

1 .BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

Case No. MD-16-1257A

3 **MICHAEL S. KUNTZLEMAN, M.D.**

**FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER FOR LETTER
OF REPRIMAND AND PROBATION
WITH PRACTICE RESTRICTION**

4 Holder of License No. 13565
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 August 2, 2017. Michael S. Kuntzleman, M.D. ("Respondent"), appeared with legal
9 counsel, Kathleen M. Rogers, Esq., before the Board for a Formal Interview pursuant to
10 the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue
11 Findings of Fact, Conclusions of Law and Order after due consideration of the facts and
12 law applicable to this matter.

13 **FINDINGS OF FACT**

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

16 2. Respondent is the holder of license number 13565 for the practice of
17 allopathic medicine in the State of Arizona.

18 3. The Board initiated case number MD-16-1257A after receiving a complaint
19 regarding Respondent's care and treatment of several patients at a methadone/suboxone
20 clinic where Respondent was employed ("Clinic"), alleging failure to properly treat the
21 patients and inappropriate prescribing.

22 **Patient A.R.**

23 4. Patient A.R., a 31 year-old female patient, established care with the Clinic on
24 February 29, 2016. The Physician Assistant ("PA") who performed the establishment
25 examination documented that A.R. was taking 100 mg methadone per day with an
impression of opioid dependence and a history of benzodiazepine abuse.

1 5. A.R. saw Respondent March 18, 2016 in follow-up, who documented a
2 diagnosis of opioid dependence/anxiety/depression and noted that A.R. obtained Xanax
3 “from the streets.” Respondent continued A.R.’s methadone and prescribed Xanax 2 mg
4 twice a day and clonidine 0.1 mg as needed.

5 6. A.R. saw a psychiatric provider at the Clinic on April 28, 2016, who
6 documented that A.R. had run out of her Xanax prescription early, as well as potential
7 inappropriate amphetamine use based on the results of a urine drug screen. The
8 psychiatrist also documented subjective indications of medication overuse and an
9 unsuccessful attempt to convince A.R. to detox. Noting that benzodiazepine use was
10 contraindicated, the psychiatrist discontinued the Xanax, and started Remeron to address
11 A.R.’s depression. The psychiatrist also continued methadone and clonidine. A.R. failed to
12 present for her May 18, 2016 appointment with the psychiatrist.

13 7. At A.R.’s next Clinic appointment with Respondent on July 17, 2016, A.R.
14 reported itching from gabapentin that had been prescribed by her primary care provider for
15 symptoms of restless leg syndrome (“RLS”). Respondent started A.R. on a trial of Soma
16 for the RLS symptoms, prescribed clonazepam 1 mg three times a day with five refills, and
17 continued A.R.’s methadone and clonidine.

18 8. A progress note dated August 18, 2016 indicates that Respondent continued
19 A.R. on prescriptions for methadone, clonidine, gabapentin and clonazepam. On the next
20 visit, dated September 1, 2016, Respondent documented a primary concern of anxiety,
21 and ordered increased individual therapy and a plan to continue clonazepam for PTSD-
22 related anxiety, continue methadone, discontinue carisoprodol and reinstitute gabapentin
23 with an 8 week follow-up.

24
25

1 9. A.R. saw the psychiatrist on October 5, 10, and 11, 2016 who documented
2 low blood pressure and altered mental status on all visits. At the October 11 visit, the
3 psychiatrist decreased A.R.'s Klonopin and clonidine.

4 10. At A.R.'s last visit with Respondent dated October 27, 2016, Respondent
5 recommended an increase in the clonidine and continuation of the clonazepam with follow-
6 up in five weeks.

7 **Patient D.W.**

8 11. Patient D.W. was seen at the Clinic for methadone maintenance between
9 February 5, 2013 and November 8, 2016. Clinic records include D.W.'s admission of
10 street Klonopin abuse, and urine drug screens indicating benzodiazepine abuse during
11 treatment. D.W. also received 30 weeks of alprazolam prescriptions during a 22 week
12 period in 2015 and 31 weeks of alprazolam prescriptions in a 26 week period in 2016.

13 12. D.W. was first seen by Respondent on January 13, 2015 and Respondent
14 documented that the primary concern was street benzodiazepine use for anxiety.
15 Respondent prescribed an increase in alprazolam to 2 mg every 12 hours for triggered
16 anxiety/panic in addition to continuation of methadone 145 mg per day. At a subsequent
17 visit, Respondent added a trial of amitriptyline to facilitate sleep in addition to the
18 alprazolam and methadone.

