

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

Case No. MD-14-0520A

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

**ORDER FOR SURRENDER  
OF LICENSE AND CONSENT  
TO THE SAME**

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

7 Rodney S. Iancovici, M.D. ("Respondent"), elects to permanently waive any right to  
8 a hearing and appeal with respect to this Order for Surrender of License; admits the  
9 jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order  
10 by the Board.

11 **FINDINGS OF FACT**

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

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

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

19 4. In a prior matter, case number MD-12-1383A, Respondent entered into an  
20 Order for Letter of Reprimand and Probation and Consent to Same ("Order") on August 8,  
21 2013. Pursuant to the Order, Respondent was required to enter into a contract with a  
22 Board approved monitoring company ("Monitor") to conduct quarterly chart reviews for a  
23 period of one year.

24 5. The Monitor's second report identified several deficiencies related to pain  
25 prescribing.

1           6.    On May 6, 2014, Respondent entered into an Interim Practice Restriction,  
2 prohibiting him from prescribing controlled substances.

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

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

10          9.    During a subsequent interview, Respondent admitted to prescribing zolpidem  
11 tartrate (Ambien) to patient RC, temazepam (Restoril) to patient LG, and diazepam  
12 (Valium) to patient RR after the Interim Practice Restriction became effective.

13          10.   A random audit of ten patient charts (EJ, OK, ML, EH, TG, GG, JM, SB, CL,  
14 LG) that Respondent treated for chronic pain revealed the following deficiencies:  
15 information entered into patient charts was either missing, partial or difficult to read.  
16 Respondent either partially entered medication information or failed to list medications and  
17 dosages prescribed to the patients. Urine drug screens performed on all patients except  
18 patient OK showed results inconsistent with medications prescribed by Respondent;  
19 however, Respondent failed to take action with regard to the inconsistencies. Patient OK's  
20 chart did not contain any urine drug screen results. Patients EH, TG and LG had urine  
21 drug screen results showing THC; however, Respondent continued to prescribe these  
22 patients controlled substances. For Patients OK, GG, and CL, medical tests, therapy or  
23 diagnoses were listed that required follow-up care, but no such follow-up was documented  
24 in the charts.

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1           11.    Additionally, Respondent treated patient SR between January 25, 2012 to  
2 November 22, 2013 for neck and low back pain. Respondent's documentation was  
3 missing, incomplete or difficult to read. Respondent failed to identify current medications  
4 on any of SR's records. Respondent documented a diagnosis of alcoholism on October 9,  
5 2012, but failed to take any action to adjust his treatment regimen, despite the fact that on  
6 January 2, 2013 Respondent documented that SR smelled of alcohol and SR's chart  
7 contained twelve hospital or emergency room admission records relating to alcohol  
8 intoxication between August 10, 2012 and June 18, 2013.

9           12.    The standard of care required Respondent to monitor the patient's response  
10 to the medications prescribed, as well as side effects to the treatment plan and aberrant  
11 behavior. In the charts reviewed, Respondent deviated from the standard of care by  
12 failing to monitor the patients' responses to the medications prescribed, side effects to the  
13 treatment plan, and aberrant behavior.

14           13.    The standard of care required Respondent to discuss abnormal urine drug  
15 screen ("UDS") results with the patients and to amend the plan of care if need be. In the  
16 charts reviewed, Respondent deviated from the standard of care by failing to discuss UDS  
17 results with his patients and by failing to amend the plan of care if need be.

18           14.    The standard of care required Respondent to discontinue or wean the  
19 patient's medication, trial non-opioid medications, interventions, therapies, or psychology  
20 when the patient is clearly noncompliant with the medications for the management of their  
21 chronic pain. In the charts reviewed, Respondent deviated from the standard of care by  
22 failing to discontinue or wean his patients' opioids, trial non-opioid medications,  
23 interventions, therapies, or psychology when the patient was clearly noncompliant with the  
24 medications for the management of their chronic pain.

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ORIGINAL of the foregoing filed this  
4<sup>th</sup> day of June, 2015 with:

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

Mary Baker  
Board Staff  
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