

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **RODNEY S. IANCOVICI, M.D.**

4 Holder of License No. 28530
5 For the Practice of Medicine
6 In the State of Arizona.

Case No. MD-14-0520A

**INTERIM FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER
FOR SUMMARY SUSPENSION OF
LICENSE**

7 The above-captioned matter came on for discussion before the Arizona Medical
8 Board ("Board") at its Summary Action meeting on April 1, 2015. After reviewing relevant
9 information and deliberating, the Board voted to consider proceedings for a summary
10 action against Rodney S. Iancovici, M.D. ("Respondent"). Having considered the
11 information in the matter and being fully advised, the Board enters the following Interim
12 Findings of Fact, Conclusions of Law and Order for Summary Suspension of License,
13 pending formal hearings or other Board action. A.R.S. § 32-1451(D).

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15 **INTERIM FINDINGS OF FACT**

16 1. The Board is the duly constituted authority for the regulation and control of
17 the practice of allopathic medicine in the State of Arizona.

18 2. Respondent is the holder of license number 28530 for the practice of
19 allopathic medicine in the State of Arizona.

20 3. The Board initiated case number MD-14-0520A after receiving a report from
21 a Board appointed practice monitor raising concerns regarding Respondent's
22 understanding and management of patients with pain.

23 4. In a prior matter, case number MD-12-1383A, Respondent entered into an
24 Order for Letter of Reprimand and Probation and Consent to Same ("Order") on August 8,
25 2013. Pursuant to the Order, Respondent was required to enter into a contract with a

1 Board approved monitoring company ("Monitor") to conduct quarterly chart reviews for a
2 period of one year.

3 5. The Monitor's second report identified several deficiencies related to pain
4 medication prescribing.

5 6. On May 6, 2014, Respondent entered into an Interim Practice Restriction
6 ("IPR"), prohibiting him from prescribing controlled substances.

7 7. On May 21, 2014, Board staff received a Controlled Substance Prescription
8 Monitoring Program ("CSPMP") report indicating that Respondent wrote controlled
9 substance prescriptions in violation of his IPR. The CSPMP report showed that
10 Respondent wrote a controlled substance to OI, who is Respondent's mother, on two
11 occasions prior to entering into the IPR.

12 8. During an interview with Board staff on September 9, 2014, Respondent
13 admitted he prescribed medications to OI in violation of A.R.S. § 32-1401(27)(h).

14 9. During a subsequent phone interview on September 11, 2014, Respondent
15 admitted to prescribing zolpidem tartrate (Ambien) to patient RC, temazepam (Restoril) to
16 patient LG, and diazepam (Valium) to patient RR after the IPR became effective.
17 Respondent was advised during the course of the interview that the IPR prohibited him
18 from prescribing these medications.

19 10. A random audit of ten patient charts (EJ, OK, ML, EH, TG, GG, JM, SB, CL,
20 LG) that Respondent treated for chronic pain revealed the following deficiencies:
21 information entered into patient charts was either missing, partial or difficult to read.
22 Respondent either partially entered medication information or failed to list medications and
23 dosages prescribed to the patients. Urine drug screens performed on all patients except
24 Patient OK showed results inconsistent with medications prescribed by Respondent;
25 however, Respondent failed to take action with regard to the inconsistencies. Patient OK's

1 chart did not contain any urine drug screen results. Patients EH, TG and LG had urine
2 drug screen results showing THC; however, Respondent continued to prescribe these
3 patients controlled substances. For Patients OK, GG, and CL, medical tests, therapy or
4 diagnoses were listed that required follow-up care, but no such follow-up was documented
5 in the charts.

6 11. Additionally, Respondent treated patient SR between January 25, 2012 to
7 November 22, 2013 for neck and low back pain. Respondent's documentation was
8 missing, incomplete or difficult to read. Respondent failed to identify current medications
9 on any of SR's records. Respondent documented a diagnosis of alcoholism on October 9,
10 2012, but failed to take any action to adjust his treatment regimen, despite the fact that on
11 January 2, 2013 Respondent documented that SR smelled of alcohol and SR's chart
12 contained twelve hospital or emergency room admission records relating to alcohol
13 intoxication between August 10, 2012 and June 18, 2013.

