nearly eight times greater for hydrocodone, and nearly seven times greater for other opioids.[12]

Dr. Andreassen was roughly on par with peers, however, in the percentage of his opioid prescriptions written for lower-dose amounts. The seminal 2016 CDC Guideline on opioid prescribing for chronic pain recommends escalating levels of caution for opioid dosages greater than 50 MMEs, with still more caution for any patient prescribed greater than 90 MME.[13] Of Dr. Andreassen's opioid prescriptions during the same 6-month period, 78% were dosages at or below 50 MME, and 12% were between 51-90 MME. His percentage of opioid prescriptions above 90 MME was nearly identical to peers.[14] However, his percentage of total prescriptions above 200 daily MMEs was twice that of peers.[15]

D. Specific treatment issues that arose

1. Patients whose care is at issue

Hearing testimony was taken about Dr. Andreassen's controlled substance prescribing as to ten specific patients in the two years preceding his February 2021 surrender of his DEA certificate.

- Patient 1, a 35-year old woman from Tetlin, began seeing Dr. Andreassen as her primary care provider sometime before 2019, and saw him for chronic joint pain, acne vulgaris, and anxiety. Patient 1's life during this time was chaotic and dysfunctional, with challenges including child protection and law enforcement involvement, multiple family members' deaths, and losing her home in a fire.

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[10] As to this relationship between this statistic and Dr. Andreassen's estimate that pain management comprised about five percent (and rose to ten percent) of his practice, neither party introduced evidence as to Dr. Andreassen's active patient count.

[11] Ex. 21. *Compare* 98 prescriptions per month *with* 12 for peers; 4,250 dosage units; 347 for peers.

[12] Ex. 21. Monthly average prescription volumes (total MME): Oxycodone-containing products (Respondent: 47,694; family medicine physicians: 9,144); Hydrocodone-containing products (Respondent: 16,408; family med. physicians: 2,716); other opioids (Respondent: 55,740; family med. physicians: 8,406).

[13] Ex. 2.

[14] Ex. 21 (Dr. Andreassen: 10%; all family medicine physicians: 9%).

[15] Ex. 21 (Dr. Andreassen: 5%; all family medicine physicians: 2.5%).

Between May 2019 and May 2020, Dr. Andreassen prescribed Patient 1 more than 2,700 opioid tablets and more than 2,400 tablets of Xanax.[16]

- Patient 2, a 41-year-old Tetlin resident, required a right-leg amputation in August 2019 following complications of a heroin overdose. Dr. Andreassen prescribed her high-dose benzodiazepines both before and after that overdose, and high-dose opioids for pain after the amputation. He believes these contributed to her overall functioning and considers her heroin overdose to have been unrelated to his controlled substance prescribing.[17]
- Patients 3 and 4, a married couple in their fifties with longstanding and severe polysubstance abuse problems, both withdrew from nascent substance abuse treatment in Fairbanks in January 2020 and began seeing Dr. Andreassen for pain management. While he accepted both only as "bridge" patients that he would see pending referral to a pain management clinic, he prescribed opioids to both – as well as benzodiazepines and stimulants to Patient 4 – continuously over the next year.[18]
- Patient 5, a 28-year old Delta Junction resident whose family had received medical care from Dr. Andreassen since her childhood, received high-dose Xanax and Adderall prescriptions from Dr. Andreassen throughout the period under review, during which she overdosed twice on heroin.[19]
- Patient 6, a 27-year-old Percocet-addicted patient, began seeing Dr. Andreassen in July 2020, shortly after committing to suboxone treatment elsewhere. Dr. Andreassen then prescribed a combination of oxycodone and benzodiazepines.[20]
- Patient 7, a 28-year old opiate-addicted patient to whom Dr. Andreassen prescribed between 300 and 500 MMEs per day for back pain throughout the period under review, and as to whom another physician called Dr. Andreassen with concerns about these prescriptions.[21]
- Patient 8 began seeing Dr. Andreassen for primary care in 2006 as a military spouse living in Fort Greeley. At the time relevant to this case, she was in her mid-thirties and being treated for chronic pancreatitis and chronic joint pain, for which he prescribed ongoing opioids at dosages above 500 MMEs, along with high dose benzodiazepines for anxiety.[22]
- Patient 9, a 43-year old Fairbanks resident with a severe substance use disorder, was prescribed Xanax, Klonopin, Adderall, and oxycodone by Dr. Andreassen.[23]
- Patient 10, a 60-year old Tetlin resident, died five days after an apparent overdose in May 2020.[24] Patient 10 had falsely convinced Dr. Andreassen that she had terminal

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16 Ex. 23 (780 Tramadol; 1,965 Oxycodone; 2,427 Xanax).

17 Andreassen test.; Ex. 26; Ex. 28.

18 Dillon test.; Ex. 48 (Patient 3), Ex. 31 (Patient 4)., Ex. 11.

19 Andreassen test.; Patient 5 test. For readability, brand-names are used in lieu of generic drug names throughout for alprazolam (Xanax), clonazepam (Klonopin), and dextroamphetamine-amphetamine (Adderall), oxycodone-acetaminophen (Percocet); and hydrocodone-acetaminophen (Vicodin).

20 Norton Aff. (Ex. 59).

21 Marcotte testimony; Ex. V; Ex. 52, p. 37.

22 Patient 8 testimony; Andreassen test.; Ex. 34; Ex. 38; Ex X.

23 Andreassen test.; Dillon test; Ex. 52.

24 Ex. 42; Button Aff. (Ex. 58); Andreassen test.

> uterine cancer, and used this deception to obtain high-dose narcotics. In the year preceding her death, Dr. Andreassen had provided her prescriptions for more than 2,300 30-mg oxycodone tablets.[25]

It is undisputed that the patients whose care is at issue in this case were a small subset of unusually challenging patients whose care was complicated by a variety of factors and whose course of treatment was not representative of Dr. Andreassen's family medicine practice – or, most likely, even his practice of pain management. Dr. Andreassen describes these patients as being "way outside the norm" of his overall patient population, characterizing them as extremely difficult situations. The Division's expert, Dr. Brose, concedes that the available documentation describes "a very high level of dysfunction that would make these very challenging patients."[26]

Dr. Andreassen's treatment approach as to the "very challenging" patients at issue in this case is driven by his perception of his role as "counseling people on multiple planes – physical, economic, spiritual," with the overarching focus being to "give people hope." He describes his treatment of the patients in this case in terms of care at a "psychiatric, physical, mental and spiritual" level, saying, in the case of Patient 1, that he was "working aggressively to get her out of the problem and not be in the problem." In explaining his use of high dosages of controlled substances, Dr. Andreassen believes that patients whose prescribed pain medications don't "meet their needs in the physical world" will "go to the street," so he prescribed higher doses intending to avoid what he sees as a more dangerous alternative. He describes his prescribing as "trying to titrate them to the need of their medical problems," based on a core belief that, for patients with substance abuse disorders, stabilizing pain – even through high dose opioids – is necessary to "reduce their risk."

2. Dosage and concurrent prescription concerns

The 2016 CDC Guideline advises that "when opioids are started, clinicians should prescribe the lowest effective dosage," and that "clinicians should use caution when prescribing opioids at any dosage." Its dose-dependent recommendations advise clinicians to "carefully reassess evidence of individual benefits and risks" if considering increasing dosage to 50 MMEs or higher, and to avoid or "carefully justify a decision to titrate dosage to ≥90 MME/day."[27] While nearly 80% of Dr. Andreassen's opioid prescriptions were within the < 50 MME range,

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[25] Andreassen test.; Ex. 43; Button Affidavit (Ex. 58), Ex. 52, p. 107-114 (Brose record summary: "Pt presented with urine tox scree + for THC/marijuana, methamphetamine/amphetamine, opiate, oxycodone from Tox Clinic and UDS + for cannabinoids, methamphetamine, opiate, oxycodone at FMH").

[26] Brose test.

[27] Ex. 2; s*ee also,* Richardson Aff. ("there is rarely much medical benefit to prescribing over 100 MME/day").

10% were in the critically high range above 90 MMEs. Most of the patients whose care is at issue in this case were in that very high range, with several patients having prescribed dosages significantly above 90 MMEs.

Patients 1 and 2 had MME doses ranging from 90 to 135.[28] With Patient 4, who began seeing Dr. Andreassen after dropping out of substance abuse treatment and being removed from pain management due to a positive drug test, Dr. Andreassen escalated her opioid dosing from below 50 MMEs to 90 MMEs during the first six weeks of care.[29] One complaint to the Medical Board cited Patient 8 receiving dosages above 450 MMEs per day, and by late 2019 her dosages exceeded 550 MMEs per day.[30]

A related concern about Dr. Andreassen's prescribing practices was the combination of high dose opioids with benzodiazepines, a practice known to carry an increased risk of overdose death. Concurrent use of opioids and benzodiazepines has been the subject of an FDA "boxed warning" since August 2016.[31] Dr. Andreassen's October 2019 PDMP report card showed 46 separate patients to whom he was concurrently prescribing benzodiazepines with opioids – as well as seven additional patients on concurrent prescriptions where he was prescribing one component or the other.[32]

Concurrent prescribing of benzodiazepines compounds the already "high risk of overdose" faced by patients on doses above 90 MMEs.[33] For Alaska providers, the PDMP calculates individual patients' overdose risk score, ranging from 000 - 999; 75% of patients on controlled substances have an overdose risk score below 500, and only 1% have a score greater than 650.[34] Four of the patients in this case – a number representing about 5% of Dr. Andreassen's total opioid patients – had overdose risk scores close to or above 650.

- Patient 1's PDMP records reflect that, from December 2018 – February 2021, Dr. Andreassen prescribed her Xanax along with oxycodone, in varying doses from 10 to

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28 Ex. 52, pp. 60, 96 (Pt. 1); Ex. 2 (Pt. 2: Nov. 2019 through Dec. 2020).

29 Ex. 52, pp. 49; Ex. 31 (1/23/20: 30 MME; 2/7/20: 45 MME; 3/3/20: 90 MME).

30 Ex. 60 (120 oxycodone (180 MME), 50 fentanyl patches (300 MME) per month); Ex. 38, p. 2 (e.g. October 2019 and ongoing, 50 mcg fentanyl patch (360 MME) and 4 oxycodone 30 ML per day (180 MME)).

31 "FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning," Drug Safety Communications, U.S. Food and Drug Administration, August 31, 2016 (advising providers that concurrent use of opioids with benzodiazepines "may result in profound sedation, respiratory depression, coma, and/or death," and to "[r]eserve concomitant prescribing of opioid analgesics with benzodiazepines or other CNS depressants for use in patients for whom alternative treatment options are inadequate"), *available at* https://www.fda.gov/media/99761.

32 Ex. 21; Sherrell test.

33 Dillon test.

34 Sherrell test.

30 mg, typically three times per day. Chart entries in November 2019, January 2020, and May 2020 list overdose risk scores ranging from 810 to 840.[35]

- Patient 2 was also concurrently prescribed multiple opioids (fentanyl and oxycodone) alongside multiple benzodiazepines (Klonopin and Xanax) throughout the period under review, with overdose risk scores fluctuating between 680 and 780.[36]
- Patient 4, to whom Dr. Andreassen prescribed Xanax, Klonopin, Adderall, and several opiates throughout 2020, had an overdose risk score of 430 when she established care with Dr. Andreassen, with that score rising above 700 four months later.[37]
- Patient 8's PDMP records reflect that Dr. Andreassen prescribed her high dose benzodiazepines alongside with daily fentanyl patches and other opioids from January 2018 through February 2021. By late 2019, Patient 8 had been on opioids for back pain for nearly nine years, and Dr. Andreassen was prescribing a daily regimen of opioid dosages above 500 MMEs alongside high dose benzodiazepines made her overdose risk score 630 – placing her near the top 1% in terms of risk.[38]

In explaining his rationale for concurrent prescribing, Dr. Andreassen observed that the boxed warning represents a *caution*, not a prohibition, and stated his belief that, when he engaged in concurrent prescribing, the circumstances justified doing so. While acknowledging that views about certain medications, classes of mediations, and other prescribing practices have shifted over time, he notes that, "in [his] experience," benzodiazepines and opioids "work really well together."

3. Substance abuse concerns

a. Patients with substance abuse disorders

A number of the patients identified above had known substance abuse disorders at the time that Dr. Andreassen was treating them with high doses of opioids and benzodiazepines.

- Patient 1. While Dr. Andreassen was not the first provider to prescribe opiates to 35-year old Patient 1, he prescribed opiates and benzodiazepines to her continuously throughout the period at issue in this case, despite multiple indications of a substance use problem and even while documenting her concerns about her prescribed medication being "too addictive," and her professed desire to decrease controlled substances.[39] While Dr. Andreassen documented spending "considerable time …

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[35] Ex. 22, pp. 27-28 (Nov. 2019: 810); pp. 14-15 (Jan. 2020: 840); pp. 8-9 (May 2020: 820).

[36] Ex. 26, p. 43 (May 8, 2020: 690), p. 49 (April 7, 2020: 700), p. 62 (March 16, 2020: 680), p. 64 (Feb. 27, 2020: 710), p. 69 (Jan. 29, 2020: 770), p. 76 (Dec. 30, 2019: 800), p. 78 (Dec. 3, 2019: 800), p. 86 (Nov. 15, 2019: 780), p. 92 (Oct. 23, 2019: 730).

[37] Ex. 30, pp. 59 (May 2020: 430), 61 (June 2020: 760).

[38] Andreassen test.; Ex. 34; Ex. 38 (50-mg fentanyl patches (360 MMEs), 4 30-mg oxycodone (180 MMEs), and 4 2-mg Xanax). A June 2020 chart note states that "Pt has had gastric bypass and this effects the way her body absorbs her medications and requires higher dosages of medications then normal." Ex. 34, p. 120. Patient 8 testified Dr. Andreassen was the only provider to ever caution her about the dangers of such high doses.

[39] Ex. 22, p. 72 (June 1: "Patient is not wanting to continue on the 20 mg Oxycodone meds. This is too addictive. The 10 mg oxycodone did not seem to do this for her."); pp. 70-71 (June 8: "Patient has chronic pain but

discussing the pros and cons of treatment," and reports continuously urging her towards sobriety, he ultimately continued prescribing controlled substances to Patient 1. Urgent Care records eighteen months after she expressed wanting to decrease controlled substance use reflect "what seemed to be very high doses of combination benzo-diazepam use and other opiates" still being prescribed by Dr. Andreassen, the provider's advice to discontinue their use given their risk, and that, "I offered a referral to addiction medicine and she states Dr. Andreassen is working with her and she declines."[40]

- Patient 2. Patient 2, the patient whose leg was amputated after an overdose, had known substance abuse habits before that overdose. Chart notes in April 2019 describe recent heroin use, four months of abstinence from opioids, and "wondering if she is getting immune" to Klonopin, as she is "taking 4 mg three times daily" without symptom relief. After a chart note in May 2019 described discussions of her "continued meth use," which "she is requesting help to stop," Dr. Andreassen started her on Adderall based on self-reported history of learning difficulties. She continued on Klonopin and Adderall thereafter, adding opioids and Xanax after the overdose.[41]
- Patient 3. Patient 3 began seeing Dr. Andreassen in January 2020, less than three weeks after starting suboxone treatment through the Tanana Valley Clinic. TVC records provided to Dr. Andreassen in early February 2020 note that Patient 3 has a "longstanding opiate addiction," had "spent 11 years in jail, secondary to narcotics related charges," and had recently used street drugs. Dr. Andreassen prescribed Patient 3 a 14-day supply of 42 tablets of 7.5 mg Vicodin at his first visit, increased to 10 mg tablets the next visit.[42]
- Patient 4. Patient 4 (Patient 3's wife) also joined Dr. Andreassen's practice in January 2020, five weeks after starting suboxone treatment through the Tanana Valley Clinic. At her first visit, Patient 4 disclosed that she "got into heroin for a few months, has been clean for 6 weeks. Started suboxone treatments for a few weeks but stopped, it made her feel more anxious." Additionally, she reported that "she uses crystal meth socially and we would find it along with marijuana in the drug screen." A prior pain management provider treated Patient 4 for lumbar degenerative disk disease but elected to "wean her off" opioids in late 2019 amidst concern "about the patient's drug-seeking behavior." Dr. Andreassen prescribed Vicodin and Adderall from the first visit, adding benzodiazepines three weeks later, and continued prescribing controlled substances for the following year.[43]

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is wanting to be off her medications. Patient requesting a continued reduction in the pain medication;" also, after describing a variety of physical symptoms and that she has not taken oxycodone in two days: "she does not feel this is withdrawal because this does not have the dopesick feeling."); p. 68 (June 13: "here today to request refills of alprazolam and oxycodone;" "reports she plans to go to rehab, she is 27th in line to be accepted in."); Ex. 25.

[40] Ex. Y, pp. 9-10 ("Medicines: Review of the PDMP shows that this month she was prescribed morphine 15 mg tablets #30[,] oxycodone 15 mg tablets #90[,] alprazolam 2 mg tablets 120[,] tramadol 50 mg tablets 120. The PDMP also shows she is getting a recurrent alprazolam oxycodone and tramadol prescription every month.")

[41] Ex. 26, pp. 105-107; Ex. 28.

[42] Ex. 45, pp. 34 (2/6/20: "told me he went through the pain meds way too fast. Pt. doesn't think the hydrocodone 7.5 are strong enough[;] he had to take up to 4 pills a day when his pain was bad."); 36, 52-59; Ex. 46.

[43] Ex. 30, pp. 70-74, 135, 167; Ex. 33, p. 1. Dr. Andreassen described Patient 4 as having been discharged from pain management after a positive drug test, but the records then he received from that provider reflect an October 2019 decision to "wean her off Norco" due to "concer[n] about the patient's drug-seeking behavior."

- Patient 5. Dr. Andreassen paid for Patient 5, his patient since childhood, to attend inpatient rehab for alcohol abuse when she was 18. During 2019-2020, he prescribed her benzodiazepines and stimulants even as community members reported to him that she was not using her medication as directed, even though she told him she was "dabbling in" methamphetamine use, and even after an April 2020 overdose.[44] Dr. Andreassen believed that treating Patient 5's anxiety and ADHD "kept her from using street drugs," and that the most important factor in his treatment "was that I didn't give up on her."
- Patient 6. Another provider's PDMP review found that Dr. Andreassen had prescribed oxycodone (i.e. Percocet without the Tylenol) and Klonopin to Patient 6 at the same time as he was seeking suboxone treatment for a Percocet addiction. She was particularly concerned about these prescriptions because Patient 6 had not previously been on prescription opioids; he was "a street buyer," as well as being benzodiazepine-naive.[45]
- Patient 7. Patient 7 was a 28-year old opiate- and alcohol-addicted patient to whom Dr. Andreassen prescribed opiates for back pain. Patient 7 was also seen periodically at the Tok Clinic and, after that clinic observed several relapses from sobriety, Tok physician Stuart Marcotte called Dr. Andreassen about his concerns. Dr. Marcotte relayed Patient 7's disclosures that she had an opiate addiction and that she was selling pills prescribed by Dr. Andreassen in order to purchase morphine. Dr. Marcotte perceived Dr. Andreassen as "not particularly concerned" about the possible risks, and more focused on his conviction that Patient 7's reported pain was valid and his frustrations with the Native Health System's failure to treat it. Dr. Marcotte, who saw Patient 7 roughly a dozen times between 2016 and 2019, characterizes the prescribed daily dosage of 330 MMEs as "exorbitant."[46]

b. Dr. Andreassen's treatment approach

Several providers ultimately complained to the Division about Dr. Andreassen's prescribing of high dose opioids and/or benzodiazepines to patients with known substance use disorders. These providers believed treatment for these patients with should prioritize non-opiate, non-benzodiazepine modalities, noting "it's incredibly high risk to approach these patients with that combination of medications, and particular at the high dose, high volume."[47]

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[44] Patient 5 testimony; Ex. 17; Ex. 52, pp. 167-168. At the time of the near-fatal overdose, Patient 5 reported to other providers that she was using high volumes of heroin, opioids, and methamphetamine, and refused a referral to inpatient supervised detox. Dillon test.; Ex. 12, Ex. 16, Ex. 17.