19 13. D.W. saw the psychiatrist on October 29, 2015, who discontinued
20 amitriptyline due to patient complaints of feeling 'hung over' and started a trial of Seroquel
21 along with continued alprazolam and methadone. On December 10, 2015, Respondent
22 increased the Seroquel from 12.5 mg at bedtime to 50-100 mg at bedtime to address
23 D.W.'s insomnia.

24 14. At a follow-up visit on February 5, 2016, Respondent noted that Seroquel
25 200 mg at bedtime was ineffective and that the patient had discontinued use. Respondent

1 increased D.W.'s alprazolam to 2 mg three times a day to improve sleep and scheduled an
2 8 week follow-up.

3 15. At D.W.'s last visit, Respondent documented that D.W. was doing well and
4 that he was continuing D.W. on current medications. Respondent also noted that he had
5 advised D.W. of the need to engage in therapy in order to continue with the current level of
6 prescribed benzodiazepines.

7 16. D.W. died on July 2, 2016 and the death certificate listed the cause of death
8 as "methadone and alprazolam intoxication."

9 **Patient T.W.**

10 17. T.W. was a patient with the Clinic between December 13, 2012 and January
11 13, 2016 with a diagnosis of depression and opioid dependence as well as a prior history
12 of ventriculoperitoneal shunt ("VP shunt") and diabetes. Through June 13, 2013, T.W. was
13 maintained by another provider in the Clinic on Suboxone, Seroquel, and Wellbutrin.

14 18. At Respondent's first visit with T.W. on July 19, 2013, Respondent noted a
15 plan to decrease Suboxone from 16 mg to 12 mg. Respondent subsequently maintained
16 T.W. on the same dosages of Seroquel and Wellbutrin through the remainder of 2013.

17 19. At a visit on January 31, 2014, T.W. complained of increased stress and a
18 migraine like headache. Respondent increased T.W.'s Suboxone to 24 mg per day and
19 Seroquel to 100 mg a.m. /200 mg p.m., and continued the Wellbutrin at the same dose.

20 20. On March 10, 2014, Respondent discontinued Seroquel and started a trial of
21 trazadone, based on T.W.'s complaint that the Seroquel was ineffective. Respondent also
22 changed T.W.'s Wellbutrin to 300 mg in the morning and continued the Suboxone at 24
23 mg per day.

24 21. Between June 4, 2014 and February 20, 2015, Respondent attempted trials
25 of Cymbalta (substituted for Wellbutrin) and lorazepam (twice), for sleep induction. T.W.'s

1 complaints during this time period included persistent auditory hallucinations, visual
2 hallucinations, increased anxiety, and frequent headaches. Respondent noted that T.W.
3 was non-compliant with non-psychiatric medication. During this time, Respondent also
4 increased T.W.'s Seroquel to 100 mg a.m. /400 mg p.m. At the February 20, 2015
5 appointment, Respondent also introduced busprione 100 mg a.m., and increased T.W.'s
6 lorazepam to 2 mg a.m. /4 mg p.m.

7 22. Over two appointments in March, 2015, Respondent increased T.W.'s
8 busprione to 200 mg a.m. and began "cross titration to risperidone" starting 0.5 mg at
9 bedtime while continuing Seroquel, lorazepam and Suboxone. Respondent noted
10 continued auditory and visual hallucinations, persecutory delusions, mood incongruent
11 psychiatric features and dysphoria, as well as continued inattention to T.W.'s medical
12 conditions.

13 23. Between April 17, 2015 and November 6, 2015, Respondent treated T.W.
14 who reported continuing psychiatric symptoms but some improvement with medical
15 conditions due to restarting insulin and an adjustment in her VP shunt. Respondent
16 substituted alprazolam for lorazepam. At T.W.'s July 24, 2015 visit, Respondent initiated
17 temazepam 30 mg at bedtime and on September 11, 2015, Respondent substituted
18 amitriptyline and Abilify for the Seroquel, but then restarted the Seroquel (discontinuing the
19 amitriptyline/Abilify) on September 18 after T.W. reported she did not like them. At T.W.'s
20 November 6, 2015 appointment, Respondent noted that she was homeless and wrote a
21 bridge prescription for clonazepam until T.W. was eligible for a refill of alprazolam.