14 12. The standard of care requires a physician to monitor the patient's response
15 to the medications prescribed, as well as side effects to the treatment plan and aberrant
16 behavior. In the charts reviewed, Respondent deviated from the standard of care by
17 failing to monitor the patients' responses to the medications prescribed, side effects to the
18 treatment plan, and aberrant behavior.

19 13. The standard of care requires a physician to discuss abnormal urine drug
20 screen ("UDS") results with the patients and to amend the plan of care if need be. In the
21 charts reviewed, Respondent deviated from the standard of care by failing to discuss UDS
22 results with his patients and by failing to amend the plan of care if need be.

23 14. The standard of care requires a physician to discontinue or wean the
24 patient's medication, trial non-opioid medications, interventions, therapies, or psychology
25 when the patient is clearly noncompliant with the medications for the management of their

1 chronic pain. In the charts reviewed, Respondent deviated from the standard of care by
2 failing to discontinue or wean his patients' opioids, trial non-opioid medications,
3 interventions, therapies, or psychology when the patient was clearly noncompliant with the
4 medications for the management of their chronic pain.

5 15. Respondent's patients were at risk for potential harm given the fact that
6 almost all patients reviewed received at least one controlled substance and the UDS often
7 did not reflect the medications prescribed. In two patients, THC was present and the use
8 of both is not typically endorsed. In the case of patient SR, there was significant potential
9 for harm by providing opioids (hydrocodone, oxycodone and morphine) to a patient who
10 has an active substance abuse problem, in this case alcohol abuse. Patients on controlled
11 substances are counseled to avoid alcohol use.

12 16. On March 27, 2015, the Board requested a current CSPMP profile for
13 Respondent. The CSPMP indicated that multiple controlled substance prescriptions were
14 written after Respondent was placed on the May 6, 2014 IPR and after the September 11,
15 2014 investigational interview. On September 19, 2014, Respondent wrote a prescription
16 for #30 zolpidem tartrate 10 mg with six refills for patient BJ. On December 12, 2014,
17 Respondent wrote a prescription for #30 zolpidem tartrate 10 mg with five refills for patient
18 LW.

19 17. Respondent failed to respond to multiple attempts made by Board staff to
20 contact him regarding a voluntary surrender of his medical license. Mail sent to
21 Respondent's practice address was returned as undeliverable and his voicemail box for
22 his practice phone was full.

1 **CONCLUSIONS OF LAW**

2 1. The Board possesses jurisdiction over the subject matter hereof and over
3 Respondent, holder of License No. 28530 for the practice of allopathic medicine in the
4 State of Arizona.

5 2. The conduct and circumstances described above constitute unprofessional
6 conduct pursuant to A.R.S. § 32-1401(27)(e) (“[f]ailing or refusing to maintain adequate
7 records on a patient.”).

8 3. The conduct and circumstances described above constitute unprofessional
9 conduct pursuant to A.R.S. § 32-1401(27)(h) (“[p]rescribing or dispensing controlled
10 substances to members of the physician’s immediate family.”).

11 4. The conduct and circumstances described above constitute unprofessional
12 conduct pursuant to A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or might be
13 harmful or dangerous to the health of the patient or the public.”).

14 5. The conduct and circumstances described above constitute unprofessional
15 conduct pursuant to A.R.S. § 32-1401(27)(r) (“[v]iolating a formal order, probation, consent
16 agreement or stipulation issued or entered into by the board or its executive director under
17 the provisions of this chapter.”).

18 6. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the
19 public health, safety or welfare imperatively requires emergency action. A.R.S. § 32-
20 1451(D).

21 **ORDER**

22 Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth
23 above,

24 IT IS HEREBY ORDERED THAT:
25

1 The Arizona Medical Board
2 9545 East Doubletree Ranch Road
3 Scottsdale, AZ 85258

4 Mary Baker
5 Board Staff

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