[45] Ex. 59 (Norton Aff.).

[46] Marcotte test. Dr. Marcotte believed that Patient 7 was "playing up" her reported pain and disability in order to get controlled substances, but had been unaware of a neurosurgeon's exam findings in 2016 that gave some credence to the patient's reports. *See* Ex. V. pp. 5-15. But he testified that even if her reports were accurate, her self-disclosed "dangerous, aberrant behavior" with prescribed medications required consideration of other pain management methodologies.

[47] Dillon test.; *see also*, Drake test; Norton testimony (Ex. 59) ("The combination of opioids and benzos for [Patient 6] was concerning and makes treatment of opioid addiction and opioid withdrawal difficult to deal with in a safe manner.").

Dr. Andreassen's view is that prescribing a controlled substance to an addicted person is acceptable if the controlled substance is needed for treatment of a medical problem; other providers counter that the risks are too high, given the potentially fatal risks of substance abuse, compared with chronic pain, which is itself rarely fatal.[48] Noting that the patients at issue here are his "most high risk", challenging, hard to treat patients, Dr. Andreassen describes his approach as "hav[ing] to meet them where they're at and try to lead them out of that," with a focus on helping patients through "their journey of getting well." Dr. Andreassen acknowledges that his patients with substance use disorders and on high dosages of opioids and other controlled substances were at risk of overdose. Indeed, apart from what he acknowledged were "high, concerning" overdose scores, many of the substance abuse patients to whom Dr. Andreassen was prescribing controlled substances were – unbeknownst to him at the time – continuing to abuse controlled substances.[49]

Several complainants to the Division believed that Andreassen was prescribing these substances as *treatment for* a patient's substance abuse disorder. Dr. Dillon described patients reporting, "I told Dr. Andreassen that I struggled with heroin, and he offered me oxycodone."[50] And Dr. Norton says she "presumed" that Dr. Andreassen's prescription of opioids to Patient 6 just as he was going to begin suboxone treatment was for purposes of treating his addiction.[51] Patient 1's testimony, similarly, described Dr. Andreassen "trying to help" her after she confessed her opioid addiction to him and at a time when he continued prescribing opioids to her.

Dr. Andreassen denies he was using opioids to treat addiction in patients with substance use disorders. Rather, he was treating addicted patients for chronic pain, and was simply not *withholding* opioid (and/or benzodiazepines) from those patients because they had co-occurring substance use disorders. Dr. Andreassen believed the only way to meaningfully address these patients' addictions was by first addressing their chronic pain (and in some cases anxiety) – as well as more broadly addressing their underlying psychosocial needs. In his view, at least some patients – precisely the kind of "really difficult" patients whose care is at issue here – require help well beyond traditional medical approaches. He explains: "[t]here are things that are really

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48 Marcotte test. ("Regardless of a patient's reported level of pain, you still have to be safe with what you're prescribing;" "If someone's addicted, you help them get off of that so they don't engage in dangerous behaviors"). Dillon test. (substance use is often more destructive than pain disorder).

49 Andreassen test.; Patient 1 test.; Patient 5 test..

50 Dillon test.

51 Ex. 59 (Norton Aff.).

clear to me. It takes shelter, and food, and love. And if they don't get unconditional love, I don't throw them away. Without hope, without love, they don't make it." Thus, with patients in particularly dysfunctional circumstances, Dr. Andreassen has spent "tons of energy" working to "lead them out of that," noting "they don't all make it, but many do."[52]

c. Patient overdoses

At least four of the patients in this case had overdoses during the period in question, some more than once, although it appears that most if not all overdosed on "street drugs," rather than on their prescribed medication.

- Patient 2's right leg amputation followed a heroin overdose. Dr. Andreassen was prescribing her Klonopin (12 mg per day) at the time, and then added Xanax as well as opioids for amputation-associated pain. He considered the overdose to be unrelated to controlled substances he was prescribing, noting, "she didn't overdose on medication I was giving her for left leg pain; she took and used heroin." [53]
- Six weeks after he began treating Patient 4, Dr. Andreassen increased her opioid dosage from 45 to 90 MMEs. Clinic records in her chart reflect a hospitalization for "cardiac arrest after heroin O/D," days after being prescribed 90 oxycodone, 30 Xanax, and 60 Klonopin tablets. Dr. Andreassen continued her on this dosage for another five months.[54]
- Patient 5 had near-fatal heroin overdoses in April and December 2020 while prescribed high doses of stimulants and benzodiazepines. She recounts abusing her Xanax – "taking way more than [she] should have" and then using street drugs when she ran out of her prescribed medications – and at the time of her April 2020 overdose disclosed having consumed 120 benzodiazepines over the previous three days.[55] Dr. Andreassen continued prescribing her Xanax, Klonopin, and Adderall through August 2020, and then refilled them again three days before the second overdose.[56]
- Patient 10 died in May 2020 while hospitalized after a days-long episode of altered mental status led to a larger medical crisis. On admission, she tested positive for illicitly-obtained methamphetamine and opiates, and was thought to have developed sepsis due to an inadvertent overdose on acetaminophen-containing opiates. In the year leading up to Patient 10's May 2020 death, Dr. Andreassen provided her prescriptions for more than 2,000 30-mg oxycodone tablets. During this time – with Dr. Andreassen under the apparently mistaken impression that she was experiencing end-stage cancer – her opioid dose changed six times, starting at 60 MMEs in May

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52 Andreassen test.

53 Ex. 26, pp. 96-105. Although Dr. Andreassen indicated he had been treating Patient 2's left leg pain before her amputation, the chart and PDMP entries in the record do not reflect opioid prescribing before those events.

54 Ex. 30, pp. 73, 124; Ex. 31 (Jan. 23, 2020: 30 MME; Feb. 7, 2020: 45 MME; March 3, 2020: 90 MME).

55 Patient 5 test.; Dillon test; Ex. 52, p. 169. Dr. Brose's summary notes reflect that she told Dr. Andreassen that she had turned to heroin because she had run out of her prescribed benzodiazepines. *Id*., p. 168. Patient 5 testified to this account as well.

56 Ex. 17; Ex. 52, pp. 168-169. A December 2020 emergency department record related to the second overdose reports that she is on Xanax, Klonopin, and Adderall, and "states that she has been trying to get off of both Klonopin and Xanax for the last 3 months, that she feels that they make her situation worse." Ex. 16, p. 1.

2019, reaching 360 MMEs in September, and ending at 270 MMEs for the last six months of her life.[57]

4. Monitoring and accountability in controlled substance prescribing

Prescription of controlled substances – particularly substances that are addictive and/or that pose a risk of overdose – requires heightened attention and monitoring by prescribers to prevent against abuse and diversion. Dr. Marcotte, who provides main management to Tok patients formerly treated by another provider who voluntarily suspended his license while under investigation for controlled substance prescribing concerns, uses monthly drug screens, monthly appointments, and random pill counts to ensure medications "are going to where we are prescribing." He described his agency's use of these controls as "doing everything we can to monitor appropriate use" while working to gradually wean patients down from excessively high dosages.[58]

Dr. Andreassen testified that, when he began treating more chronic pain patients, he sought out advice from an Anchorage pain specialist about how to manage this aspect of his practice, and incorporated that advice into his management of pain patients. Dr. Andreassen says his policy was for all patients being treated for pain to have a written pain contract, and describes wanting patients "to understand there was an agreement and that they were expected to function under its rules." The written pain contract signed by at least some of Dr. Andreassen's patients prohibits patients from using alcohol or illegal drugs and from driving while using "pain medication or other dangerous medications," allows random drug testing, warns that lost or destroyed medications "may not be replaced," and cautions that, "if I violate these conditions, the doctors may not refill the drugs or may require that I obtain help to decrease my use of these medications."[59] But for the patients whose care is at issue in this case, he did not monitor or enforce these measures.

a. Early refills

Early refills in controlled substance prescribing are problematic because of the possibility of diversion and because taking more medication than prescribed increases patient' overdose

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[57] Button Testimony (Ex. 58); Ex. 42, pp. 11-34; Ex. 43 (May 2019: 60 MME; June 2019: 90 MME; July 2019: 135 MME; August 2019: 270 MME; September 2019: 360 MME; October 2019: 180 MME; November 2019 and thereafter: 270 MME; Ex. 52, p. 20 (consumption in Nov. 2019 – Jan. 2020 consistent with 360 MMEs/day), pp. 108-111 (summary of May 2020 records); Andreassen test.

[58] Marcotte test.

[59] At hearing, Dr. Andreassen provided pain contracts only for Patients 1, 7, and 8. Ex. V, p. 16 (Patient 7: 9/5/18), Ex. X, p. 8 (Patient 8: 9/5/2018); Ex. Y, p. 6 (Patient 1: 8/28/18).

risk. While his pain contract expressly provides "I will not request early refills," Dr. Andreassen's chronic pain patients frequently requested and were provided with early refills.[60] The failure to enforce this aspect of the pain contract was related to Dr. Andreassen's belief in the importance of believing his patients. He feels the practice of medicine depends on believing one is being told the truth of what is occurring with the person.

Dr. Andreassen acknowledges that Patient 10, the patient who claimed to have terminal cancer, sought and received "a lot of early refills for a lot of different reasons," including claims of her belongings being lost or stolen – or, in one instance, "thrown into the honey bucket" by a family member; of needing early refills for transportation or other logistical reasons; and needing to take more than prescribed due to pain.[61] Between mid-June 2019 and late-April 2020, Patient 10 received a total of 2,487 oxycodone tablets, with a pattern of early refills reflecting consumption and/or diversion of 10-11 "oxy 30s" per day in September 2019, and 8 per day in December 2019.[62] Dr. Andreassen, "in hindsight", sees Patient 10 "as an addict that was lying to [him] and falsifying what the truth was in order to get her medicine." He acknowledges he should have done more drug screens, and that it was error to have disregarded what he assumed was a false positive drug test.[63] The oxycodone Patient 10 received over this 317-day period represented prescriptions for a total of *463* days (all at well above 90 MME per day).

Patient 1 likewise sought and received numerous early refills for numerous reasons, including claims that her house had burned down, her medications had been stolen (multiple times), and her car had been repossessed with her medications locked inside, as well as requests based on the logistical difficulties of driving the hundreds of miles from remote areas to fill prescriptions in Fairbanks.[64] While not all of Patient 1's requests for early refills or replacement of lost medication were granted, many were. Dr. Andreassen prescribed a 30-day supply of 90 oxycodone tablets (30-mg) on July 15, 2019. Just twenty days later, he wrote her a 7-day

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60 *See* Ex. 52, p. 49 (noting, for Patient 4, February 7, 2020 "escalation of opioids from hydrocodone to oxycodone," with dose increasing from 30 to 45 MME. "Only a week later, the patient describes being out early due to overuse of the oxycodone at 5 tablets a day constituting a 75 MME.")

61 Andreassen test.; Ex. 42, pp. 11-37; Ex. 43).

62 Ex. 43 (174 "oxy 20s" and 2,313 "oxy 30s"); Ex. 52, pp. 18, 20.

63 Patient records the Division provided to its expert, Dr. Brose, appear to have been more expansive than those marked as exhibits, as Dr. Brose's report describes contents of Patient 10's chart from 2020, while Ex. 42 is limited to 2019. As recounted by Dr. Brose, the chart reflects that Dr. Andreassen attempted to require a drug screen at a February 2020 visit, noting "we have not had a drug screen on file for 1.5 years;" and that, although Patient 10 left without being seen; Dr. Andreassen still refilled her pain medications at a telemedicine visit days later. Ex. 42; Ex. 52, p. 21. Patient 10's PDMP records reflect oxycodone prescriptions from Dr. Andreassen for 180 tablets each on January 21, March 3, March 18, and April 28, 2020. Ex. 43.

64 *See* Ex. 22, p. 30, 47, 66.

prescription of 21 "oxy 30s," followed by a new 30-day supply four days after that. Over a twelve-day period in September 2019, Patient 1 filled multiple Xanax prescriptions for a total of at least 360 tablets.[65] Patient 1's PDMP records suggest early or questionable refills in October, November, and December 2019, culminating in 30-day supplies of 120 Xanax (2-mg) tablets and 60 oxycodone (15-mg) tablets on December 31, 2019. Just three days later, her chart reflects a "long phone discussion of her meds," in which she is described as being "unable to explain the short fall of the oxycodone." Nonetheless, Dr. Andreassen prescribed another 60 oxycodone (15-mg) tablets, as well as another 120 Xanax (2-mg) tablets.[66] Dr. Andreassen now sees that Patient 1's "excuses were often questionable," saying he provided early refills "because I was treating the whole person," and because of a belief "that continuing to help her, to be a physician, to care about her, was helpful." He acknowledges he "was too liberal, too willing to help," noting, "I should have held the line tighter than I did with this patient."[67]

b. Accountability measures

Most patients' charts in this case contained no drug screening labs – either to determine whether they were in fact taking their prescribed medications or to determine whether they were using illicit substances – for the period under review. Dr. Andreassen testified that he did not rely on lab testing, because he didn't want or intend to "throw away" patients for non-compliance.[68]

Patient 1's sparse chart notes obliquely reference accountability regarding medications, with a January 29, 2020 "care plan" entry reading: "Discussed the medication usage. Explained that she will need to do accountability and go the distance to the first of March for her medicines."[69] It is unclear what "doing accountability" was intended to entail, however, and

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65 Ex. 22, p. 60; Ex. 23, Ex. 25. While there is some suggestion in the record that the total was even higher, it appears most likely that the 180-tablet prescription filled Sept. 25 was not *dispensed* to Patient 1, and was instead replaced by a new "90-day" 270-tablet prescription. *See* Order issued April 17, 2024; Andreassen Affidavit.

66 Ex. 22, pp. 16- 17 (January 2, 2020: " Long phone discussion of her meds; she is unable to explain the short fall of the oxycodone. Seems on schedule for the alprazolam and trimodal. Is in Fbks for getting her meds for the next month. Has spoken to the pharmacist and is ok on filling the meds for a month. Requests the alprazolam and the oxycodone to be send in tonite."). These medications were then replaced again in mid-January after she reported them stolen. *Id.*; Ex. 25.

67 Patient 1's testimony that Dr. Andreassen performed pill counts, random urine drug screens, and urinalysis at every appointment, was not credible given the lack of confirmatory evidence in her chart, and Dr. Andreassen's own contrary testimony.

68 He also testified that he doubted the reliability of local labs at the time. Indeed, when 59-year-old Patient 10 tested positive for methamphetamines, he discounted the result based on what he saw as the implausibility of a "little old lady" using meth.

69 Ex. 22, pp. 13-15. Patient 1 contends Dr. Andreassen "didn't know" she was addicted until about a year before he surrendered his DEA certificate, when she "opened up to him" about using street drugs, saying "I told him I couldn't live like this, and he tried to help me." Patient 1 test.

ultimately her Xanax and oxycodone were refilled early with 30-day prescriptions on February 23 and again on March 16.[70]

Half-hearted attempts at controlled substance accountability are also seen in Patient 2's chart. When he started her on high dose Adderall based on self-reported ADHD symptoms, Dr. Andreassen's May 22, 2019 chart note "care plan" indicated: "Rx for Adderall 20 mg TID, gave Rx in one-week increments for a month to establish accountability with patient." In reality, however, he began providing her 30-day prescriptions immediately after the initial seven-day prescription. This was so even though Patient 2 had immediately begun taking more than prescribed, revealing at her very first (May 29) check-in that she "used two at a time" so had already run out.[71]

In the case of Patient 4, suboxone clinic records received before her second visit with Dr. Andreassen described very recent polysubstance abuse while on prescribed pain medication:

> PDMP reviewed in detail. Note large prescriptions of Tylenol [four] and [Vicodin] prescribed to a local interventional pain clinic. Most of the medications recently prescribed and dispensed are now gone. The patient has been actively using methamphetamine and heroin while taking prescription pain meds. UDS markedly abnormal. Positive for methamphetamine, benzodiazepine, morphine/opiates, MDMA, marijuana, very faint for cocaine.[72]

Nonetheless, Patient 4 was not required to participate in monitoring or drug testing. While the chart from her initial visit (when Dr. Andreassen prescribed a 14-day supply of 30 opioids and stimulants) reflects she was asked "to bring in her meds at next visit," the chart note for her next visit does not suggest that this occurred. Likewise, the February 6 chart note says she was "encouraged" to go to the lab for a drug test, but the chart note for a telemedicine visit one week later makes no mention of lab work. That note states she "will be out early" because "she has to take up to 5/day some days," but, regarding a pill count, states, "Pt did not have them on her and said she would call back with the amount she had left." There is indication of such a call, nor any follow up by Dr. Andreassen – other than increasing Patient 4's opioid dosage because she had run out early due to taking more than prescribed.[73]

A related shortcoming in controlled substance management was failure to verify disposal of unused medications when patients switched from one dosage to another, getting a new

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[70] Ex. 25. (February 23: 120 Xanax (2 mg); 60 Oxycodone (15 mg); 120 Tramadol (50 mg); March 16 (90 Xanax (2 mg); 90 Oxycodone (15 mg) (plus another 30 filled March 31); 120 Tramadol (50 mg)).

[71] Ex. 26, p. 106, 103; Ex. 28, p. 1.

[72] Ex. 30, p. 153.

[73] Ex. 30, p. 66-68.

prescription shortly after filling the first one. After receiving 67 days' worth of "oxy 30s" – 201 tablets – between July 15 and August 9, 2019, Patient 1 requested a lower dose prescription on August 19, and received ninety tablets of Percocet. While Dr. Andreassen directed her to dispose of the oxy 30s, he did not verify that she had done so. He then provided an early refill of the Percocet on September 1, providing 54 more pills –supposedly a nine-day supply (per the PDMP), but described in her chart as "fill[ing] in for the extra amount of medication that was authorized beyond the prescription," followed two weeks later by a return to oxycodone.[74]

c. Consequences for misuse

Records similarly show a pattern of rare if any consequences for misuse. Dr. Andreassen says he was trying to implement measures for accountability "without abandoning [his] patients," because of a belief that "if [he] stick[s] with them" instead of "throwing them away," he can eventually reach them and help them in meaningful ways. Thus, in Patient 5's case, Dr. Andreassen continued prescribing her benzodiazepines from December 2018 through December 2020, despite disclosures that she was "running out of [Xanax] and [Klonopin] early all the time" (July 2019), using twice as much Xanax per day as prescribed (August 2019), and using more of both medications "due to having a hard month" (November 2019).[75]

Patient 1's chart reflects that in November 2019 a staff member caught her trying to access the office computer during a visit. The "Care Plan" section of the November 11 chart note describes that while she was at the clinic trying to resolve an issue with a pharmacist unwilling to refill an opioid prescription, Patient 1 "went to the computer in the exam room and tried to enter the computer to review her chart. She was caught in this. She denied that she was working on the computer."[76] The note characterizes this as "a severely serious infringement of her [rights and] privileges," and says that, "[b]ased upon this, there was no further prescriptions of any controlled substance given." As for future treatment, the note says, "Patient was not officially discharged and we will see her for medical care under close observation."[77] Five days later, she returned to the clinic apparently in acute narcotic withdrawal, her chart describing:

> Patient shows up for help w her vomiting and diarrhea w belly cramps. She has been out of Narcotics for 8 days. This month she has los[t] her meds thru stolen at

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74 Ex. 22, pp. 59-63; Ex. 23, p. 1.

75 Ex. 17; Ex. 52, pp. 160, 167. Neither party ultimately moved to admit Patient 5's medical chart (Ex. 14) into evidence, although it was discussed at hearing, but it is summarized in Dr. Brose's report. Ex. 52, pp. 160-169.