22 24. At T.W.'s January 13, 2016 visit, Respondent noted that T.W. was living with
23 her mother which was difficult due to the mother's drug addiction and documented a plan
24 to increase T.W.'s Seroquel to 800 mg. T.W. died on February 3, 2016, with a cause of
25

1 death listed as VP shunt failure with pseudotumor of cerebri and other significant features
2 including opioid dependence on Suboxone and diabetes mellitus.

3 **Patient D.L.-R.**

4 25. Patient D.L.-R. was a patient at the clinic between April 9, 2012 and March 2,
5 2016. She saw Respondent between April 9, 2102 and July 24, 2012, then again between
6 November 19, 2015 and March 2, 2016. In June, 2016, D.L.-R. was hospitalized for renal
7 failure and diabetic crisis, requiring amputation and a significant course of hospitalization.
8 D.L.-R. died in September, 2016. D.L.-R. had a number of psychiatric diagnoses including
9 bipolar disorder type I, opioid dependence, depression and PTSD as well as medical
10 diagnoses including diabetes, hypertension, degenerative joint disease, and migraines.

11 26. Prior to Respondent's November 18, 2015 appointment, another provider at
12 the Clinic, who last saw D.L.-R. on May 6, 2015, had prescribed D.L.-R. Lamictal,
13 Cymbalta, Remeron, temazepam, Ativan and methadone.

14 27. At the November 18, 2015 appointment, Respondent documented an
15 unremarkable mental status examination, and continued D.L.-R. on temazepam 30 mg at
16 bedtime; methadone, 68 mg per day; Lamictal 200 mg and Cymbalta 12 mg in the
17 morning; Ativan 1 mg three times a day and clonidine 0.1 mg twice a day as needed for
18 anxiety. Respondent noted that D.L.-R. was supposed to be in a wheelchair due to a
19 metatarsal fracture and that she was taking Percocet from another provider.

20 28. Respondent saw D.L.-R. again on March 12, 2016, where he continued other
21 medications and increased her Ativan to 2 mg twice a day.

22 **Patient J.F.**

23 29. Patient J.F. was a patient at the Clinic. Respondent noted on January 13,
24 2014 that J.F.s' primary care provider ("PCP") would be prescribing pain medications with
25 his recommendations. A Clinic progress note dated August 8, 2014 by a Nurse

1 Practitioner ("NP") states that J.F. was seen for methadone for pain management that the
2 PCP would not provide any longer. The NP informed J.F. that the Clinic was unable to
3 prescribe methadone for pain and recommended follow-up with her PCP or detox.

4 30. Respondent's first visit with J.F. occurred on September 15, 2014 who noted
5 a history of depression, PTSD, opioid dependence secondary to pain management and
6 chronic pain. J.F. subsequently saw other providers at the Clinic who prescribed Remeron
7 and lorazepam. It was also noted that J.F. was taking morphine sulfate.

8 31. Respondent continued to see J.F. between May 20, 2015 and September 23,
9 2016 for medication management. Respondent's treatment included Oxycodone and
10 codeine for pain, clonazepam, and Adderall, as well as methadone. Drug screens during
11 this time period revealed multiple incidents of non-prescribed and illicit substances,
12 including alprazolam, amphetamine, Oxycodone, temazepam and THC.

13 **Deviations from the Standard of Care**

14 **Patient A.R.**

15 32. The standard of care required Respondent to prescribe medication with
16 appropriate indication to support the treatment plan. Respondent deviated from the
17 standard of care by prescribing Soma for A.R.'s restless leg syndrome.

18 33. The standard of care prohibited Respondent from prescribing Xanax and
19 Klonopin to a patient with a past substance abuse history and ongoing abuse.
20 Respondent deviated from the standard of care by prescribing Xanax and subsequently
21 Klonopin in light of A.R.'s past substance abuse history and ongoing abuse.

22 34. The standard of care when initiating treatment with Xanax required
23 Respondent to start A.R. on a low medication dose and titrate upward. Respondent
24 deviated from the standard of care by starting A.R. on Xanax at a high dose rather than
25 starting at a low dose and titrating upward.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Patient T.W.

35. The standard of care required Respondent to titrate T.W.'s Suboxone dose as to avoid long-term use on the maximum dosage. Respondent deviated from the standard of care by increasing T.W.'s Suboxone dose to the maximum recommended dose of 24 mg per day.