76 Patient 1 had visited the clinic the previous day, apparently having run out of Xanax and oxycodone prescribed 8 days earlier. Described as "having some anxiety issues and some withdrawal issues," she was given an injection of morphine, as well as sample packs of Klonopin, treatment for nausea. Ex. 22, p. 37-39.

77 Andreassen test.; Ex. 22, p. 35.

> FM store; house burned down with her meds destroyed; car confiscated for being late on payments with her meds locked in the car. Pharmacies have refused to replace her meds so she has been out for 8 days. WG in fbks will fill the meds today. Pt here to get help on the vomiting and to get a replacement for her lost meds.

The "care plan" in the November 16 chart note describes a plan to "fill her medicine for the present," with Patient 1 returning "within the next 2 weeks to see where we go from here in the process of pain management as well as the continued direction she wants to go of finding ways to eliminate the opioid medications in her pain management." Her PDMP records reflect that 15-day prescriptions for Xanax (60 tablets) and oxycodone (45 tablets) were filled that day, followed by an additional 13 days of oxycodone (42 tablets) on November 20, and then 30-day prescriptions of both oxycodone and Xanax (90 tablets each) on November 22.[78]

On August 27, 2020, a chart note for Patient 4 reflects concern about misuse of medication. While Patient 4 had run out of Xanax two weeks early and was on track to run out of oxycodone one week early, the note's focus is the PDMP appearing to reflect she has also received (undisclosed) Sublocade, cautioning she "should be questioned carefully regarding opioids before refilling."[79] Dr. Andreassen did then withhold oxycodone at an appointment five days later, but reversed course two days after that, following a lengthy phone call with Patient 4. His September 4 "care plan" reflects both his doubts about Patient 4's story and his inclination to accept his patients' implausible accounts, stating: "This looks like something is not quite square with [the] story, but I believe the patient is actually telling the truth."[80]

Dr. Andreassen's general approach to patient misuse of controlled substances is informed by his concern that "throwing away" patients in crisis is bad for patients, the medical profession,

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[78] Ex. 22, p. 30-32; Ex. 25, p. 2-3. Patient 1 had visited the clinic on November 14 "to talk about the acute stress she's having" related to the recent traumatic death of a family member, and about having fallen and injured her wrist within "the last few hours," but no controlled substances were prescribed. She returned November 20, saying she had fallen and landed on her arm again, and was prescribed oxycodone at that time. A November 22 chart note says she "has not been able to get her pain meds from the pharmacies," and "has requested her regular monthly amount of the Oxy 10's be sent to WG-E in Fairbanks." The "Care Plan" says, "Due to the loss, fire, stolen meds over the past 30 days and then the acute injury to her wrist, she has needed more meds then her normal of 10 mg oxy tid. She was given authorization to use up to 2 tid for three or four days for the acute injury."

[79] Sublocade is the injectable form of buprenorphine, while suboxone is the form given as a dissolvable oral film. Ex. 30, pp. 49-50. Like other chart notes here, the note is challenging to decipher, reading: "Patient's PDMP would say she is getting some medicines in regard to opioids and taking some located. Patient should be questioned carefully regarding opioids before refilling." Only context clues from later notes and the PDMP entries showing Sublocade make its meaning clear. Ex. 30, pp. 44-45, 47-38; Ex. 33.

[80] Compare Ex. 30, p. 45 *with* pp. 47-48 ("Discussed medications needed and refilled, except for the Oxycodone...patient getting Sublocade for PA Finch and the last shot should go to middle of September. Pt says she is NOT using both the Sublocade and the Oxycodone and I informed her the PDMP does not show this, AND THIS is not acceptable (text message by text phone and Messenger))".

and society, and his belief that such situations represent "crucial times in someone's life when they need help."[81]

d. PDMP usage

Like most states, Alaska's response to the opioid epidemic included strengthening its prescription drug monitoring program, making it mandatory for providers to review the database before prescribing controlled substances in most contexts. Dr. Andreassen's October 2019 provider report card reflects that, while he wrote 96 opioid prescriptions for a total of 73 different patients during the six-month review period, he only checked the PDMP 50 times during that period. Both the "family medicine physicians" and "family medicine peer groups," by contrast, had more PDMP checks than individual patients receiving opioid prescriptions.[82] However, the exhibits generally demonstrate that Dr. Andreassen checked the PDMP at least once each month while prescribing to the patients whose care is at issue here. But in some cases, Dr. Andreassen's chart notes assert that the PDMP was reviewed when, in fact, the PDMP search results do not show this to have occurred.[83]

Additionally, there is some evidence suggesting that Dr. Andreassen could have used the PDMP to more value. As to Patient 1, even after accounting for the inaccuracies in the Division's initial PDMP exhibit, the volume of prescribing documented in Exhibit 25 – reflecting more than 400 Xanax dispensed during this two week window – is, as Dr. Andreassen himself noted, "very concerning," and it showcases the PDMP's value as a tool to monitor controlled substance prescribing. While Patient 1 testified that Dr. Andreassen would review the PDMP screen with her during her appointments and would specifically discuss with her the high risk of overdose pertaining to her prescriptions, there is no indication in her chart of any discussion

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[81] Andreassen test. ("I can remember when I was a kid and I was in trouble and somebody helped me. There are crucial times in someone's life when they need help").

[82] Ex. 21. Dr. Andreassen testified that he would sometimes have difficulty accessing the PDMP database, although any such difficulties did not arise from systemwide database failures. Nor did he report these difficulties to the PDMP administrators. Sherrell test.

[83] *Compare* Ex. 26, pp. 125-126, 81-82 (5/25/19, 11/25/19) *with* Ex. 29. There was also some question at hearing about whether Dr. Andreassen checked Patient 2's PDMP following her hospital discharge, but the records support that he did. The first chart note after her discharge was October 1, 2019; Dr. Andreassen checked her PDMP that day. Ex. 29. (Note that the PDMP records are in universal time (UCT). The record shows a check on October 2 at 1:10 a.m. UTC, which would be 5:10 p.m. Alaska time on October 1. *See* Exs. 56, 57). The October 1 chart note contains a detailed description of Patient 2's account of her pain medication use and needs, but nothing indicating the PDMP was checked before or during the visit. Ex. 26, pp. 94-95. A chart note the next day reflects her insurance being unwilling to cover Percocet from Dr. Andreassen "because she already filled thirty from her surgeon this month;" this is not inconsistent with the October 1 note that she is taking 4-6 per day and "says she is not getting enough from her surgeon to last a week and cover the pain." *Id*., pp. 93-94.

about 400 Xanax being dispensed in a two-week window (if even to reflect a discussion clarifying that not all of those tablets were picked up).

And as to Patient 4, as noted, Dr. Andreassen briefly withheld her opioid refills in August 2020 after discovering that her PDMP records reflected that she was receiving Sublocade from another provider. The August 27 chart note cautioned that Patient 4 "should be questioned carefully regarding opioids before refilling," and indeed, at a follow up appointment on September 2, Dr. Andreassen withheld oxycodone based on the PDMP showing she is receiving Sublocade. Of note, however, Patient 4's PDMP reveals she has received naloxone before this time – on June 25 and July 19 – and Sublocade on August 18.[84] Dr. Andreassen did not note this issue in her chart until late August, and continued prescribing opioids despite the naloxone visible on PDMP beginning in June.

e. Coordination of care

Another concern raised in this case is whether Dr. Andreassen appropriately engaged in coordination of care – both in terms of obtaining other providers' records for shared patients, and in terms of referrals of patients to other providers. Dr. Andreassen did not consistently obtain records from other providers when his patients were seen elsewhere. Again the most glaring example is Patient 10, who lied about a cancer diagnosis and treatment in order to obtain high doses of opioids. While the er chart contains references to Patient 10 having been requested to provide records, her ongoing failure to do so did not prompt either a change in prescribing patterns or any other action by Dr. Andreassen.[85]

In other cases, Dr. Andreassen provided post-operative care without coordination with other providers or viewing their records. In May 2019, when Patient 1 repeatedly revealed that she had taken more than her prescribed amount of opioids and benzodiazepines, and attributed this to post-surgical pain from recent hernia and spleen surgeries, he did not obtain records relating to those recent surgeries, nor attempt to coordinate care with the surgeon.[86] Likewise, when treating Patient 2 for wound care and infection issues after an unexpected amputation, he did not request or obtain her hospital records relating to the amputation, nor did he otherwise coordinate care (neither pain management nor other care) during her complicated post-operative course.[87]

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84 Ex. 30, pp. 49-50; Ex. 30, pp. 47-48; *see* Ex. 33.
85 *See* Ex. 42, Ex. 43.
86 Ex. 22, p. 69-78.
87 Ex. 26 (chart), Ex. 28 (PDMP).

Dr. Andreassen had also failed to obtain emergency department records from an earlier visit – prior to the overdose and amputation – after Patient 2 disclosed to him that she had recently visited the emergency department. Labs taken at that visit – but never obtained by Dr. Andreassen – were positive for THC, amphetamine, benzodiazepines, MDMA, methamphetamine, and opioids.[88] Several of Dr. Andreassen's patients on high-dose opioids were in motor vehicle accidents during the time he was treating them with concurrently-prescribed opioids and benzodiazepines. While there is no evidence in the record establishing that the patients' prescribed medications contributed to these accidents, he did not consistently take steps to obtain records that would enable him to make such a determination.[89]

Dr. Andreassen's referral of patients to pain clinics appears to have been inconsistent and without timely or consistent follow up. As noted previously in another context, Dr. Andreassen accepted Patient 3 in January 2020 as a patient only for bridge pain treatment, with chart notes stating Patient 3 "will be aiming at pain management and referral to AA pain clinic or Algone pain clinic in the near future." The earliest reference to an actual referral having been sent is not until nearly a year later, when a December 30, 2020 chart notes mentions an "initial referral" sent to Fireweed Pain Center on December 15, 2020. Fireweed responded to that referral one day later, stating "the referral is for epidural steroid consideration which we do not provide," while noting that they "welcome referrals both for chronic pain management when all other therapies and modalities have failed, and referrals for the treatment of opioid use disorder." There is no indication that Dr. Andreassen followed up to clarify whether Patient 3 could be referred for broader pain management. In the meantime, despite saying he would be providing bridge care only and not "ongoing pain meds," Dr. Andreassen prescribed continuous opioids to Patient 3

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88 *See* Ex. 52, p. 52 (Patient 2). Dr. Brose similarly noted the absence in Dr. Andreassen's records of any apparent awareness of – and therefore any consideration of – multiday inpatient hospitalizations for Patient 5 (in September 2019) and Patient 4 (in March 2020, after an overdose). In both instances, the hospital records, reviewed by Dr. Brose, were relevant to Dr. Andreassen's ongoing prescriptions of controlled substances to these patients, but he does not appear to have been aware of either hospitalization, and continued prescribing the same medications thereafter. Ex. 52, p. 46; Ex. 17 (Patient 5); Ex. 52, p. 49; Ex. 30; Ex. 31 (Patient 4).

89 Patient 3, one month after his dosage was increased from 30 MMEs to 45 MMEs, disclosed being in "a very bad" motor vehicle accident the day before, which he described as "driving a semi-truck at 15 mph and on a curve flipped the truck over." Although "he was seen in ER," there is no indication that Dr. Andreassen requested copies of those records. Ex. 45, p. 22; Ex. 46. Dr. Andreassen testified that patients on long-term controlled substance prescriptions functioned better on controlled substances, even to the extent that they were safer drivers than they would be without them.

Patient 8's chart does contain emergency department records from a February 2020 car accident attributed to her car being struck by another vehicle (Ex. 34, p. 164), but there are no records related to a December 2019 car accident, which she identified as the reason for finishing her oxycodone early. Ex. 34, p. 7.

from the time of his first appointment until surrendering his DEA certificate a year later.[90] Patient 4 was likewise accepted for bridge pain treatment in January 2020, with chart notes stating Dr. Andreassen would refer her "to AA Pain for pain management," but the earliest reference to an actual referral having been sent was not until five months later.[91] Dr. Andreassen apparently attempted to refer Patient 8 to AA Spine & Pain in December 2018 and February 2019, and to Algone in July 2019, but neither referral resulted in a transfer of care. As to each referral, the chart contains a response from the referent requesting additional supporting records; it is unclear from the chart whether those records were provided.[92]

Dr. Andreassen testified that he experienced many challenges obtaining records from other providers, attributing this to the general difficulties of rural medicine. However, there is no evidence in his patients' charts to suggest that the general lack of supporting documentation was caused by other providers' refusing to honor his document requests. Dr. Andreassen also testified that the realities of rural medicine created serious limitations to his ability to refer patients to other providers – either for specialized care or for adjunctive pain relief. As to the general lack of such referrals for patients whose care is at issue here, Dr. Andreassen testified that he offered various types of alternative modalities to his patients, and/or that it was too difficult for his rural patients to obtain referrals or actually access specialized care.

Dr. Andreassen did not consult with addiction specialists when providing controlled substances to patients with substance abuse disorders. He testified he was unaware of any "addiction specialists" practicing in Alaska. He was aware of suboxone clinics operating in

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90 Ex. 45, p. 7, p. 37 ("Patient is aware that this is a bridge between where he is now in going to the pain management clinics. I have indicated that I will not be going through ongoing chronic pain meds. He will need to go to pain specialty clinic for ongoing and this is only a 'bridge' to the pain clinics"), p 43; Ex. 48 (1,278 opioid tablets between January 23, 2020 and January 27, 2021).

91 Patient 4's chart is unclear as to when a referral was finally sent, as the only referral in the chart is an October 2020 referral to AA Pain Clinic, but the chart mentions a referral in June, and includes copies of denial letters from other clinics in July and December 2020. Ex. 30, pp. 73, 57-58 (6/5/20: "Patient reports she has been attempting to make an appointment with Algone Pain Clinic, trying to schedule an appointment within next couple weeks… Patient is to call Algone and get her appointment. We will not be continuing to prescribe opiates and pain medicine for her. Patient to call back to get a referral if they do not have one."); 54 (7/2/2020: ("Patient reports she had been attempting to make an appointment for Algone Pain Clinic, for which they told her they didn't receive a referral. I resent the referral to Algone Pain clinic in Anchorage."); pp. 93-95 (referral); 109 (Algone, July 2, 2020: "Thank you for referring [Patient 4] to Algone. We wanted to advise you that: We are no longer able to accept new Medicaid patients as our office is capped off."); 80-81 (Fireweed Health Care, December 29, 2020: "Unfortunately, we are not currently taking patients from Fairbanks for pain management at this time").

92 Ex. 34, pp. 210-219, 208, 230-232 (referrals; AA Pain requesting "more notes and radiology"), 198 (Algone requesting "supporting chart notes, imaging reports, surgery/procedure notes, and diagnostic testing/labs"). Patient 8 and Dr. Andreassen disagree about whether he referred her to physical therapy, but it is undisputed he did not refer her to chiropractic care, massage, acupuncture, "fascial distortion," or other complementary treatments.

Fairbanks, but was unaware of any aspect of their practice beyond the administration of suboxone. At the time of the hearing in this case, Dr. Andreassen did not believe there was "an addiction specialist [he] could send people to," although he allowed, "I could be wrong; I could just be ignorant." Several witnesses who testified in this case provided addiction medicine to patients in the communities Dr. Andreassen serves, including Dr. Marcotte, who testified to attempting to coordinate care with Dr. Andreassen, and ANP Barbara Drake, who described difficulties obtaining patient records from Dr. Andreassen's clinic.

In at least some instances, patients declined suggested referrals when other providers presented alternatives to Dr. Andreassen's controlled substance prescribing. In the case of Patient 1, a January 2021 Urgent Care visit in Tok documents the provider's offer to provide referrals to physical therapy, for osteopathic manipulation, and for addiction medicine, all of which the patient declined.[93] And Patient 5, after an overdose that required resuscitation, similarly refused Dr. Dillon's emphatic suggestion that she participate in a detox program. Both patients instead continued controlled substance-based care with Dr. Andreassen.

Delta Junction is in a remote area with limited services, and at least some of Dr. Andreassen's patients are in significantly more remote areas. Certain modalities, such as physical therapy, are inherently more difficult to access for patients in remote settings. However, many people treated in Delta receive additional medical services in Fairbanks if not Anchorage.[94] Indeed, both Medicaid and Tribal health services coordinate out-of-area care for eligible patients. The evidence does support that Dr. Andreassen's efforts to refer patients at least to Anchorage-based pain management providers were frustrated by resource unavailability – with clinics declining to take Fairbanks-based patients, or stating they could not take on new Medicaid patients. However, between his professed total unawareness of addiction support specialists and the lack of coordination with Fairbanks-based providers, it is also clear that Dr. Andreassen was underinformed about the scope of related services available in Fairbanks.[95]

f. Patients traveling long distances

Lastly, and related to the remoteness of Delta Junction, some provider complaints about Dr. Andreassen's prescriptive practices raised the issue of patients traveling long distances to see

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93 Ex. Y, p. 9 (expressing concern about "what seemed to be very high doses of combination benzo diazepam use and other opiates" prescribed by Dr. Andreassen).

94 Dillon test.

95 While agreeing that Alaska health care suffers from "a resource problem," Dr. Dillon, who has practiced in Fairbanks since 2010, testified Fairbanks has had "various pain management services" throughout that time.

him.[96] Patients 1 and 10, for example, lived in a small village 130 miles past Delta Junction; Patients 3 and 4 lived in Fairbanks, 100 miles in the other direction; other patients lived in Tok (just over 100 miles southeast). While patients living in Northway, Eagle, Tetlin, or Tok have access to geographically closer health care, including a Tanana Chiefs clinic in Tok, residents of those communities also travel to Fairbanks periodically for other services or for groceries, and some patients visit Dr. Andreassen's clinic as part of those trips.[97] At least some Fairbanks-based patients likewise travel the 100 miles to Delta to see Dr. Andreassen because of the personalized nature of the care he provides, or because of scheduling availability.[98]

The concern here is that patients might be selecting Dr. Andreassen over closer providers because of his lax prescribing practices. Certainly, such an inference is reasonably made as to Patients 3 and 4, Fairbanks residents who established care 100 miles away in the middle of winter, solely for pain management, shortly after at least one was "fired" by her longtime pain clinic. As to his patient population as a whole, however, Dr. Andreassen reports that surrendering his DEA certificate has not reduced the number of patients traveling long distances to see him. He presented the testimony of a former longtime Delta Junction resident who has been his primary care patient since the 1980s, and continues to travel to his clinic for primary care despite having moved to North Pole. Describing decades of attentive and coordinated primary care, including for complicated diabetes-related issues (and never involving controlled substances), he testified credibly that Dr. Andreassen's genuine care and concern in their longstanding treatment relationship have motivated him to continue seeing Dr. Andreassen despite now being 80 miles away.

5. Documentation of patient care

Testimony and opinion evidence was presented about Dr. Andreassen's documentation and whether it met current standards, particularly as to controlled substance prescribing. Dr. Andreassen views concerns on this issue as a disconnect between what he was doing and what he was writing down. His response to criticisms of his charting is that he had long visits with

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96 *See,* e.g., Ex. 12 ("I have learned that patients from Fairbanks will drive three hours round trip to visit Dr. Andreassen in order to obtain prescriptions. These patients often lack the basic resources for transportation, but are rewarded for their journey with several hundred prescription pain pills when they return to Fairbanks.").

97 Dr. Andreassen noted that some of his patients have expressed unhappiness with the Tok clinic, and prefer to take the significantly longer journey to Delta; he estimates that he has about 20 primary care patients who live in Tetlin. Andreassen test.

98 In particular, Dr. Andreassen also offers medical examinations required for immigration and service members documentation needs, and testified that some patients will travel from Fairbanks or even Anchorage for these exams due to local providers' extensive waitlists.

patients during which he assessed their functioning and made appropriate adjustments as needed. He says he spent his time "listening and taking in information" and "counseling" patients, and was focused on those tasks, rather than on "trying to establish a document." He also candidly admits he was unaware of the heightened requirements in effect for charting in connection with controlled substance prescribing. In fact, the Board's controlled substance prescribing regulation was amended in 2018 to require that licensees prescribing a controlled substance "shall create and maintain a complete, clear, and legible written record of care that includes:

> (A) a patient history and evaluation sufficient to support a diagnosis;
> (B) a diagnosis and treatment plan for the diagnosis;
> (C) a plan for monitoring the patient for the primary condition that necessitates the drug, side effects of the drug, and results of the drug, as appropriate;
> (D) a record of each drug prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills[.][99]

Evidence from Dr. Andreassen's patient documentation is considered below.

a. Adequacy of documented reason to prescribe opioids

The 2016 CDC Guideline advises providers to start opioid treatment only if the expected benefits outweigh the risks, and to continue it only if clinically meaningful improvement in pain and function outweigh the risks. Critics of Dr. Andreassen's opioid prescribing practices note shifting, generalized diagnoses or other insufficient bases for chronic opioid prescribing.

The most striking example is Patient 10, to whom Dr. Andreassen prescribed high dose opioids for what he believed was end-stage cancer pain, but who, in fact, did not have cancer.[100] As to the remaining patients, regrettably, the Division did not always assemble a complete record, but the indications are troubling. Patient charts were only put into evidence for Patients 1, 2, 3, 4, 8, and 8. As to at least some of these patients, the conclusions of the Division's expert's (Dr. Brose) about a lack of diagnostic justification appears to have arisen from the scope of the subpoenas issued in this case – that is, at least some patients' charts contained underlying documentation not provided to him because it predated the 12-18 month date range identified in the Division's subpoena.[101] Thus, while Dr. Brose found that the charts lacked documentation of

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[99] 12 AAC 40.975(1)

[100] *See* Ex. 42, p. 32 (7/1/19: "Patient is going to get the documentation of the cancer and type of cancer and bring it to us as soon as possible. The imaging was done at the imaging center at Fairbanks [Memorial] Hospital and the uterine biopsy was performed at the hospital. Pathology reports should be available.").; Ex. 58 (Button Aff.).

[101] Dr. Brose acknowledged the possibility "that such documentation was available earlier in the longitudinal record of Dr. Andreassen," as "no evidence of such information was carried forward in these patient charts."

"a validated cause for chronic pain and the prescribing of chronic opioid therapy," Dr. Andreassen demonstrated that, at least as to some patients, his charts contained relevant documentation that – because of the Division's oversight – had not been provided to Dr. Brose. While the nature of the that documentation is sparse, it does undermine the argument that Dr. Andreassen's charts had no diagnostic information related to chronic pain diagnoses and prescribing decisions.[102]

At least in some cases, however, patients prescribed opioids for a certain condition would use them for other conditions, with no indication of any consideration of whether opioids were an appropriate treatment in that situation. Dr. Andreassen was prescribing long-term opioids to Patient 1 for low back pain and a painful skin condition, but her chart notes also reflect that she was using them for acute post-operative pain, vaginal pain, and hand pain after a fight. The records do not reflect an individualized inquiry into the appropriateness of opioids for these separate and distinct conditions (nor any coordination of care regarding post-operative pain), let alone decisionmaking as to a greater treatment plan.[103]

Additionally, and separate from the sufficiency of information to justify an initial period of opioid prescribing, the patient records in this case are notable for a lack of periodic reconsideration of the suitability of *ongoing* opioid treatment. Again considering Patient 1, the September 2017 MRI coverage denial letter denied the request because the "pain is confined to low back without radicular pain or neurological deficits."[104] But by June 2019, she was reporting "radiating pain down the left leg, numbness and tingling to right leg."[105] There is no indication in Patient 1's chart that Dr. Andreassen considered further diagnostic workup in light of these symptoms. Dr. Andreassen testified that he would not pursue diagnostic testing for Patient 1 because he would not expect it to show anything, because, "with her, everything hurts … that's what happens with people with anxiety, depression – they just hurt everywhere."[106]

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[102] *Compare* Ex. 52, pp. 32-33 *with* Ex. X, pp. 2-3 (Patient 8: 2015 MRI reports documenting "mild thoracic spondylosis" and two "minimal disc bulges"), Ex. Y, pp. 1-5 (Patient 1: Sept. 2017 x-ray report documenting "lower lumber facet arthrosis").

[103] *See* Ex. 52, pp. 61-62 (As to Patient 1: "The presence of changing diagnoses and characterization of various acute and chronic conditions suggests an absence of a discerning medical decision-making being involved and as a consequence would represent a threat and similarly a gross deviation in medical decision making.").

[104] Ex. Y. While the letter includes a statement of Medicaid Fair Hearing/Appeal Rights setting out the ability for either Patient 1 or Dr. Andreassen to appeal that denial, there is no indication this was pursued.

[105] Ex. 22, p. 67.

[106] *But see* Ex. Y, pp. 9. (January 2021 Urgent Care notes identifying suspicion that Patient 1's pain is caused by soft tissue/myofascial pain syndrome, and offering a referral "to osteopathic manipulation for management" as well as to physical therapy, both of which she declined).

As for Patient 4, the "bridge pain management" patient, Dr. Andreassen's January 22 intake chart note reports, "Pt states she has 100% disability because of her back she has degenerative disc disorder and saw [Dr.] Jiang for her pain treatment care for 10 years." But Dr. Jiang's records, marked in Dr. Andreassen's chart as received on January 23, reflect that Patient 4's SSDI claim was denied, that her physical exam is normal, and that, while there may be some "lumbar degenerative disc disease at L5-S1 in the setting of a Tarlov cyst at the S2 level," Dr. Jiang is "more concerned about the patient's drug-seeking behavior."[107] Subsequent chart notes do not reflect any reconsideration of whether a sufficient basis for opioid prescribing exists. Further, even when subsequent chart notes explicitly say that controlled substance prescribing will be discontinued, this did not occur.[108]

Similar concerns exist with regard to Dr. Andreassen's prescribing of benzodiazepines and stimulants. Dr. Brose noted that such prescribing, with no record evidence of "clearly enumerated DSM5 diagnostic criteria or supportive consultative specialty opinions," raised concerns about diagnostic rigor, without which a well-intentioned provider may "instead subject the patients to palliative treatments when more curative treatments may be available."[109] Every patient discussed in this case was receiving benzodiazepines "for anxiety." But patient charts do not reflect diagnoses from specialists, specialized mental health treatment, application of enumerated diagnostic criteria, treatment alternatives, or education as to or appreciation of the risks associated with high dose, long-term benzodiazepine prescribing. Multiple patients in this case were likewise prescribed stimulants for "ADHD" without external diagnostic confirmation.

Dr. Andreassen diagnosed Patient 2 with ADHD and started her on Adderall in May 2019, at a visit in which she disclosed significant current meth use, which "she is requesting help to stop." The ADHD-related symptoms described in his chart note are poor academic performance and paradoxical effects of caffeine; no objective testing is reported. Dr. Andreassen began Patient 2 on a three-times per day regimen of 20 mg Adderall, which he increased to four times her day two weeks later after she "ran out early."[110] Dr. Andreassen testified that he would not prescribe a non-stimulant ADHD medication to a patient who had been using stimulants; that

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107 *Compare* Ex. 30, p. 73 *with* p. 166-167.

108 *Compare*, Ex. 30, pp. 56-58 (6/5/20: Care plan: "We will not be continuing to prescribe opiates and pain medicine for her.") *with* Ex. 31 (continued opiate prescriptions July 2, July 30, September 4, October 9, October 26, October 29, December 1, December 22, and 30).

109 Ex. 52, p. 2

110 Ex. 26, pp. 105-106.

is – he selected Adderall *because of* Patient 2's disclosure of meth use.[111] Although the initial May 2019 chart note indicates a "referral to Hats of Wisdom for testing to confirm" ADD/ADHD, no documentation of (or reference to) testing/confirmation appears in the chart. Nonetheless, Dr. Andreassen continued Patient 2 on Adderall – 20 mg, four times per day – into 2021.[112]

b. Dosage-related documentation

Information on medication prescribed was spotty and incomplete in Dr. Andreassen's charts, as was documentation relating to dosage adjustments. At times, prescriptions in the patient PDMP records do not correlate to any chart entry. Dr. Andreassen testified that if a patient's PDMP record showed a prescription without a chart note, it would likely be because he saw a patient after hours and charted late; he was unable to explain why chart would have no entry for the date of some prescriptions. Patient 1's PDMP records for the year under review contained at least six separate controlled substance prescriptions – three Xanax prescriptions and three oxycodone prescriptions over a four month period – without accompanying chart notes.[113] Other times, chart notes for a visit are missing any indication of a medication that was prescribed.

The chart note for Patient 4's initial visit in January 2020 reflects that a single medication, Vicodin, was prescribed. But her PDMP records shows a second prescription from that visit – a 14-day supply of Adderall – which not documented in any way in the January 22 visit note.[114] The Adderall prescription does not appear in Patient 4's chart until her second visit two weeks later, in which Dr. Andreassen describes that the "Adderall is working okay but pt is having high amount of anxiety would like to have something prescribed for it." With no further discussion in the note about Adderall or the bases for its use – and despite that it is "working okay" and that she is having a "high amount of anxiety" – and the medication list in the note and

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111 Andreassen test. There is no indication from the record or his testimony as to how he identified 60 mg as the appropriate starting dose. The manufacturer's recommended maximum dose is 40 mg, with dosage instructions providing, "only in rare cases will it be necessary to exceed a total of 40 mg per day." Stimulant and Related Medications: U.S. Food and Drug Administration-Approved Indications and Dosages for Use in Adults. Centers for Medicare & Medicaid Services, October 2015. https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/pharmacy-education-materials/downloads/stim-adult-dosingchart11-14.pdf.

112 Ex. 26, pp. 105-107; Ex. 28.

113 Ex. 22; Ex. 25 (11/5/19 alprazolam, 11/21/19 oxycodone, 12/21/19 oxycodone, 12/13/19 alprazolam, 12/16/19 oxycodone, 3/16/20 alprazolam).

114 *Compare* Ex. 30, pp. 74-75 *with* Ex. 31. While both the "Diagnosis" list and a "Problems List" at the very end of the note list ADHD among Patient 4's diagnoses, there is nothing in the note to reflect that Dr. Andreassen has assessed or treated Patient 4 for ADHD at this visit – and certainly nothing to indicate that he has prescribed her a controlled stimulant.

the PDMP records both reflect that Dr. Andreassen tripled Patient 4's Adderall dose at this second visit.[115]

As to documentation of prescribing information, Dr. Andreassen's charting of controlled substance prescribing for most of the patients herein included the name of the medication and the dose of the individual pill, and, occasionally, the date through which the prescription was intended to last; he typically did not include prescribing directions (i.e. number of pills/number of times per day), nor total number of pills dispensed.[116] As a result, when patients sought early refills, the chart likewise did not include notations as to how many pills had been consumed early or were otherwise unaccounted for.

Patient records reviewed at hearing reflect that Dr. Andreassen made frequent adjustments to patient controlled substance prescriptions, typically without documenting his medical decisionmaking in the patient's chart. In May 2019, Dr. Andreassen adjusted Patient 1's medication dosage repeatedly following visits in which she revealed that she had taken more than her prescribed amount of opioids and benzodiazepines due to pain from recent abdominal surgery. Over less than three weeks in May 2019, she received 270 oxycodone tablets, representing three separate "30-day" supplies at different dosages ranging from 45 to 90 MMEs.[117] Her Xanax dose during this time likewise varied from three to four 2-mg tablets per day, with 90 tablets provided on May 1, 2019, followed by 120 more on May 24, 2019.[118] Dr. Andreassen recognizes in retrospect that much of the shift in dosages during this time was attributable to drug-seeking by Patient 1, likely including that she was "buying on the streets" and coming to him with contrived excuses "when she ran out."

Patient 2's records reflect various benzodiazepine dosage adjustments between 2, 4 and 6 Xanax tablets per day and between 6 and 15 Klonopin per day.[119] Dr. Andreassen says that sometimes these adjustments were made for purposes of "getting her on a numbers cycle" –

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115 The PDMP record shows 28 10-mg tablets as a 14-day supply on January 22, followed by 45 20-mg tablets as a 15-day supply on February 6 – an increase from 20 mg/day to 60 mg/day. The February 6 chart note does not document the decisionmaking around this change. The note likewise does not document any aspect of the decisionmaking that led Dr. Andreassen to prescribe buspirone for anxiety. Just one week later, he would begin prescribing Patient 4 two different benzodiazepines.

116 *See*, e.g., Ex. 22 (Pt. 1), pp. 5-6 (Only three of 14 listed controlled substance prescriptions list prescribed frequency of use); Ex. 45 (Pt. 3), p. 4 (one of seven); Ex. 34 (Pt. 8), p. 4 (two of ten); Ex. 42 (Pt. 10), pp. 4-5 (while all other prescriptions listed include dosage/use directions, none of the six controlled substance prescriptions do so).

117 Ex. 23 (May 1: 90 10-mg oxycodone (45 MMEs); May 7: 90 15-mg oxycodone (67.5 MMEs); May 20: 90 20-mg oxycodone (90 MMEs)).

118 *Id*. Dr. Andreassen explains this ebb and flow by noting that people have anxiety for a variety of short-term and long-term reasons, and also that he suspects that her need for Xanax increased when she had less oxycodone.

119 Ex. 26 (chart), Ex. 28 (PDMP).

seemingly a reference to adjusting a written prescription to ensure insurance coverage over a desired period of time. Absent from the records is any clear justification – and often any mention at all – from which a reviewer might be able to identify the medical basis for these treatment decisions.

Broadly speaking, Dr. Andreassen describes adjusting dosages as appeared necessary for patients to reach a functional level, and acknowledges that his chart typically did not document the decisionmaking process associated with those changes. Dr. Andreassen testified that he adjusted patients' medication dosages based on their self-reported functioning, always making sure to tell patients to "come back in if things aren't working or need to be adjusted." He acknowledges an overall dearth of documentation on medication dosages, agreeing "it would be nice to have" that documentation in the chart, saying he was unaware before this case was filed that he was "supposed to document these things."

c. Documentation of informed consent, treatment plans, and progress

Dr. Andreassen's charts in this case were generally lacking documentation of informed consent of risks of long-term chronic opioid therapy, evidence of the prescribed drugs' effect on the patients' functioning, drug tests, or a documented treatment plan related to controlled substance prescribing. One piece of documentation missing from most charts is any reference to discussions with patients about the dangers of concurrent prescriptions of sedatives and opioids. Three of the nine patients had pain contracts, but there is no documentation for the remaining patients as to whether and what patients were told about the risk of addictive controlled substances generally, or concurrent prescriptions in particular, either in terms of giving informed consent for care, or in terms of safety vis-à-vis overdose risk. Dr. Andreassen reports he counseled patients about risk and appropriate use of controlled substances; Patients 1, 5, and 8 all testified similarly.[120] Many patients appear to have been prescribed Narcan, although again, there is a general lack of documentation about what education was provided.

Dr. Andreassen testified that he charts using the S-O-A-P method of identifying a patient's subjective reports, the provider's objective observations, the provider's assessment based on the first two items, and a plan based on that assessment. While his career has spanned

[120] Dr. Andreassen also testified to his view that a number of patients at issue here, with documented substance abuse history, were uniquely aware of the dangers related to controlled substance use. For example, between July 2 and August 21, 2020, Patient 3's dosage was increased from 30 MMEs to 45 MMEs to 67.5 MMEs. There is no discussion in his chart about any discussion of the added risks of the serially higher doses. Dr. Andreassen testified that Patient 3 was aware of the risks because of his longtime heroin use. Ex. 45, p. 22-27; Ex. 46.

the transition from handwritten to electronic records, for the period at issue in this case, Dr. Andreassen's clinic has solely used electronic medical records. His chart notes have four large headings with further subheadings: Subjective (Chief Complaint, Medication List); Objective (Physical Exam, Constitutional); Assessment (Diagnosis List); and Plan (Procedures; Prescribe; Care Plan; Problem List).

Throughout the records in this case, the bulk of the notes' content is typically found in the "Chief Complaint" section, while the "Assessment" section is typically limited to a diagnosis list, and the "Plan" is often limited to a note that the patient will return in a month. There is a fair amount of inconsistency as to the charting of prescriptions, with prescriptions written after a given visit sometimes appearing under the "Medications List" at the start of the note for that visit, and other times appearing under the "Plan – Prescribe" heading, and sometimes be absent altogether, and with prescription entries rarely including full details of the dosage and administration directions.

For some of the patients here, Dr. Andreassen's documentation contained very little detail, sometimes limited to the "subjective reporting" component, with no explanation of what was done or intended as a result. As to any assessment of the effect of either the underlying condition or the controlled substance on the patient's functioning, Dr. Andreassen's notes tended to summarize the patient's stated reason for the visit and their subjective reporting – typically limited to descriptions such as "meds helping" or "using more than prescribed" – but not to document any objective findings. Dr. Andreassen virtually never deployed a fixed format questionnaire as part of his clinical assessment, and to the extent he was conducting a clinical assessment through sitting and talking with patients, he did not typically document the results of such assessments in his charts.[121] Dr. Andreassen testified that such information was discernible by "reading between the lines," for example, when he increased a medication dose.[122] Other times, he surmised that, "there must have been something that happened that I didn't write down."[123]

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[121] Brose test; *but see* Ex. 34, pp. 136-137 (Pt. 8 6/18/19 chart note containing responses to detailed "Chronic Pain Evaluation").

[122] Andreassen test. (re: May 2019 increase of Patient 1's oxycodone and Xanax doses after she ran out early).

[123] Andreassen test. (re: Patient 4's oxycodone dose doubling from 45 to 90 MMEs following March 4, 2020 telemedicine visit for which the entirety of documentation on medication use or effectiveness – or any other medical symptoms or treatment – is: "Per pt all medications are working well with no side effects. Pt says she did run out of oxycodone 10 mg as she was taking them QID instead of the instructed TID. Pt says the Adderall is working well for her and helping her focus."); *see also,* Ex. 30, pp. 66-67; Ex. 31. At least some charts entries *were* more detailed, with the notes of Patient 4's next visit, on March 30, containing a more robust discussion, documenting her reported

Follow-through between visits is difficult to identify in the charts. Where the prior visit's Plan includes action items such as the patient needing to bring medications to their next visit, the next visit typically does not followed up on those items.[124] Similarly, information received between visits is not referenced and does not appear to inform decisionmaking. Again considering the start of Patient 4's treatment, the day after her first visit (and a Vicodin prescription) Dr. Andreassen received records from her prior pain management provider, appearing to raise doubts about some of her representations. At her second visit, two weeks later, Dr. Andreassen moved her from Vicodin to a fentanyl patch, without either describing the decisionmaking or noting any concerns associated with the records received in the meantime. The decision to discontinue Vicodin is inferred by its absence from the medication list for this February 6 chart note; no express statement of that decision is contained in the note. The "subjective" portion of the note states that Patient 4 describes her pain as "usually a 6 out of 10," that she "feels like the [Vicodin] wasn't working as well due to taking Subox[o]ne" and "is concerned about the Tylenol causing liver issues," and "is requesting more pain medications and anxiety medications today." After an "Assessment" section consisting solely of a list of three diagnoses, the "Care Plan" then describes instructions for using fentanyl patches and a plan for a telemedicine visit in a week to discuss those. But there is no documentation of the underlying decisionmaking.[125]

As to a treatment plan, Dr. Andreassen's chart notes generally contained, at most, a list of medications and sometimes a statement of the patient's near-term plans. But largely missing from his charts were discussion of a long-term treatment plan, such as a plan to determine if medications are working, or when and how to titrate off them. While several patients and Dr. Andreassen testified that he did not intend to keep them on controlled substances "forever," their records generally did not corroborate active or sustained efforts to titrate them off of opioids or

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pain levels during different activities and circumstances, and with versus without pain medication. Ex. 30, p. 64. But these entries are the distinct exception in the charts entered into evidence. *See* Ex. 52, p. 51 ("While the care and treatment of [Patient 4] may represent some of the more standardized treatment that Dr. Andreassen's review suggests for his patients with chronic pain," documentation and treatment were still below the standard of care).