36. The standard of care required Respondent to monitor T.W.'s Suboxone therapy, and to consider adjustments to the medication dose during the course of treatment. Respondent deviated from the standard of care by failing to consider adjusting T.W.'s Suboxone dose during the course of her treatment.

37. The standard of care prohibited Respondent from prescribing benzodiazepines for a patient on narcotics with concurrent contraindicated medical conditions. Respondent deviated from the standard of care by prescribing benzodiazepines with narcotics to T.W. who had concurrent contraindicated medical conditions.

Patient D.L.-R.

38. The standard of care required Respondent to see D.L.-R. on a frequent basis in order to monitor her for treatment compliance. Respondent deviated from the standard of care by failing to frequently follow up with D.L.-R. in an effort to monitor her for treatment compliance.

Patient J.F.

39. The standard of care prohibited Respondent from prescribing benzodiazepines to a patient with contraindications including risk with concurrent narcotics, history of substance abuse, and ongoing evidence of misuse and abuse of benzodiazepines via urine drug screens. Respondent deviated from the standard of care

1 by prescribing benzodiazepines to J.F. despite contraindications including risk with
2 concurrent narcotics, history of substance abuse, and ongoing evidence of misuse and
3 abuse of benzodiazepines via urine drug screens.

4 40. The standard of care required Respondent to clearly identify the rationale
5 involved with prescribing Adderall to a patient with a documented history of amphetamine
6 abuse. Respondent deviated from the standard of care by prescribing Adderall to J.F. with
7 minimal rationale to this patient who was documented as having abused amphetamines.

8 **Patient D.W.**

9 41. The standard of care prohibits a physician from prescribing benzodiazepines
10 in a patient with contraindications including concurrent methadone, illicit use, and in
11 conformity with Clinical Policy. Respondent deviated from the standard of care by
12 prescribing a benzodiazepine to D.W. upon her initial visit despite contraindications
13 including concurrent methadone, illicit use, and Clinical Policy.

14 42. The standard of care prohibited Respondent from continuing the prescribing
15 of benzodiazepines in the face of multiple drug screens documenting the patient's
16 continued abuse of additional benzodiazepines and other illicit substances including
17 amphetamines, cocaine, and cannabis. Respondent deviated from the standard of care by
18 continuing to prescribe fairly high doses of Alprazolam to D.W. despite drug screens
19 documenting the patient's continued abuse of additional benzodiazepines and other illicit
20 substances including amphetamines, cocaine and cannabis.

21 43. The standard of care required Respondent to follow up with his patient on a
22 frequent basis in an effort to monitor the patient's treatment compliance. Respondent
23 deviated from the standard of care by failing to follow up with D.W. on a frequent basis in
24 an effort to monitor the patient's treatment compliance.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Actual and Potential Patient Harm

44. All patients reviewed received sub-optimal care. The patients were at risk for potential drug to drug interactions, addiction and diversion of multiple controlled substances. Additionally there was potential for sedation, impairment, overdose and death for whom benzodiazepines were used in combination with sedative-hypnotics and opioids. Failure to address aberrant drug screens could contribute to addiction, diversion, and potential for drug misuse and overdose.

Procedural History

45. Subsequent to the care provided in this case, Respondent resigned from the Clinic, and obtained employment in a different addiction treatment clinic, and he reported to the Board that his care was limited to prescribing buprenorphine.

46. On June 8, 2017, Respondent entered into an Interim Consent Agreement for Practice Restriction ("ICA"), prohibiting him from prescribing controlled substances in the State of Arizona until completion of a Board-staff approved intensive, in-person continuing medical education ("CME") course in controlled substance prescribing scheduled for June 24-26, 2017. The ICA further provided that Respondent would be permitted to prescribe buprenorphine for treatment of addiction and in generally accepted dosages pending the outcome of a Formal Interview in the matter.

47. Respondent successfully completed the CME course as scheduled and was permitted to prescribe buprenorphine as indicated in the ICA.

48. During a Formal Interview on this matter, Respondent testified that his current practice was limited to 12-14 hours per week, consisting of patient care only, and in a much more highly structured system. Respondent reported that he does not prescribe benzodiazepines, CNS stimulants, or opioids other than buprenorphine for treatment of

1 opioid dependence. Respondent further reported that he intends to remain employed at
2 this current clinic.