[124] *See, e.g.,* Ex. 30, pp.. 75 (asked to bring meds to next visit), 71-72 (prior request never mentioned).

[125] *Compare* Ex. 30, p. 73 *with* p. 166-167. A chart entry the day after this visit reflects that the pharmacy refused to fill the fentanyl prescription, leading Dr. Andreassen to instead prescribe 10-mg oxycodone three times daily. A telemedicine visit note one week later says Patient 4 has "slowly increased" her oxycodone dose and reports that "approximately 50 mg oxycodone per day" (i.e. nearly twice her prescribed dose) "cuts the pain to a 2-3 level." A plan is therefore made to double her dose after she uses up her remaining supply. Ex. 30, pp. 69-70.

benzodiazepines, nor reflect the discussions the patients describe about planning to get them off of controlled substances.[126]

We already saw, in connection with PDMP usage, Patient 1's November 16, 2019 chart note describing a plan to see her in two weeks "to see where we go from here in the process of pain management as well as the continued direction she wants to go of finding ways to eliminate the opioid medications in her pain management." The ensuing fact pattern presents not only PDMP deficiencies but also charting deficiencies – ones that raise questions about Dr. Andreassen's implementation of treatment planning. This plan is never discussed again in the chart provided, even after the January 2020 "long phone discussion of her meds," in which "she is unable to explain the shortfall of the oxycodone."[127] And in fact by March 2020, her opioid dosage has returned to nearly 90 MMEs, and Dr. Andreassen continued prescribing both opioids and benzodiazepines until surrendering his DEA certificate. [128]

Few of the available records described alternatives considered or deployed. At most, Dr. Andreassen's charts admitted in this case noted for some patients, such as Patient 4, continued but seemingly empty cautions that no more refills would be provided.[129] The majority of patient records, for the majority of time available in this case, do not appear to contemplate any plan beyond continuing with the ongoing controlled substance prescribing.[130] Speaking specifically about Patient 1, Dr. Andreassen says his chart notes simply fail to tell the full story of his treatment process with this patient, describing that her frequent appointments invariably entailed lengthy discussions of curtailing her controlled substance use and were always focused on identifying a sustainable rehabilitative path for her health and her life. The paucity of documentation for these visits, however, then leaves any reviewer of these charts with perhaps the misimpression that controlled substance prescribing is "the totality of the plan."[131]

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126 Patient 8 test. An exception to this general rule, Patient 3's chart contains discussions of alternative treatments, including heat, NSAIDs, steroid injections, and e-stim; similar discussions are not found in other patient charts. *See* Ex. 45.

127 Ex. 22, p. 17.

128 *See* Ex. 23; Patient 1 test.

129 Although a similar pattern is seen for Patient 4's spouse, Patient 3, his chart actually contains the most notable example of meaningful treatment alternatives: a discussion – albeit eleven months into his treatment – about using steroid shots to "taper off the oxy." Ex. 45, p. 15.

130 See, e.g, Ex. 26 (Pt. 2), p. 14 (12/17/2020 "Care Plan: Discussed patient's concerns for today. Discussed medications and refilled meds as noted in medication section. Instructed patient to return via face to face or telemedicine as needed for continuity of care Reviewed patient's need of health care maintenance issues"). Ex. 42, (Pt. 10) p. 26 (8/1/2020: note includes no care plan section); Ex. 34 (Pt. 8), p. 138 ("Care Plan: Dilaudid, fentanyl and alprazolam renewed for 3 months and sent to her pharmacy. PDMP/MME Prescription Drug Monitoring Program / Morphine Milligram Equivalents: [Blank]").

131 Brose test.

E. Board complaints and other concerns

In April 2018 Fairbanks-based addiction medicine physician Peter Dillon contacted an investigator for the Board with concerns about Dr. Andreassen's prescribing practices. While concerns about preserving patient confidentiality initially led him to withhold filing a formal complaint, Dr. Dillon and two colleagues eventually submitted a written complaint "that Dr. Andreassen is prescribing opiates to known opiate addicts, and prescribing potentially dangerous combinations of opiates, stimulants and benzodiazepines."[132] Citing patient reports, PDMP reviews, and concerns expressed by other local physicians and pharmacists about "unusually high volumes of controlled substances being prescribed as well as individual daily morphine equivalents above acceptable standards of care," the November 2018 complaint urged that "[t]hese prescribing habits are dangerous and potentiate the abuse and misuse of opiates and opioids."[133] In the meantime, the Division had also received a complaint in September 2018 from Pharmacist Donald Hudson, Medical Director of pharmacies in both Glenallen and Delta, who expressed concern about "a large number of controlled Rx" by Dr. Andreassen compared to all other providers" in the two locations, noting, "he writes for a seemingly large # opioids."[134]

The Division did not notify Dr. Andreassen of these complaints for more than two years, although Dr. Andreassen did have other indications of concerns. At least by March 2019, if not earlier, Dr. Andreassen was receiving pushback from pharmacists on his controlled substance prescribing. The dosage in a March 2019 Xanax prescription for Patient 9 was reduced after a pharmacist contacted Dr. Andreassen to express feeling "uncomfortable starting the higher dosage of Xanax and it was agreed to drop it to 1 mg twice a day."[135] Dr. Andreassen similarly attributes at least some of Patient 1's dose fluctuations to similar issues, saying that some occurred because "the pharmacy … wouldn't give it to her." Patient 1 testified that at some point both Delta Junction pharmacies told her they couldn't or wouldn't fill her prescriptions from Dr. Andreassen any longer, and describes pharmacists telling her that Dr. Andreassen "shouldn't be prescribing those."[136]

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132 Ex. 12; Dillion test.

133 Ex. 12.

134 Ex. 13.

135 Ex. 52, p. 27 (Pt. 9) The Division marked Patient 9's chart as an exhibit, but did not introduce the exhibit. This summary in Dr. Brose's report is consistent with the testimony of witnesses, including Dr. Andreassen, about pharmacists sometimes being unwilling to fill Dr. Andreassen's prescriptions.

136 Andreassen test.; Patient 1 test. Patient 1 testified that she was able to find another pharmacy (in North Pole, two hundred miles from her home) that would fill them, and that, pursuant to her pain contract, she told Dr. Andreassen where she was getting her prescriptions filled.

Dr. Andreassen acknowledges it was "really clear to [him] that we were making a significant change" because pharmacies would "butt heads" with him on prescriptions. He says that he was "clearly aware" of the changed landscape of controlled substance prescribing: "I'm doing the PDMP, and it's giving me the overdose scores and the MMEs—the world that I'm in says we have changed." He notes receiving the PDMP prescriber's reports, and was aware they showed him as an outlier, recalling, "I always felt so bad about myself when I got the PDMP." At the same time, he says he was unaware of concerns about his practices, insisting that, "[i]f there'd been any official who had in some way gotten in my face, talked to me, given me something," he would have changed his practice accordingly.

On March 26, 2020, a Division investigator sent Dr. Andreassen a certified letter notifying him of two complaints the Board had received about his prescriptive practices, and that the "the complainants allege your prescriptive practices are not appropriate and may place the patients at risk of accidental overdose." The investigator said she was contacting Dr. Andreassen "as part of an initial inquiry into this possible violation," although, "[a]t this time, you are not the subject of an official investigation."[137] She enclosed a subpoena for Dr. Andreassen's 2019 "medical and prescriptive records" for four patients, including Patients 8 and 10, stated that he would be contacted for a meeting after the records were received, and provided her contact information if he had "any questions."[138] There is no evidence either that Dr. Andreassen contacted the Division in response, or that the Division contacted him.

In the months that followed, Dr. Andreassen received prior authorization denials – in particular, from the State of Alaska Medicaid program – regarding his controlled substance prescriptions. In April, June, and September 2020, Klonopin prescriptions for Patient 2 were rejected by the Alaska Medicaid program as above the plan's dosage limit, and requiring documentation of a "treatment (and taper) plan," as well as rationale for exceeding the dose set by the manufacturer.[139] And a June 2020 denial on an oxycodone prescription for Patient 4 raised concerns about a conflict between the quantity he had prescribed and the written dispensing information, and about the presence of "addictive behaviors."[140]

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137 Ex. 6, p. 1 (emphasis omitted).

138 Ex. 6, p. 1. Ex. 34, pp. 1-2.

139 Ex. 26, p. 153, 148. Indeed, the dosage prescribed by Dr. Andreassen – 8 to 16 mg per day, was two to four times the manufacturer's dosage of 4 mg per day. *See* Ex. 26, 145.

140 Ex. 30, p. 117. In November 2020, a prior authorization denial of 15 mg oxycodone for Patient 3 advised that the prescription was only available if the patient had "failed or [had] an intolerance to at least 2 non-opioid therapies." Ex. 45, p. 46 ("The member must be unable to be either safely or effectively treated with a combination opioid analgesic with acetaminophen, aspirin, or ibuprofen (such as Hydrocodone/APAP or Oxycodone/APAP)").

In the meantime the Division received several more complaints. In June 2020, a Fairbanks Memorial Hospital Pharmacy Manager contacted the Board about concerns after Patient 10's death that her PDMP records and patient chart provided no imaging or diagnostic support "to explain the significantly high MMEs she was prescribed."[141] In August 2020, a Chief Andrew Isaac Clinic physician contacted the Board after Patient 6, being seen for a Percocet addiction and due to start Suboxone, had been seen by Dr. Andreassen, obtained 45 oxycodone and 40 Klonopin, and then "appeared at [Chief Andrew Isaac] clinic on withdrawal and asking for help."[142]

The Division sent Dr. Andreassen a second Notice of Complaint in August 2020, stating the Division had received a complaint that "alleges your prescriptive practices for several patients are not appropriate and may place the patients at risk of accidental overdose." The Notice was accompanied by a records subpoena for three additional patients' May 2019 – May 2020 records, and contained the same information as the March 2020 Notice about the status of the Division's inquiry.[143]

F. DEA actions and surrender of controlled substance prescribing authority

Apparently at the same time the Division was receiving complaints about Dr. Andreassen, the DEA was receiving complaints as well. These eventually led Dr. Andreassen to surrender his DEA registration in early 2021.

This was Dr. Andreassen's second notable encounter with the DEA, the first having occurred nearly ten years earlier. But the first occurred in a very different context. Each encounter is significant to this case in a different way, and the two encounters are described below. Initially, we will return to the first encounter.

The first encounter occurred in the context of the Family Medical Center's operation of a dispensary. Under the Controlled Substances Act, the DEA is authorized to conduct "administrative inspections" of controlled premises for "inspecting, copying, and verifying the correctness of records, reports, or other documents required to be kept or made under [the Act]."[144] Its regulations provide for the frequency of such inspections to be "based in part on the

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141 Ex. 58.
142 Ex. 59, p. 1.
143 Ex. 6, p. 2.
144 21 U.S.C. §§822(f), 880.

registrant's history of compliance with the requirements of this chapter and maintenance of effective controls and procedures to guard against the diversion of controlled substances."[145]

At times in the Family Medical Center's history, its operations included running a dispensary, a practice under which physicians may dispense medicines to their patients. In July 2012 DEA investigators conducted an administrative inspection of the Center.[146] This was its third such inspection, and Dr. Andreassen recalls it as essentially uneventful, other than being shorter than prior inspections.

In May 2013, however, the DEA filed a Complaint against Dr. Andreassen in the United States District Court for Alaska. Characterizing its July 2012 inspection as having been "prompted by the large quantities of narcotics purchased by Andreassen," the Complaint sought civil penalties against Dr. Andreassen for alleged Controlled Substances Act violations ostensibly "identified" through "the investigation."[147] These were, broadly speaking, allegations of inaccurate or insufficient recordkeeping, as well as a failure to establish effective controls and procedures to guard against theft or diversion by staff.[148] Dr. Andreassen characterizes these concerns as pertaining to the Medical Center's dispensary paperwork by staff, describing the underlying issue as "a clerical thing" related to how dispensary staff were using a particular DEA form. The concerns did not relate to either patient care or patient care documentation.

Dr. Andreassen eventually entered into an agreement with the DEA to settle the 2013 matter, admitting no fault or wrongdoing, but agreeing to pay $30,000, representing "a compromise amount for the civil penalties set forth in the complaint," and in June 2015 the parties, though counsel, stipulated to dismissal of the action.[149]

When he applied to renew his Alaska Medical License in October 2014, Dr. Andreassen answered "No" to all professional fitness questions, including question 13, which asked whether he had been "investigated . . . by the Drug Enforcement Administration" since the date of his last application or within the past two years. When he again applied to renew his Medical License in November 2016, he again answered "No" to all professional fitness questions, including question 12, which asked if he had been "investigated or disciplined by the Drug Enforcement

145 21 C.F.R. 1316.
146 Ex. T; Ex. 1, p. 3.
147 Ex. 1, p. 2.
148 Ex. 1, pp. 3-5.
149 Ex. 2, pp. 1-2; Ex. 3.

Administration" within the past two years or since the date of his last application.[150] He now explains that he considered the DEA matter to relate to the Family Medical Center dispensary, not to him as an individual practitioner (although both the federal complaint and his later Surrender for Cause reference the same medical practitioner registration number).[151] He also suggests that DEA "administrative inspections" are routine procedures that do not rise to the level of an "investigation," and that the civil settlement agreement did not constitute "discipline."

The record does not reflect any further interactions between Dr. Andreassen and the DEA until February 26, 2021, the date of his for-cause surrender of his DEA Certificate of Registration. As he describes this event, two DEA agents came to the clinic, met with him, and described in detail concerns about this prescribing practices. Characterizing this as "the first I knew I was in trouble," Dr. Andreassen says he agreed at that meeting to surrendered his registration. The signed surrender document recites in pertinent part:

> In view of my alleged failure to comply with the Federal requirements pertaining to controlled substances or list 1 chemicals, and as an indication of my good faith in desiring to remedy any incorrect or unlawful practices on my part, I hereby surrender for cause my Drug Enforcement Administration (DEA) Certificate of Registration.[152]

G. Post-Surrender Practice

Although he no longer prescribes controlled substances, Dr. Andreassen testified that his overall practice volume and patient composition has not changed as a result of surrendering his DEA registration. He still sees roughly 18-20 patients per day, including patients from remote areas more than one hundred miles past Delta, and patients from the Fairbanks area.

The patients whose care is at issue and who testified on Dr. Andreassen's behalf in this case all testified that they resolved their addiction shortly after he surrendered his DEA certificate, with Patients 1 and 5 specifically identifying the unavailability of prescribed medications as a significant driving force in that event.[153]

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150 Ex. 4, p. 1 (2014; the full text of Question 13 is: "Since the date of your last application for a license in Alaska or within the past two years have you been investigated or disciplined by the Drug Enforcement Administration or have you surrendered your federal or any state controlled substance registration for any reason or is any such action pending?"); Ex. 5, p. 2 (2016).

151 Dr. Andreassen held DEA medical practitioner controlled substances registration No. AA2284571. While he apparently also held a separate DEA registration related to overseeing EMS services, both the federal complaint and the DEA Surrender for Cause in evidence in this case reference No. AA2285471. Ex. 1, p. 2; Ex. 11.

152 Ex. 11.

153 Ex. 38.

Patient 1 began suboxone treatment five months after Dr. Andreassen surrendered his DEA certificate. She says that after Dr. Andreassen could no longer "help me with my care of trying to get off opiates," she "was buying them off the street," resulting in two fentanyl overdoses, and ultimately a decision to "get clean." She described Dr. Andreassen as someone who "won't try to hurt your feelings but he'll be honest with you" – including that "he'd lecture [her] on how to be more responsible towards [her] medications" – and believes that he helped her both by managing her pain and by being supportive of her desire to get off of opioids. Although Patient 1 did not get sober until Dr. Andreassen surrendered his DEA certificate, Dr. Andreassen "believes [he] helped her considerably in getting her life together enough that she could even consider getting on suboxone." While he concedes that he could have handled it better, he considers the outcome in Patient 1's case a success.[154] Patient 5 likewise stopped using benzodiazepines after Dr. Andreassen stopped being able to prescribe them, saying, she "could've gotten them from the other clinic, but they wouldn't give me as much as I wanted. I realized that was a turning point in my life and I needed to knock it off."

Patient 8, whose spouse's military assignment had led her to the Delta Junction area, testified that her family left Alaska in a military move at the end of 2021, but that she stopped seeing Dr. Andreassen "when COVID started" in 2020.[155] But her PDMP records show continued controlled substance prescriptions from Dr. Andreassen until his DEA certificate surrender, including filling prescriptions for 120 2-mg Klonopin tablets, 30 3-mg eszipliclone ("Lunesta") tablets, 30 360-MME fentanyl patches, and 120 30-mg oxycodone tablets on February 2, 2021 – three weeks days before he surrendered his certificate. The only controlled substance on her PDMP report after Dr. Andreassen's surrender is suboxone, which she began taking on March 11, 2021 under a prescription from another provider.[156] Patient 8 – who describes a period of unrelenting pain related to orthopedic and gastroenterological disorders alongside severe anxiety and depression related both to chronic pain and significant childhood trauma – considers her treatment by Dr. Andreassen to have been profoundly beneficial. She believes that Dr. Andreassen, unlike other providers she had seen, was actively "trying to get to the root of the problem, not just masking it." Recalling that Dr. Andreassen "would listen to me

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154 Patient 1 test.; Andreassen test.

155 Patient 8 test; Ex. 38, p. 3.

156 Patient 8 now treats her pain and anxiety with medical marijuana, which had not been an option for her in Alaska because of military housing requirements

and be reassuring and talk me through it and let me know there was more out there for me," she believes that Dr. Andreassen "saved [her] life."

As to all three, Dr. Andreassen considers his acceptance-based treatment as having laid necessary groundwork for their eventual sobriety.

H. Notice of Investigation and Consent Agreement

On March 9, 2021, eleven months after the Notice of Complaint and ten days after he surrendered his DEA Certificate, Inv. Wall-Rood sent Dr. Andreassen a Notice of Investigation, stating that, following the three complaints, "[a]n inquiry was conducted including but not limited to the following allegations: professional incompetence, gross negligence, repeated negligent conduct, and inappropriate prescriptive practices[.]" The notice then advised that, "after review with licensed physicians representing the Board, it was determined the allegations in these matters violate the laws governing your medical license. The purpose of this letter is to advise you that you are now under official investigation by the Board[.]"[157]

The Division retained Dr. William Brose, a Board-certified Anesthesiologist and Pain Management physician with more than 30 years of clinical experience, to review records of ten patients and provide a written opinion about the controlled substance prescribing issues in this case. His August 10, 2021 report addresses Dr. Andreassen treatment of Patients 1, 2, 4, 5, 6, 8, 9, 10, based on records the Division had subpoenaed.[158] Dr. Brose concluded that Dr. Andreassen's files "do suggest a high level of care as evidenced by the frequent, at times daily, reevaluation interval of the patients by Dr. Andreassen." But he found "the pattern of repeated controlled substance prescribing" to be "of grave concern." His concerns included many issues noted above, including high dose and concurrent prescribing, sufficiency of justifications for controlled substance use, and adequacy of treatment documentation, all of which he found to be violations of the standard of care.[159]

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157 Ex. 7.

158 Ex. 52; Ex. 53. Dr. Brose also provided a written opinion about two patients not otherwise raised in this case, B.S. and L.M., whose treatment will not be addressed here. As to Patient 9, about whom limited testimony was presented, the only opinion offered concerned Dr. Andreassen providing monthly amounts of oxycodone, Klonopin, Xanax, Adderall, and phentermine to a transient patient without access to a recognizable secure location, which Dr. Brose calls "an extreme deviation in medical decision making from the standard of care as the loss of control over the medication facilitates the diversion of the medication to unintended parties." Dr. Brose opined that, given the risk of diversion, the standard of care required "specific documentation describing the monitoring of prescription doses, quantities, and use patterns to allow the characterization of the magnitude of the substance use disorder." *Id*., p. 30. As no evidence was presented on these issues, they are not considered here.

159 Dr. Brose was unaware at the time of his report that only a relatively small subsection of Dr. Andreassen's patients were receiving controlled substances, let alone at the levels represented in the same he reviewed. And as

At some point, as is typical in licensing investigations, the Division provided the materials gathered in its investigation to a reviewing board member. This process generally entails the Division investigator asking the reviewing board member to provide their input on whether the evidence gathered appears to support a violation of the board's statutes and/or regulations and, if so, what level of discipline the reviewing board member believes would be appropriate. That information is then used to inform the decision on a possible compromise arrangement with a licensee. The division prepares a proposed consent agreement with the disciplinary terms suggested by the reviewing board member, and offers that agreement to the licensee. If the licensee accepts, the parties then offer the agreement to the board, which can either accept or reject the agreement.

In this case, for reasons that are unclear, several board members appear to have served in some type of reviewing board member capacity. At some point, the reviewing board member(s) assigned to the case made a recommendation about the appropriate sanction, after which the Division and Dr. Andreassen reached an agreement memorialized in a proposed consent agreement. The Board, however, rejected the parties' consent agreement.[160] Of course, no evidentiary record had been developed at that time, and the Board's decision not to authorize a settlement had the effect only of requiring that such a record be assembled, with the Board free to reach any appropriate resolution based on that record. This process thus followed.

I. Administrative Hearing Process

On October 26, 2022, the Division filed a five-count disciplinary accusation in this case. Dr. Andreassen timely requested a hearing. The Division amended its accusation in November 2023. By agreement of the parties, the hearing was scheduled for and held over a two-week period beginning February 26, 2024.

1. Witnesses

In addition to Dr. Andreassen, the Division presented testimony from investigators William Homestead and Michelle Wall-Rood, PDMP Program Director Lisa Sherrell, three of the professionals who had submitted complaints to the board (Drs. Peter Dillon and Stuart Marcotte, and Barbara Drake, RN), and pain management expert Dr. William Brose. The

noted above, it was further established that some but certainty not all of the deficiencies Dr. Brose identified were at least partially mitigated by the completeness of information he reviewed.

[160] Further, after an executive session, a board member moved for revocation of Dr. Andreassen's license. This motion initially passed, before later being reconsidered in light of "consultation with the Department of Law and due process rights." The Board then voted to reject the proposed consent agreement.

Division also presented testimony by affidavit of three additional complainants, Drs. Gail Norton and Sean Richardson, and pharmacist James Button.[161]

Dr. Andreassen presented testimony from a number of current and former patients, with live hearing testimony from Patients 1, 5, 8, and a primary care patient; testimony by affidavit from five primary care patients (C.S., J.D., D.G., P.G., and A.G.); testimony by affidavit from retired nurse Jeanette Brasier, and live hearing testimony from PA Katie Steer.

2. Patient-specific evidence presented

Although Dr. Andreassen's controlled substance prescribing to ten specific patients was addressed in hearing testimony in some way, the evidence presented as to specific patients varied widely in scope. Of the ten patients, the Division only offered into evidence PDMP records for only seven patients (Patients 1, 2, 3, 4, 5, 8, and 10), Dr. Andreassen's charts for only six (Patients 1, 2, 3, 4, 8, and 10), and Dr. Andreassen's PDMP searches for only four (Patients 1, 2, 4, 10).[162]

Additionally, as to all patient charts the Division introduced into evidence, the charts were generally time-limited to a period of less than two years. In some instances, this provided an incomplete picture of whether Dr. Andreassen's recordkeeping reflected, for example, justification for controlled substance prescribing.

The most complete presentations by far were as to Patients 1, 2, 4, 8, and 10, for whom the evidence included Dr. Andreassen's testimony, chart, and PDMP records, as well Dr. Brose's medical records summary and written opinion. A detailed but less complete picture was presented as to Patients 3 and 5 . For Patient 5, the Division did not submit her chart into evidence, but she testified and other exhibits and testimony was also provided. Patient 3's care was not reviewed by Dr. Brose, but a relatively robust evidentiary picture was presented through his chart, PDMP records, and testimony of Dr. Andreassen and Dr. Dillon.

The least detailed presentations were as to Patients 6 and 7. Patient 6 was addressed only through very limited witness affidavit testimony; no medical records were provided for Patient

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[161] Treatment of affidavits is governed by AS 44.62.470, which provides a mechanism for a party to request to cross-examine the affiant, and restricts the treatment of affidavit testimony depending on whether cross-examination has been made available. Ultimately, all witness affidavits were admitted and all cross examination waived. Accordingly, the witness affidavits admitted in this matter are given the same effect as if the affiants had testified orally.

[162] The Division did not offer Dr. Andreassen's charts for Patients 5, 6, 7, or 9, although its evidence did include Dr. Brose's very detailed records summaries for Patients 5, 7, and 9. Charts for Patients 5 and 7, PDMP records for Patients 7 and 9, and PDMP search records for Patients 3, 8, and 9 were all marked as exhibits but not offered into evidence.

6.[163] Patient 7 was addressed very briefly through affidavit and live witness testimony (Dr. Marcotte); the only records for Patient 7 were 22 pages of records in Respondent's Ex. V, and Dr. Brose's records summary.

3. Significance of Dr. Andreassen's DEA Surrender

The testimony at hearing concerned deficiencies only as to Dr. Andreassen's controlled substance prescribing. As to his primary care practice, no concerns were identified or testified to. Dr. Brose was unaware until the hearing in this case three years later that only a relatively small subsection of Dr. Andreassen's patients were receiving controlled substances, and certainly only a small subset receiving them at the levels described above. More significantly, for purposes of the ultimate outcome here, Dr. Brose was unaware until the hearing that Dr. Andreassen had surrendered his DEA registration six months before he issued his report. He testified that the concerns identified in his report are ameliorated by Dr. Andreassen's surrender of prescribing authority, and that he has no concerns outside of controlled substance prescribing. The Division, in closing arguments, conceded that its pursuit of revocation as a remedy was based only on controlled substance prescribing concerns, and that, if the Board is able to restrict controlled substance prescribing, it believes that a lesser remedy is appropriate.

III. Discussion

A. Applicable Law

1. Board general provisions

The State Medical Board is vested with the significant responsibility of regulating the practice of medicine in Alaska.[164] One aspect of that oversight is the Board's authority to discipline licensees for violations of the statutes and regulations governing the profession.[165] The Board has a range of disciplinary options available to it depending on the severity of the violations and its evaluation of the full surrounding circumstances.[166]

2. Evidentiary considerations

Because this proceeding is governed by the administrative adjudication provisions of the Administrative Procedure Act, "hearsay evidence may be used to supplement or explain direct evidence but is not sufficient by itself to support a finding unless it would be admissible over

163 Ex. 59, Norton Aff.
164 AS 08.64.101.
165 AS 08.64.101(a)(3), AS 08.64.326; AS 08.64.331; AS 64.62.330(a)(5); AS 64.62.360.
166 AS 08.64.331.

objection in a civil action."[167] Dr. Brose's report (Exhibit 52) was admitted into evidence over objection as to its hearsay nature, and as to its accuracy, with Dr. Andreassen's counsel establishing several factual oversights or errors in the 170-page report. For each of the patients whose care he considered, including eight of the ten patients about whom evidence was presented here, Dr. Brose's report contains both a narrative discussion and a detailed bullet-point summary of the medical records he reviewed and relied on. Some of the shortcomings of his records review are addressed further below. However, when his overall summaries are compared to the charts in evidence, the summaries are sufficiently consistent with the charts to support reliance on the other hearsay summaries to supplement and explain other admissible evidence in this case. Where the summary is consistent with other evidence in the record, that summary has occasionally been used to supplement and explain that evidence. No chart entry summarized by Dr. Brose has been relied on as the sole basis for any finding in this case, however.

A significantly smaller portion of Dr. Brose's report contains his actual opinions in this case. Dr. Brose's testimony was clear that his opinions in this matter are set out in full detail in the bolded sections of the report, which he authored three years before the hearing in this case. Those portions of the report are used herein to supplement and explain Dr. Brose's testimony. However, as to patients where the Division did not present any hearing testimony, and as to events and conclusions raised in Dr. Brose's report but not raised at all at hearing, the report has not been considered.

An issue also arose after hearing about the reliability of the Division's PDMP exhibits. The full history of this dispute is documented in the Order dated April 17, 2024, and the parties' responses to that order. Dr. Andreassen's response argued that Exhibits 29 and 43 – Dr. Andreassen's PDMP search histories for Patients 2 and 10 – should be disregarded because the Division's counsel did not expressly verify their accuracy in her submission dated April 22, 2024. But Dr. Andreassen's counsel, who has full access to the same underlying records, did not argue that these exhibits were actually inaccurate. In the absence of evidence that the inaccuracy extended beyond the issue in Exhibit 23, the PDMP records have not been disregarded. Both

[167] AS 44.62.460(d). The prehearing scheduling order advised the parties that, "[b]ecause the hearsay status of documents or testimony is not always self-evident and because technical hearsay issues can be curable, the limitation regarding use of hearsay in AS 44.62.460(d) will be applied only if a hearsay objection is timely asserted at the hearing."

exhibits are relied on in this decision to conclude that the Division did not meet its burden as to the PDMP review allegations for those patients.

B. Did the Division meet its burden of proving that Dr. Andreassen violated statutes or regulations governing the practice of medicine?

For the sake of organization, the Division's allegations are discussed in the following categories: (1) improper controlled substance prescribing, (2) recordkeeping deficiencies, and (3) securing a license renewal through fraud/deceit.

1. Did the Division meet its burden of proving that Dr. Andreassen failed to practice pain management with sufficient skills and training and by standards adopted by the Board?

a. "Specialty board practice standards" and consistency with adopted guidelines (Counts VI, X)

The Board's controlled substance prescribing regulations require that a licensee prescribing a controlled substance must practice pain management "with sufficient knowledge, skills, and training, and in accordance with specialty board practice standards," and "in accordance with" the CDC 2016 Guideline for Prescribing Opioids for Chronic Pain and the FSMB 2017 Guidelines for the Chronic Use of Opioid Analgesics. Otherwise, such a provider shall "refer a patient to a pain management physician."[168] Counts VI and X of the Amended Accusation allege that Dr. Andreassen's practice fell materially short of these requirements. Notably, Dr. Andreassen admitted these allegations in general terms in his prehearing brief.[169]

i. Failure to meaningfully consider (and/or reconsider) non-opioid alternatives

The CDC Guideline and FSMB guidelines both set out the importance of measured decisionmaking in both initial and continued opioid prescribing decisions.[170] Clinicians are advised to "consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh the risks to the patient," and to reevaluate continuation of opioid therapy at least every three months.[171]

Dr. Brose characterizes Dr. Andreassen's charts for the patients considered here as reflecting controlled substance prescribing driven by "intuitive medical decisionmaking" rather

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168 12 AAC 40.975(4).

169 Respondent's Prehearing Brief, p. 6 ("Dr. Andreassen recognizes and admits that his prescribing practices for controlled substances was improper and out of date, but *only* as of 2017 when Alaska began modifying regulations per CDC national guidelines") (emphasis in original).

170 *See* Ex. 19; pp. 9-11, 14-15; Ex. 20, pp. 9-10.

171 Ex. 19, pp. 9-11, 14.

than rational, evidence-based decisionmaking, and explained that this did not meet "the contemporaneous standard of care for controlled substance prescribing."[172] It was later established that at least some of Dr. Brose's opinions were materially limited by the scope of materials to which he had access. For example, while he concluded that the lack of evidence of informed consent, and the inconsistent evidence of discussions of overdose risk, in Dr. Andreassen's charts reflected violations of the standard of care, he had not been provided the signed pain contracts that were in some or most of those patients' charts, as these predated the subpoena date range. He testified that these contracts would satisfy informed consent concerns. Similarly, Dr. Andreassen produced evidence that the charts of at least some patients at issue had historical diagnostic documentation predating the range of documents provided to Dr. Brose, and which Dr. Brose acknowledged represent the kind of diagnostic material he had believed to have been wholly absent. In other instances, Dr. Brose had overlooked information contained in the records he was provided – such as, in the case of Patient 2, photographs of a visibly painful amputation wound, which he conceded was relevant to the diagnostic calculus of pain management prescribing. Similarly, as to mitigating the risks of opioid prescribing, Dr. Brose had overlooked multiple patients' prescriptions for Narcan, which he had believed was not provided and which he agreed would reflect an important and appropriate component of risk management around Dr. Andreassen's opioid prescribing. Even with these caveats to Dr. Brose's conclusions, however, the evidence still requires the conclusion that Dr. Andreassen fell below the standard of care for controlled substance prescribing.

Dr. Andreassen is correct that the CDC and FSMB Guidelines cannot be read to absolutely preclude controlled substance prescribing in certain situations – that they provide guidance, but not rigid dictates or prohibitions. The FSMB guideline advises clinicians to "consider the circumstances and unique needs of each patient when providing care,"[173] and Dr. Andreassen's generalized response to the allegations about his prescriptive practices is that he was meeting the very unique needs and circumstances of his particular, and particularly challenging, patients. But the proviso to consider patients' unique needs and circumstances cannot be read in a vacuum. That is, clinicians have discretion to use clinical judgment, but they cannot use that discretion as a shield from their obligation to practice to the current standard of care, informed by the current level of knowledge and expectations. Dr. Andreassen absolutely

172 Ex. 52, p. 2.
173 Ex. 20, p. 2.

had discretion to exceed the recommended 50 MME threshold, for example, but doing so would only be justified if it were based on reasonable and informed medical decisionmaking, including ongoing assessment of benefits and risk.

For the vast majority of patients considered in this case there is no evidence that Dr. Andreassen meaningfully considered alternatives to controlled substance prescribing, even when the patients continually reported that the medications were not relieving their symptoms, and even in the face of strong evidence of misuse or diversion.[174] At least as to the patients considered in this case, Dr. Andreassen defaulted to opioid prescribing without any regard to the guidance and cautions in the CDC Guideline, and with no indication of the treatment planning required for such prescribing.

The danger of the high dose opioid prescribing in this group of patients was significantly compounded by Dr. Andreassen's frequent concurrent prescribing of benzodiazepines – also at high doses. The concurrent use of benzodiazepines and opioids "greatly increases the risk of adverse events including death."[175] While both the CDC and FSMB guidelines advise clinicians to avoid concurrent prescribing of opioid pain medication and benzodiazepines "whenever possible,"[176] Dr. Andreassen's prescribing did not reflect the level of caution contemplated by the guidelines and specialty (or other) practice standards. Instead, he continued to co-prescribe these medications based on his personal belief that they "work really well together." Again, while licensees have wide discretion to prescribe based on the actual needs of their patients, they have a duty to actually *exercise* that discretion; here, the evidence does not support a finding that Dr. Andreassen engaged in the kind of meaningful and rigorous examination that might appropriately support such significant deviation from the guidelines and from standard practice.

As discussed above, as to at least some patients, Dr. Brose's criticism of a lack of diagnostic justification appears to have lacked the benefit of the fuller patient file, which in some instances contained more complete documentation. Undeniably absent in Dr. Andreassen's charts at issue in this case, however, is charting that reflects reassessment of whether opioid

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174 *See* Ex. 52, p. 50 (Patient 4: "Medication ineffectiveness seems to be characterized and yet continued prescriptions for each of the controlled substances is provided."); p. 57 (Patient 2: records throughout ongoing escalation of opioid prescribing "fail to contain any characterization of the medical decision-making with regards to the opioid prescriptions and/or clinical responses to that opioid prescribing;" falling below standard of care "both for the prescribing of controlled substances [and] documentation of medical decision-making around the controlled substances.").

175 Ex. 20, p. 10.

176 Ex. 19, p. 17 (CDC); Ex. 20, p. 10 (FSMB).

prescribing remains appropriate.[177] Setting aside whether at least some of the charts contain historical documentation of some underlying injury or pathology, they do not contain evidence of any evaluation of the appropriateness of opioid therapy to treat those conditions, either initially or on an ongoing basis. The danger to the patient is multifaceted. It includes the risks of addiction, overdose, and death. It also includes an opportunity cost from a failure to look for possible curative treatment options. "The prescribing of controlled substances for these conditions being intractable presumes an exhaustion of usual curative and alternative treatments, such as would be considered in the usual course of medical practice."[178] In Patient 1's case, for example, another provider's note raises at least the possibility that Patient 1's pain might have a treatable cause, rather than, as Dr. Andreassen believes, be simply caused by her depression and anxiety.

In short, the Division met its burden of showing that, for the patients whose care is at issue here, Dr. Andreassen's controlled substance prescribing, at very high doses, without attention to the risk of concurrent prescribing and without reassessment as to the appropriateness of controlled substance use, fell below the standard of care. Further, beyond the standard of care for chronic pain-related opioid prescribing generally, Dr. Dillon explained that the standard of care with opioid-addicted patients is to place primacy on non-opioid treatment methods. Dr. Andreassen did not did so for the patients in this case. Instead, over a multiyear period, he continued prescribing very high doses of opioids, very often alongside high doses of benzodiazepines. While providers are not prohibited from prescribing opioids to opioid-addicted patients, the decision to do so requires greater care and attention to the unique dangers of that decision. As the evidence did not support a finding that Dr. Andreassen's prescribing to patients with opioid addictions was informed by those concerns, his practice in this regard likewise fell below the standard of care.

ii. Inadequate monitoring of controlled substance use

Dr. Andreassen's controlled substance prescribing was also materially deficient as to monitoring patients' controlled substance use. The standard of care for controlled substance prescribing includes monitoring for misuse. Both the CDC and FSMB guidelines advise periodic urine drug screening during opioid therapy, as well as other tools and strategies to identify

[177] Ex. 52, p. 2 (describing "custom and habit of continued and repeated prescriptions in the absence of such rational prescribing information" as representing "an intuitive, rather than rational, medical decision making relative to those controlled substances").
[178] Ex. 52, p. 2.

misuse or diversion.[179] Dr. Brose's testimony and report identified monitoring strategies including smaller prescription amounts, pill counts, and closer monitoring of use patterns.[180] The preponderance of the evidence supports a finding that Dr. Andreassen's monitoring of patients' controlled substance use fell below the standard of care.

In response to questions about whether he had informed his patients of the risks and benefits of high dose opioid and benzodiazepine use, Dr. Andreassen denied suggestions that his patients were unaware of the risks associated with their controlled substance use. He also noted that he used pain contracts and ensured that patients prescribed opioids had access to Narcan. However, he acknowledged that when his high-risk patients engaged in "red flag behavior" – such as serial excuses for early refills – he did not implement recognized safety measures such as pill counts or urine drug screens. Dr. Andreassen appears to acknowledge that, as to various patients whose care is at issue in this case, he was more permissive than he should have been, and that at least in some instances his trustful approach to patients' narratives should have been modulated.

In testimony, Dr. Andreassen suggested that his opioid prescribing for many patients discussed herein was informed by their having previously been treated by pain specialists. But this explanation ignores, and his records do not address, the disconnect between this justification and those same patients having been "fired" by those pain specialists for drug seeking behavior.[181] While Dr. Andreassen was clear about his philosophical disagreement with that treatment approach, he did not present evidence to support that his alternative model of, essentially, radical acceptance and trust, meets the standard of care. Of particular concern, given his election to continue prescribing controlled substances to patients whose abuse of those substances in prior "pain management" settings was documented, was his failure to them implement monitoring and controls to promote patient safety and reduce the risk of community harm through diversion.