3 49. Respondent further testified that he implemented other practice changes
4 including improved self-care, documenting lab results more attentively, and stated that has
5 maintained ongoing therapy supervision with a psychiatric consultant. Respondent
6 provided letters of recommendation from both his current medical director and his prior
7 employer.

8 50. In response to Board member questions, Respondent noted that some of the
9 patients reviewed by the Board were resistant to treatment, and had difficulty obtaining
10 primary care services. Respondent stated that he initiated treatment in attempts to
11 stabilize his patients and to avoid patients attempting to obtain similar drugs on the street.
12 Respondent noted that the patients reviewed represented the exception to his care at the
13 Clinic, and not the rule.

14 51. During that same Formal Interview, Board members commented that
15 Respondent's changes in practice, recommendations and compliance with the ICA were
16 mitigating factors. Board members also agreed that the problems identified during the
17 Board's investigation were serious and that further monitoring was warranted to ensure
18 that Respondent had incorporated changes to his practice discussed during the interview.

19 **CONCLUSIONS OF LAW**

20 1. The Board possesses jurisdiction over the subject matter hereof and over
21 Respondent.

22 2. The conduct and circumstances described above constitute unprofessional
23 conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate
24 records on a patient.").

1 3. The conduct and circumstances described above constitute unprofessional
2 conduct pursuant to A.R.S. § 32-1401(27)(q) ("Any conduct or practice that is or might be
3 harmful or dangerous to the health of the patient or the public.").

4 **ORDER**

5 IT IS HEREBY ORDERED THAT:

- 6 1. Respondent is issued a Letter of Reprimand
7 2. Respondent is placed on Probation for a period of 5 years with the following terms
8 and conditions:

9 **a. Practice Restriction**

10 Respondent's practice is restricted, in that Respondent shall not prescribe
11 controlled substances in the State of Arizona, except that Respondent may prescribe
12 Suboxone or buprenorphine for the purposes of addiction treatment.

13 **b. Chart Reviews**

14 Within 30 days of the effective date of this Order, Respondent shall enter into a
15 contract with a Board-approved monitoring company to perform periodic chart reviews at
16 Respondent's expense. The chart reviews shall involve current patients' charts for care
17 rendered after August 18, 2017. Based upon the chart review, the Board retains
18 jurisdiction to take additional disciplinary or remedial action.

19 **c. Obey All Laws**

20 Respondent shall obey all state, federal and local laws, all rules governing the
21 practice of medicine in Arizona, and remain in full compliance with any court ordered
22 criminal probation, payments and other orders.

23 **d. Probation Termination**

24 The Probation shall not terminate except upon affirmative request of the
25 Respondent and approval by the Board. Respondent's request for release will be placed

1 on the next pending Board agenda, provided a complete submission is received by Board
2 staff no less than 30 days prior to the Board meeting. Respondent's request for release
3 must be submitted in writing, and shall provide the Board with evidence establishing that
4 he has successfully satisfied all of the terms and conditions of this Order. The Board may
5 require any combination of examinations and/or evaluations in order to determine whether
6 or not Respondent is safe to prescribe controlled substances and the Board may continue
7 the Practice Restriction. The Board has the sole discretion to determine whether all of the
8 terms and conditions of this Order have been met or whether to take any other action
9 consistent with its authority prior to a full release from Probation.

10 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

11 Respondent is hereby notified that he/she has the right to petition for a rehearing or
12 review. The petition for rehearing or review must be filed with the Board's Executive
13 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
14 petition for rehearing or review must set forth legally sufficient reasons for granting a
15 rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after
16 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,
17 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

18 Respondent is further notified that the filing of a motion for rehearing or review is
19 required to preserve any rights of appeal to the Superior Court.

20 DATED AND EFFECTIVE this 4th day of October, 2017.

21 ARIZONA MEDICAL BOARD


22
23 By Patricia E. McSorley
24 Patricia E. McSorley
25 Executive Director

1 EXECUTED COPY of the foregoing mailed
this 4th day of October, 2017 to:

2
3 Kathleen M. Rogers, Esq.
4 Slutes, Sakrison & Rogers PC
5 4801 E Broadway Blvd, Suite 301
6 Tucson, AZ 85711
7 Attorney for Respondent

8 ORIGINAL of the foregoing filed
9 this 4th day of October, 2017 with:

10
11 Arizona Medical Board
12 9545 E. Doubletree Ranch Road
13 Scottsdale, AZ 85258

14
15
16
17
18
19
20
21
22
23
24
25

Board staff