Multiple witnesses testified that treatment of patients with substance abuse disorders with controlled substances creates a heightened risk that in turn requires heightened care.[182] Dr. Andreassen counters that providers should not use "a person's history" as a basis to "stop [the provider] from trying to give them legitimate care." Dr. Andreassen's approach to patient

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179 Ex. 19, p. 17.; Ex. 20, p. 11.
180 Ex. 52, pp. 15, 30.
181 *See, e.g.,* Ex. 30, pp. 74-75 (Patient 4).
182 Dillon test; Norton test.

monitoring in the context of controlled substance use was undeniably informed by his drive to meet his patients' panoply of needs. He believes that mainstream pain management specialists typically apply measures like pain contracts and pill counts in a "punitive" manner, and in ways that protect doctors more than patients, when what is really necessary is "working aggressively to move the patient in the positive direction" by being "avidly engaged in the whole package of their life." While acknowledging that, "looking back on this, I should not have been as willing to believe" patients' stories, Dr. Andreassen indicates that his focus was on gaining patient trust in order to facilitate "open, honest communication," which he sees as a necessary component to true recovery.[183]

Although some entries in some patient charts appear to reflect an awareness of the need for heightened monitoring and control of controlled substance prescribing, the charts for the patients discussed herein do not reflect action consistent with that need. As Dr. Brose observed, multiple patient charts reflect a "pattern of treatment planning suggesting that the patient's medication refills need to last for a certain duration, and then having subsequent medication refill appointments requested made with those refills being early," demonstrating "inadequate medical decision making regarding the continued prescriptions in the context of" problems suggesting overuse and possible diversion.[184] The Division has established that Dr. Andreassen's continued prescribing of high dose controlled substances while failing to implement monitoring procedures consistent with specialty practice guidelines violated the standard of care.

b. Initial prescribing requirements (Count IV)

Separate from the broader expectations surrounding controlled substance prescribing generally, Alaska law also establishes specific limitations on initial dosage and supply for new opioid prescriptions. Alaska Statute 08.64.363, enacted in 2017, prohibits a licensee from issuing an initial opioid prescription in excess of a seven-day supply.[185] The statute then identifies two potentially relevant exceptions to the initial seven-day supply provision, "if in the professional medical judgment of the licensee, more than a seven-day supply is needed" for one of these contingencies. The statute provides exceptions for treatment of "the patient's acute medical condition, chronic pain management, pain associated with cancer, or pain experienced

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183 Andreassen test. ("I can remember when I was a kid and I was in trouble and somebody helped me. There are crucial times in someone's life when they need help").

184 Ex. 52, p. 22 (re: Patient 10).

185 AS 08.64.363(a); AS 08.64.326(a)(14) (authorizing Board to impose a sanction upon finding, after a hearing, that a licensee prescribed or dispensed an opioid in excess of the maximum dosage authorized under AS 08.64.363).

while the patient is in palliative care" or for "a patient who is unable to access a practitioner within the time necessary for a refill of the seven-day supply because of a logistical or travel barrier." Both exceptions require the licensee to document the specific basis for the exception, and "that a nonopioid alternative was not appropriate to address the medical condition"

The evidence establishes that Dr. Andreassen violated AS 08.64.363 as to Patients 3 and 4. While both received initial doses under the applicable 50 MME dosage limit, Dr. Andreassen provided each a fourteen-day initial opioid prescription after their first visit.[186]

Neither chart contains documentation nor any suggestions that more than a seven-day supply was considered necessary. Specifically, while the statute contemplates the possibility that it may be required due to "a logistical or travel barrier," and although Patients 3 and 4 live 100 miles from Dr. Andreassen's clinic, the vast majority of "visits" after their initial in-person visit were conducted by phone or video. In any event, neither patient's chart contains any indication that a 14-day supply had been deemed necessary due to a logistical or travel barrier; there is simply no acknowledgment that the seven-day limitation exists.[187]

Because a licensee can only issue an initial opioid prescription in excess of a seven-day supply when an exception applies and is documented, the Division met its burden to show that Dr. Andreassen violated AS 08.64.363 by prescribing greater than seven day initial supplies to Patients 3 and 4.

c. PDMP review (Count IX)

The Board's regulations require prescribers of controlled substances to review a patient's PDMP record (1) prior to initially prescribing a controlled substance, (2) at least every 30 days for up to ninety days, and (3) at least once every three months if a course of treatment continues beyond ninety days, and define unprofessional conduct to include failing to review the PDMP when prescribing Schedule II or III controlled substances.[188] In Count IX of the Amended

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[186] *See* 12 AAC 40.975(3) ("[T]he maximum daily dosage for an initial opioid prescription issued under AS 08.64.363(a) may not exceed 50 morphine milligram equivalents"); Ex. 31 (Pt. 4: 1/23/20: initial dose of 14-day supply of 30 MME hydrocodone); Ex. 48 (Pt. 3: 1/22/20 initial dose of 14-day supply of 22.5 MME hydrocodone).

[187] Given his repeated acknowledgement during the hearing of having been unaware of changes to the Board's controlled substance prescribing regulations, it is likely Dr. Andreassen was similarly unaware of this provision.

[188] 12 AAC 40.975(2) ("When prescribing a drug that is a controlled substance, an individual licensed under this chapter shall … review the information from the [PDMP] before initially dispensing, prescribing, or administering a controlled substance designated schedule II or III under federal law to the patient, and at least once every 30 days for up to 90 days, and at least once every three months if a course of treatment continues for more than 90 days[.]"); 12 AAC 40.967(34).

Accusation, the Division alleges that Dr. Andreassen failed to conduct PDMP reviews at the required frequency.

The Division introduced PDMP search histories for only four patients (Patients 1, 2, 4, and 10), and established a violation as to only Patient 4.[189] As to Patient 4, the records reflect that Dr. Andreassen did not review her PDMP at least every 30 days for the first 90 days of controlled substance prescribing. Patient 4's first appointment with Dr. Andreassen was on January 22, 2020; the chart note from that visit reflects that Dr. Andreassen "reviewed [PDMP] in room with patient before prescribing."[190] The PDMP search records confirm that Dr. Andreassen reviewed Patient 4's PDMP that day, and again on February 6. Thereafter, he did not review Patient 4's PDMP again until March 30, despite having two separate "medicine reviews" in the interim.[191] This was a violation of the requirement to review the PDMP at least every 30 days for the first 90 days of prescribing controlled substances to Patient 4. Dr. Andreassen's reviews of Patient 4's PDMP quickly became more frequent, however, with reviews at least twice each month (and sometimes more than six times per month) from June 2020 through February 2021.

There is certainly evidence suggesting that Dr. Andreassen was not as rigorous with the PDMP as he should have been. Most notably, the October 2019 PDMP prescriber report reflects that, while he wrote 96 opioid prescriptions for a total of 73 different patients during the six-month review period, he only checked the PDMP 50 times during that period..[192] However, the Division did not establish with specificity any other violations of the PDMP requirements for the patients whose care is at issue in this case.

The remaining three patients for whom PDMP search records were introduced appear to have been receiving controlled substances from Dr. Andreassen prior to the period covered by the Division's subpoenas, making it most likely that the governing requirement was for Dr. Andreassen to review the PDMP "at least every three months."[193] Each of the three search

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189 Ex. 24 (Patient 1), Ex. 29 (Patient 2), Ex. 32 (Patient 4), Ex. 44 (Patient 10). The Division withdrew its exhibits regarding PDMP search histories of Patients 3 (Ex. 47), 8 (Ex. 37), and 9 (Ex. 41), and submitted no search histories for Patients 5, 6, and 7.

190 Ex. 30, p. 75.

191 Ex. 30, pp. 66 - 69 (February 13 and March 3), Ex. 32.

192 Ex. 21.

193 The Division appears to assume that "every three months" provision requires that such reviews occur prior to prescribing activity. But that limitation does not appear in the provision, which only says that the provider must review the PDMP "at least every three months," and does not further specify when in the course of prescribing activity that review is to occur.

history exhibits show that Dr. Andreassen reviewed the patient's PDMP at least once every month from the date of the first search shown. The exhibit for Patient 1 runs from January 2019 through February 2021, and reflects that Dr. Andreassen reviewed Patient 1's PDMP information at least once per month, but often up to six times per month, over this period.[194] The exhibit for Patient 2 runs from April 2019 through February 2021, and shows Dr. Andreassen having reviewed Patient 2's PDMP records at least once every two months during this period, with a greater frequency beginning in September 2020.[195] The exhibit for Patient 10 runs from May 2019 through June 2020, and shows that Dr. Andreassen reviewed her PDMP at about every six weeks from May 2019 through her last prescription in late April 2020 (as well as once in June 2020, after learning of her death).[196]

2. Did the Division meet its burden of proving that Dr. Andreassen violated recordkeeping regulations governing his practice? (Counts II, III, VIII)

The second broad category of alleged deficiencies is in Dr. Andreassen's documentation, which the Division alleges fell below the requirements for charting generally and as to the heightened requirements that apply to controlled substance prescribing.

The Board's regulations require licensees to "maintain adequate records for each patient for whom the licensee performs a professional service."[197] The "minimum requirements" for patient records under this provision include that the record must "reflect the treatment provided to or recommended for the patient" and "document the patient's progress during the course of treatment provided by the licensee."[198] At least some of the records here fall materially short of the minimum threshold.

As described above, Dr. Andreassen's documentation for the patients discussed herein was sparse and inconsistent. Dr. Andreassen maintains that concerns about his charting elevate form over substance, and that he was primarily focused on listening, taking in information, and using his education, training and experience to "come to the right diagnosis" and "take good care of you," rather than "primarily to make a beautiful document." But some of the patient records

194 Ex. 24.
195 Ex. 29.
196 Ex. 44; Andreassen test.
197 12 AAC 40.940.
198 12 AAC 40.940(b)(9), (10). Other requirements include that the record must: "(4) indicate the dates that professional services were provided to the patient; (5) reflect what examinations, vital signs, and tests were obtained, performed, or ordered concerning the patient and the findings and results of each; (6) indicate the chief complaint of the patient; (7) indicate the licensee's diagnostic impressions of the patient; [and] (8) indicate the medications prescribed for, dispensed to, or administered to the patient and the quantity and strength of each medication[.]"

at issue here were missing any indication of certain patient encounters, with the patient's PDMP record showing a controlled substance prescription that is not otherwise reflected in Dr. Andreassen's chart. While most provider records will likely have room for improvement, and the purpose of the "adequate records" requirements is not to impose unreasonable or unattainable burdens on licensees, failing to document an encounter at all, or a prescription at all, is plainly a material violation of the minimum requirements.

Beyond the minimal requirements for patient records generally, the Board's regulations in effect since 2018 set a heightened documentation requirements in controlled substance prescribing, requiring in 12 AAC 40.975(1) that a licensee prescribing a controlled substance "shall create and maintain a complete, clear, and legible written record of care that includes:

> (A) a patient history and evaluation sufficient to support a diagnosis;
> (B) a diagnosis and treatment plan for the diagnosis;
> (C) a plan for monitoring the patient for the primary condition that necessitates the drug, side effects of the drug, and results of the drug, as appropriate;
> (D) a record of each drug prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills[.]

Dr. Andreassen repeatedly testified that he had been unaware of these requirements before being asked to surrender his DEA certificate, and agreed that documentation was "one area where [he] could have done a better job." Of course, unawareness of the Board's regulation in this area does not excuse a physician's failure to comply. Despite his later testimony that he felt his records satisfied the requirements even though he had been unaware of them, the evidence supports a finding that Dr. Andreassen did not meet the standards set out in 12 AAC 40.975(1).[199]

The determination whether patient records contained a "patient history and evaluation sufficient to support a diagnosis" is complicated by the patient records introduced in this case being, in most cases, a subsection of a longer patient record. Some, but not all, of the patient records introduced are too incomplete to determine their sufficiency on this factor. As to Patient 10, to whom Dr. Andreassen prescribed opioids for "cancer pain" for more than a year without any documentation supporting a cancer diagnosis, Dr. Andreassen's records fell below the minimum threshold requirements for "a patient history and evaluation sufficient to support a diagnosis." As to Patient 4, her chart is concerning for a lack of diagnostic work-up as Dr.

[199] Brose test (documentation fell short of "the usual standard of controlled substance monitoring").

Andreassen continued prescribing high dose opioids as "bridge care" for more than a year. The only diagnostic records in Patient 4's chart are prior provider's records expressly questioning her diagnosis. To the extent that Dr. Andreassen reached a contrary conclusion through his own examination of the patient, he simply failed to document that examination or his decisionmaking process.

The documentation introduced in this case largely failed to meet the remaining requirements. As to the requirement that the record of care include "a diagnosis and treatment plan for the diagnosis," the charts introduced here did not contain diagnosis-specific treatment plans beyond ongoing controlled substance use. The charts did not reflect a "plan for monitoring the primary condition being treated by the controlled substance," nor for monitoring either side effects or the results of treatment. Monitoring the effects of treatment was largely accomplished through describing self-reported anecdotal descriptions, typically with no objective measures of treatment outcome. This was true for opioids, stimulants, and benzodiazepines. Typically, the only "treatment monitoring" apparent in the chart was dosing changes, from which Dr. Andreassen suggests one can "read between the lines" to determine the dose was adjusted in response to patient reports about the medication's impact. But the records largely contained neither objective measures of treatment outcome , nor assessment of whether controlled substance prescribing remains appropriate.[200] And of course the threshold purpose of the regulation is to provide an actual record of decisionmaking, not a puzzle from which to decipher meaning.

As to the requirement that the record of care include "a record of each drug prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills," this information was likewise largely absent from patient charts. As noted elsewhere, there are multiple instances of PDMP entries with no corresponding chart entry. But more broadly, as to drugs prescribed during documented visits, Dr. Andreassen rarely if ever documented *all* of the information required by the regulation. Entries related to a visit were sometimes incomplete or missing. Even when included in the "prescribed" section of the chart, entries rarely included dose information.

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[200] Ex. 52, p. 2 (describing "custom and habit of continued and repeated prescriptions in the absence of such rational prescribing information" as representing "an intuitive, rather than rational, medical decision making relative to those controlled substances"). The exception is Patient 3, whose chart contains a discussion – albeit eleven months into his treatment – about using steroid shots to "taper off the oxy." Ex. 45, p. 15.

The evidence supports a finding that Dr. Andreassen failed to satisfy the requirements of 12 AAC 40.975, a violation that constitutes unprofessional conduct under the Board's regulations.[201]

3. Did the Division meet its burden of proving that Dr. Andreassen's practice violations described above constituted "gross and repeated negligence"? (Count VII)

The Board's disciplinary statute authorizes the Board to impose a sanction upon finding, after a hearing, that a licensee has demonstrated either "gross negligence" or "repeated negligent conduct."[202] Dr. Brose's report and testimony offer the opinion that Dr. Andreassen committed repeated simple violations that then combine and compound to what he considers an "extreme violation." He does not opine that Dr. Andreassen committed gross negligence, but he does contend these acts justify a finding of repeated negligent conduct.

The evidence supports such a finding. It is clear from Dr. Andreassen's own testimony that his controlled substance decisionmaking in this case was not an isolated incident but, as to these patients, a constant, repeated pattern of conduct and decisionmaking over a period of years. The continuous provision of concurrent high dose prescriptions to multiple patients, without implementing any measures to detect or deter misuse, and without regard to evidence of misuse, constitutes "repeated negligent conduct."

Likewise, as to the charting and documentation deficiencies identified in this case, Dr. Andreassen described the charting practices seen in this case as consistent with his charting generally, noting that this was how he maintained *all* of his patients' charts. There were, in particular, multiple instances in which Dr. Andreassen had failed to accurately and completely document what medications he had prescribed. This is repeated negligent conduct for purposes of the Board's disciplinary authority.

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[201] 12 AAC 40.967(9) (Unprofessional conduct includes failure "to prepare and maintain accurate, complete, and legible records in accordance with generally accepted standards of practice for each patient"); Amended Accusation, Count VIII (Unprofessional Conduct); Count III (failing to reflect the treatment provided to or recommended to patients; failing to "document the patient's progress during the course of treatment provided while prescribing opioids, benzodiazepines, stimulants and other narcotics, sometimes in dangerous combinations.").

[202] AS 08.64.326(a)(8)(A) ("The board may impose a sanction if the board finds after a hearing that a licensee … (8) has demonstrated (A) professional incompetence, gross negligence, or repeated negligent conduct; the board may not base a finding of professional incompetence solely on the basis that a licensee's practice is unconventional or experimental in the absence of demonstrable physical harm to a patient").

4. Did the Division meet its burden of proving that Dr. Andreassen secured a license through fraud or deceit by not disclosing the DEA matters on his 2015-2016 or 2016-2017 license renewal applications? (Count I)

Lastly, the Board's disciplinary statute authorizes the Board to impose a sanction upon finding, after a hearing, that a licensee secured a license through deceit, fraud, or intentional misrepresentation.[203]

This Board has previously explained that it is not necessary to prove a specific "intent to deceive," but rather, it is sufficient that the representation have been made in circumstances in which it is reasonable "to expect the other's conduct will be influenced." The Board has also explained that intent is a question of fact that may be proven by inference through circumstantial evidence.[204]

Dr. Andreassen did not disclose the 2013 DEA matter on the online renewal application he submitted in October 2014, nor did he disclose the matter or the settlement on the online renewal application submitted in November 2016, both of which asked whether he had been "investigated or disciplined" by the DEA since the date of his last application or within the past two years.[205] The Division contends that both denials were inaccurate and should subject Dr. Andreassen to professional discipline. Dr. Andreassen argues that the DEA matter was not an "investigation," or that it was not an investigation of *him*, and that his payment of a settlement to resolve the matter was not "discipline" by the DEA.

As to the 2014 renewal, the Division has not established that the initial July 2012 administrative inspection triggered a disclosure obligation. But by the time of the May 2013 complaint, the DEA had filed pleadings in federal court characterized that inspection as having been "prompted by" concerns about Dr. Andreassen (not "the dispensary") purchasing "large quantities of narcotics," and described its conclusions as to the ultimate outcome of that inspection in terms of an "investigation." The same pleading described eight different provisions of the Controlled Substances Act the DEA contended Dr. Andreassen (not "the dispensary") had violated – including, in some cases, noting that such violations had been found as to "at least 16 schedule III-V invoices," "at least 29 DEA Official Order Forms," or in "87" separate records.[206]

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203 AS 08.64.326(a)(1).

204 *In re Muir*, OAH No. 04-0286-MED (Alaska State Med. Bd. 2006); *In re Kohler*, OAH No. 07-0367-MED (Alaska State Med. Bd. 2008) ("Kohler I").

205 Ex. 4 (2015-2016 renewal), Ex. 5 (2016-2017 renewal).

206 Ex. 1, p. 3 (¶¶ 10, 13).

When Dr. Andreassen applied to renew his Alaska Medical License in October 2014, he knew that DEA had filed a complaint accusing him of multiple violations of the Controlled Substances Act, which violations it represented it had uncovered as a result of the July 2012 inspection. Under these circumstances, his answer of "no" to Question 13 – *"Since the date of your last application for a license in Alaska or within the past two years have you been investigated . . . by the Drug Enforcement Administration…?"*— was both incorrect and unreasonable.

In *Matter of Kohler* ("Kohler I"), the Board rejected a licensee's attempts to excuse away a "no" answer about investigations in another state. The licensee acknowledged having been "contacted" by the investigating entity, but described that state's investigation process as a multi-tiered approach in which not all contacts are "investigations," and in any event denied any objective intent to deceive the Board. The Board rejected this defense as unreasonable where the other state had informed the licensee in written correspondence that investigations had been opened, were being processed, and were eventually closed. Noting the lack of ambiguity in the application question's wording – "ever been under investigation" – the Board concluded that, "[e]ven if Dr. Kohler's motivation was not consciously dishonest, misrepresentation was made with the intent of inducing reliance by Alaska's medical Board and for the purpose of obtaining a license. …This is sufficient to constitute "intentional misrepresentation."

In *Matter of Meyers*, the Board again rejected a licensee's attempt to characterize another state's professional conduct investigation as merely a "preliminary review" not requiring disclosure.[207] There, as in *Kohler I* and as here, the characterization was at odds with the plain language of contemporaneous documents pertaining to the investigation. While professing a belief that the matter was not a formal investigation and did not need to be disclosed, Dr. Meyers had received a letter informing him that the New York Office of Professional Medical Conduct "is currently investigating your professional conduct."[208] Dr. Andreassen, similarly, denies believing he had been "investigated" by the DEA. But he had received a federal court complaint filed by the DEA in which the DEA described its inquiries as an "investigation." In both cases, any professed belief that the nondisclosed matter "was anything other than a formal investigation subject to disclosure under the clear and express provisions of the Alaska online [renewal] form" was "unreasonable." Dr. Andreassen's October 2014 denial of a DEA Investigation was, at best,

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207 *In re Meyers*, OAH No. 12-0042-MED (Alaska State Med. Bd. 2013).
208 *Id*., at p. 11.

reckless with regard to the truth. Accordingly, the Division has met its burden of showing misrepresentation in Dr. Andreassen's October 2014 renewal application.

The Division has not met its burden as to the 2016 renewal application, however. To the extent the Division contends that Dr. Andreassen was obligated to provide a yes answer to Question 12 on the basis that the settlement of the DEA action meant he had been "disciplined" by the DEA, the Division did not meet its burden. The evidence in the record was that the complaint was settled with no admission of fault and an agreement to pay "a compromise amount" which was not characterized as a penalty. Without some evidence that this agreement constitutes "discipline" by the DEA, the Division has not established that Dr. Andreassen's 2016 answer was false or misleading.

C. What sanction, if any, is appropriate?

Alaska Statute 08.64.326 sets forth the bases upon which the Board may exercise the disciplinary powers provided by Alaska's centralized licensing statutes at AS 08.01.075. Of relevance to the facts of this case, the Board may impose disciplinary sanctions if it finds, after a hearing, that the physician has

- "(1) secured a license through deceit, fraud, or intentional misrepresentation;"
- "(5) procured, sold, prescribed, or dispensed drugs in violation of a law regardless of whether there has been a criminal action or harm to the patient;"
- "(7) failed to comply with [AS 08.64], a regulation adopted under [AS 08.64], or an order of the board;"
- "(9) engaged in unprofessional conduct … in connection with the delivery of professional services to patients;"
- "(14) prescribed or dispensed an opioid in excess of the maximum dosage authorized under AS 08.64.363"[209]

If violations of any of the foregoing sections are found, the Board may exercise its discretionary authority to impose sanctions. Under AS 08.36.315, the Board may consider the nature and circumstances of the conduct at issue, community reaction to conduct, the licensee's experience and professional record, any other relevant information, and its actions in comparable prior case.[210] The legislature has directed that the Board apply disciplinary sanctions consistently, and

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209 AS 08.64.326(a).

210 *Lookhart v. State, Board of Dental Examiners, __ P3d __, at ___ (Alaska 2024); Wendte v. State, Bd. of Real Estate Appraisers*, 70 P.3d 1089, 1095, n. 33 (Alaska 2003); *In re Pappenheim*, 22-0613-MED (Alaska State Med. Bd. 2023) ("Pappenheim II"); *In re Gerlay*, OAH No. 05-0321-MED (Alaska State Med. Bd. 2008).

explain significant departures from prior decisions in factually comparable cases that the same Board has issued.[211] Where helpful, Alaska professional licensing boards frequently looks to decisions of other licensing boards for guidance.[212]

1. Review of prior cases

The Board's most recent consideration of controlled substance prescribing concerns in a published decision was in *Matter of Ahmad*, in 2016. However, that decision considered only the question of summary suspension, which the Board found to be clearly warranted for a provider who was actively engaged in high-volume controlled substance prescribing. Dr. Ahmad surrendered his license thereafter. In addition to Dr. Ahmad, the Board has accepted negotiated license surrenders and retirements of license for a number of providers under active investigation for controlled substance prescribing concerns. The Board has clearly acknowledged that license revocation may be appropriate in some such cases.

On the other end of the disciplinary spectrum, the Board has also repeatedly accepted consent agreements imposing significantly less drastic outcomes. Very recently, the Board considered and approved a consent agreement for a physician who admitting to having failed to conduct any PDMP review for more than 1,100 prescriptions; and to prescribing a high proportion of controlled substances, controlled substances at unusually high doses, and concurrent prescriptions, as well as prescribing to patients in circumstances suspicious for misuse/diversion. The Board approved an agreement placing the provider on probation for one year, with a $25,000 fine and completion of 24 hours of additional continuing medical education. The Board approved this agreement at its February 2024 meeting, two weeks before the hearing in this case began.[213] And in a much older case with at least some facially similar factual elements – a Fairbanks-based physician admitted to having engaged in medication overprescribing, including providing frequent and early refills as well as lax practices that were resulting in double prescriptions – the Board approved a 5-year term of probation, a $14,000 fine, completion of pain management reeducation, practice monitoring, and a reprimand.[214]

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211 AS 08.64.331(f).

212 *See, e.g., Pappenheim II* at 21-25; *In re Lookhart*, OAH No. 17-0607-DEN (Alaska State Bd. of Dental Examiners 2020), at 26-29.

213 *In re Kevin Hall*, Case No. 2022-00023 (Approved Settlement).

214 *In re Kindell*, Case No. 2010-00495 et. seq. (Approved Settlement, July 26, 2012). *See also*, *In re Brudenell*, No. 2800-04-055 (Approved Settlement, July 21, 2005) (reprimand, $10,000 fine with $6,000 suspended; licensee (MD) prescribed Schedule II controlled substances without direct patient contact); *In re McKinley*, No. 2800-02-045 (Approved Settlement, October 24, 2002) (probation, reprimand, $10,000 fine with $5,000 suspended; licensee (MD) forged controlled substances prescriptions for her personal use). *In re Aaron*, No. 2800-02-037

Outside of the controlled substance realm entirely, an extremely useful prior case comparator here is *Kohler II*, where the evidence established that a surgeon lacked the skill and aptitude to perform a particular class of surgeries. But the evidence also established that he was otherwise "an asset to the medical community in important respects," including being a "a compassionate physician who is willing to serve a difficult patient population that many [providers] avoid." Concluding there was "no basis to restrict Dr. Kohler's practice in areas in which incompetence has not been demonstrated, and doing so could deprive the community of a useful resource," the remedy fashioned by the Board was a practice restriction to preclude him from performing the type of surgery for which the evidence established a lack of skill, while leaving him able to continue practicing otherwise.[215]

Lastly, let us review prior Board discipline relating to failure to disclose an investigation on a renewal application, as Dr. Andreassen had one instance of this violation in 2014. The sanction applied to Dr. Kohler in *Kohler I* was a reprimand and a civil fine of $2,500.[216] The sanction applied to the nondisclosure aspect of Dr. Meyers' 2012 case was a civil fine of $1,500, with a finding that a reprimand would also have been imposed except that the license was being revoked on wholly different grounds, making the reprimand moot.[217] In other cases involving nondisclosures that were more than negligent, the Board has imposed fines ranging from $500 to $3,000, coupled with a reprimand.[218] This case fits into the midpoint of the pattern for these prior nondisclosure cases; there is only one proven instance of nondisclosure, and while it reflects poorly on Dr. Andreassen, it is possible to understand how he might have convinced himself he did not have a disclosable investigation as to his medical practice.

2. Factors relevant to the determination of a sanction in this case

This is an unusual case for a number of reasons. The facts here are different from prior cases of this and other Boards in which controlled substance overprescribing was considered in the context of a business model based on controlled substance prescribing. In *Matter of Ahmad*, for example, strong evidence suggested that each patient seen, "apparently without exception,"

(Approved Settlement, August 2, 2002) (probation, reprimand, $5,000 fine with $4,500 suspended; licensee (MD) wrote controlled substances prescriptions for a person, not her patient, with whom she had a personal relationship).

215 *In re Kohler*, OAH No. 10-0635-MED (State Medical Board 2011) ("*Kohler II*").

216 *Kohler I* at p. 19.

217 *In re Meyers* at p. 18.

218 *Id.* at 17-18 (summarizing the prior cases).

was provided high-dose, concurrent prescriptions.[219] In Dr. Andreassen's case, it is undisputed that these prescriptions, while representing concerningly high doses far outside standard practice, represented a relatively small subsection of his overall practice.

Also relevant is that Dr. Andreassen chiefly provides primary care services to an underserved population.[220] Multiple primary care patients testified in support of the care they have received, describing Dr. Andreassen's thoughtful and skillful care, including identifying and treating of a variety of ailments, as well as their fear of losing access to his services.[221] More than 300 more Delta Junction residents have signed a petition in support of Dr. Andreassen's continued ability to practice in Delta Junction.[222] Petitions of this nature are of scant evidentiary value, as the signatories are presumed to be unaware of the specific concerns raised in a disciplinary case, and are not the arbiters of appropriate medical practice. Nonetheless, the evidence is that, years after his controlled substance prescribing stopped, Dr. Andreassen remains a valued provider to many patients in an area of the state that is significantly lacking in medical resources.

The Division did not present any direct evidence as to the sufficiency of Dr. Andreassen's primary care services. The Division's expert, Dr. Brose, testified that his concerns were limited only to controlled substance prescribing, and that, with controlled substance prescribing no longer at issue, his concerns about a path to remediation were completely resolved. Dr. Andreassen also did not present expert testimony on his primary care services, but did present, over objection, a very brief report from Richard Vaglienti, MD, Director of the Pain Center at the University of West Virginia. Noting the challenges of rural medicine, particularly in settings of "extreme geographic isolation," and arguing that those factors compound Alaska's

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219 *In re Ahmad*, OAH No. 16-0514-MED (Decision on Summary Suspension) (Alaska State Med. Bd. 2016) (p. 28: "Dr. Ahmad wrote more than 700 controlled substance prescriptions over the course of five three- to four-day weekends"). https://aws.state.ak.us/OAH/Decision/Display?rec=3403.

220 To be clear, setting up shop in a remote area of the state is not a license for misconduct. If anything, it is incumbent upon geographically isolated practitioners to ensure a level of practice quality that maintains trust in the profession. *Cf. Matter of Hicks*, OAH No. 18-0539-GUI, at 31 (Big Game Comm. Svcs. Bd 2019) (Because their work "is necessarily carried out in remote areas where oversight is minimal, licensee honesty and integrity are paramount to the efficient regulation of the industry. When [licensees] act in a manner that calls their honesty into question . . . they impair the trust that is necessary to regulation of the industry.").

221 Testimony of D.B.; Affidavits of C.S., J.D., A.G., D.G., and P.G. (PG: "If Dr. Andreassen's medical license is revoked, I do not know where I will get my primary medical care. I do not like the only other clinic available in Delta Junction and therefore I will likely be forced to travel nearly 100 miles to Fairbanks to receive my primary care.").

222 Ex. I, K, P, Q, S, W (Petition: "Dr. Andreassen is an integral part of our small rural Alaska community, and we rely heavily on De. Andreassen's excellent medical care for our continued health. Revocation of Dr. Andreassen's medical license would be devastating to our small community"); *see also*, Ex. F, G, H, J, L, M, N, O, R (patient letters of support).

already low physician numbers, Dr. Vaglienti expressed support for a disciplinary outcome that allowed Dr. Andreassen to continue providing primary care services.[223] While the evidentiary value of this opinion is limited by its author not having been presented for cross-examination, both parties at the end of this hearing, as well as Dr. Brose, reached the same position about the appropriate level of discipline.

The most unusual and significant factor in the disciplinary determination is that the issues identified in this case are, in important respects, moot. That is, the concerns here relate to controlled substance prescribing. While there are some associated underlying concerns – i.e. to the general extent that questionable decisionmaking in one area raises concerns about decisionmaking writ large – all patient care concerns in this case relate specifically to controlled substance prescribing. Dr. Andreassen surrendered his DEA certification the day he was informed about the DEA's specific concerns; his prehearing brief argues that his action in surrendering his certification "demonstrated Dr. Andreassen's recognition of the seriousness of the situation" as well as his "willingness to change and desire to protect the people of Delta Junction."[224]

In this case, both parties and their experts concluded that an appropriate path forward in this case would, as in *Kohler II*, impose practice restrictions rather than a more dire sanction. While this decision also endorses that approach, it does so only upon careful consideration of the totality of the circumstances, as well as imposing other penalties, such as a fine and reprimand, as well as measures to improve and monitor Dr. Andreassen's practices in areas where deficiencies have been identified. The seriousness of the violations in this case informs the fashioning of a remedy, as does the fact that some of the violations here have implications that cross over into general practice expectations. These include the failure to document written prescriptions, substandard documentation around medical decisionmaking, and, at times, concerns about the decisionmaking itself. Moreover, Dr. Andreassen's frequent resort to a lack-of-knowledge explanation suggests a physician who is not adequately keeping up with changes in practice standards and Board requirements. As in *Kohler II*, the appropriate remedy here also includes provisions to address those concerns.[225] At the hearing in this matter, Dr. Andreassen expressed repeatedly an openness to learning from this experience and improving his practices

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223 Ex. E; Ex. F.

224 Respondent's prehearing brief, p. 8.

225 *Id*., at p. 54, ("Additionally, to address documentation issues, all charts of operative patients will be subject to peer review, with results forwarded to the board on a quarterly basis").

where deficiencies have been identified; it is the hope and expectation of this decision that he will do so.

In terms of mitigating factors and the totality of circumstances, it is acknowledged that, by the time of the events of this case, Dr. Andreassen's longtime wife (and clinic nurse) was experiencing advanced Alzheimer's Disease, which created significant challenges both in terms of its personal toll and in terms of a range of practical impacts, such as losing his own ability to travel to continuing education conferences. While licensees are expected and required to continue to meet rise to the level of their licensure obligations as long as they continue to practice, and no matter their personal circumstances, the presence of extenuating circumstances is nonetheless relevant to determining the level of sanction that is appropriate here.

Lastly, the relative weight given to the community value of Dr. Andreassen's primary care practice is enhanced both by the time that has passed since the events giving rise to this case, and by the time that passed and the events that elapsed between when the Division learned of these concerns and when it brought them to Dr. Andreassen's attention. It has been more than six years since the Division received the initial complaints in this case. Despite the seriousness of the allegations raised in those 2018 complaints, at a time that Dr. Andreassen was actively engaged in these practices, nearly two years passed between the first concerned provider's call and the Division notifying Dr. Andreassen of any complaints. The Division then did not notify him of an investigation for another year – shortly *after* he surrendered his DEA certificate. It has now been more than three years since Dr. Andreassen stopped prescribing controlled substances. While the passage of time does not excuse the violations, any urgency that these violations may have presented in 2019 – 2021 is no longer a factor.[226] Moreover, Dr. Andreassen's apparently violation-free conduct since that time is some evidence that he can reform his conduct.

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[226] Dr. Andreassen's failure to disclose the DEA investigation occurred more than ten years ago, based on a federal court complaint filed more than eleven years ago, after an inspection a year before that..

IV. Conclusion and Order

Dr. Andreassen is a thoughtful and experienced practitioner who cares deeply about the well-being of his community and has worked in service of rural Alaskans for decades. He has also committed, as established by the Division, multiple significant violations of the statutes and regulations governing his license. His prescribing practices described above, however well-intentioned, failed to meet the requirements of the Board's regulations, as did his documentation of patient care. Ultimately, the complete excision of controlled substance prescribing from Dr. Andreassen's larger practice, as well as his longstanding and ongoing primary care practice in an underserved community, all inform the selection of a remedy in this case, as does the concession by both the Division's expert witness and its counsel that revocation is not an appropriate remedy here.[227] Instead, the sanction to be imposed in this matter is as follows:

(1) Restriction on prescribing controlled substances. The Board after finding a licensee has committed a violation under AS 08.64.326(a) may "impose limitations or conditions on the practice of a licensee."[228] Pursuant to this provision, Respondent shall refrain from prescribing controlled substances, and shall not, while licensed by this Board, seek reinstatement of his DEA certification.

(2) 3 years of probation. The Board may "place a licensee on probationary status and require the licensee to (A) report regularly to the board on matters involving the basis of probation; (B) limit practice to those areas prescribed; and (C) continue professional education until a satisfactory degree of skill has been attained in those areas determined by the board to need improvement."[229] Here, a period of probation is warranted in order for the Board to be assured that whatever judgment and decisionmaking shortcomings were represented in the findings above are not present in Dr. Andreassen's provision of primary care. A three-year period of probation is imposed, during which Respondent will:

(a) Submit quarterly reports to the Board.

(b) Satisfactorily complete, in addition to yearly CME requirements governing his license, at least 20 additional CME hours each year on documentation, ethics,

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227 Certainly, license suspension was also a remedy available to the Board in this case, and would be appropriate given the significant concerns discussed above. But it is difficult to conceive of what practical benefit a suspension would serve at this point. The violations in this case occurred nearly four years ago (and longer in some cases), and largely, in a practice context no longer at issue. Meanwhile, the negative impacts of a suspension would likely impact and disadvantage patients at least equally if not more than they would impact Dr. Andreassen. Under the totality of the circumstances, a suspension has not been imposed.

228 AS 08.64.331(a)(6).

229 AS 08.64.331(a)(5).

practice management, addiction management, non-opioid pain management, and/or other topics approved in advance by the Board's agent. The first 20 hours of CME shall be completed within 90 days of the effective date of this decision in this case.

(c) For a period of one year, Respondent shall participate in a collaborative practice monitoring process intended to ensure both evidence-based decisionmaking and its documentation, as well as enhancing respondent's connections to other knowledgeable providers.

a. Within 45 days of the effective date of this decision, respondent shall contract with a physician practice monitor who is licensed in Alaska, with no prior disciplinary action by the board and with a minimum of ten years of practice experience in one or more of the following: primary care, family medicine, or rural medicine, to monitor his medical practice for a period of one year.
b. If respondent is unable to identify a suitable practice monitor within this time, he shall notify the Board's agent, including a description of efforts made and the result of these. In this event, the Division shall assist Dr. Andreassen in identifying a suitable practice monitor. If the Division is unable to do so within thirty days of notice from Dr. Andreassen, it shall notify the Board.
c. The practice monitor will meet monthly with Respondent, in person or by videoconferencing, to review patient charts and discuss patient care and documentation issues. Charts for at least ten patients seen in the preceding month shall be reviewed. The practice monitor and Dr. Andreassen may identify a workable and beneficial method for identifying patient charts for review, and Dr. Andreassen will provide and facilitate access to all of his charts or files as necessary to the monitor's review of the care provided.
d. The monitor shall submit a monthly report to the Board's agent for the first six months of monitoring, and quarterly reports thereafter. Costs of monitoring will be the responsibility of the Respondent.

(3) Formal reprimand. Pursuant to AS 08.64.331(a)(4), Dr. Andreassen is hereby and formally reprimanded for prescriptive practices that fell below the standard of care, for documentation that fell below the standard of care, and for his failure to disclose the DEA investigation on his 2014 license renewal application.

(4) Civil fine. Respondent's violations of the Board's controlled substance prescribing practices – including the admitted failure to keep abreast of controlled substance prescribing regulations – warrants a fine, as does his nondisclosure of the DEA investigation.

Considering the range of historical practices and the totality of the circumstances in this case, and pursuant to AS 08.64.331(a)(7):

a. A civil fine of $2,000, with $1,000 suspended, is imposed for Count I.

b. A civil fine of $8,000, with $4,000 suspended is imposed collectively for the remaining counts).

c. The unsuspended portion of both fines are due within 180 days of the effective date of the Board's final decision.

This order shall become effective if adopted by the Alaska State Medical Board below.

Dated: June 10, 2024

[redacted]

Cheryl Mandala
Administrative Law Judge

ADOPTION ORDER

The ALASKA STATE MEDICAL BOARD, in accordance with AS44.64.060(e)(3), adopts this decision and revises the sanction as follows:

A three-year suspension of license is imposed followed by probation for three years.

A fine of $25,000 with $10,000 suspended.

All other conditions as outlined above.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of distribution of this decision.

DATED this 9th day of August 2024.

By: [redacted]
Eric Nimmo, M.D.
Board Chair