State of Rhode Island
Department of Health
Board of Medical Licensure & Discipline

IN THE MATTER OF:
Richard Iacobucci, MD
License No.: MD 04390
Case No.: 190115 A&B

CONSENT ORDER

Richard Iacobucci, MD ("Respondent"), is licensed as a physician in Rhode Island. The Rhode Island Board of Medical Licensure and Discipline ("Board") makes the following:

FINDINGS OF FACT

1. Respondent has been a licensed physician in the State of Rhode Island since January 19, 1972. Respondent graduated from the University of Bologna School of Medicine and Surgery on June 1, 1969. Respondent's specialty is cardiology.

2. Respondent was the attending physician for Patient A (alias).

3. The Board received two complaints relative to Respondent's care of Patient A: one from Patient A's mother, and one Patient A's sister. The complaints allege that, for more than five years, Respondent has prescribed Patient A both oxycodone (opioid) and alprazolam (benzodiazepine), even though both complainants believe Patient A not to have any health or pain issues that would necessitate these medications.

4. Patient A is 30-year-old male who began seeing Respondent as his Primary Care Provider (PCP) in May of 2015. In his written response to the Investigative Committee, Respondent

stated that his care of Patient A included ongoing medical care of Patient A's pre-existing back and wrist/arm pain, prescribing opioids, following Patient A's initial treatment therefor with an orthopedist. Respondent added that he prescribed Patient A alprazolam, as well, for anxiety and occasional panic attacks.

5. Respondent stated that he treated Patient A for chronic pain, but the medical record does not make clear the etiology, location, quality, and type of chronic pain.

6. Pursuant to its review thereof, the Investigative Committee noted substantial deficiencies in the medical record. The medical record lacked relevant history of present illness for back pain and anxiety. There was no mental status exam. The physical exam was consistently rudimentary and did not record an exam of Patient A's back or arm/wrist.

7. The medical record contains documentation from Patient A's January 26, 2019 visit to a local emergency department "after having several seizures due to being cut off his benzodiazepines." At the emergency department, Patient A was diagnosed with opiate addiction, among other co-morbidities. At a follow-up visit with Respondent on February 11, 2019, Respondent documented in the medical record that Patient A was at the emergency room on January 26 "for reasons which are not clear to [Respondent]." Respondent did not acknowledge the diagnosis of opiate addiction and, in fact, prescribed opioids to the same degree, did not refer Patient A for treatment of opioid use disorder, and did not address Patient A's critical new diagnosis in the medical record.

8. The medical record contains documentation of periodic urine drug testing. Notably, one such test from November 15, 2018 reflects that Patient A was negative for opiates and positive for THC. The Investigative Committee determined that Respondent did not maintain adequate safeguards to prevent diversion. Respondent should have addressed the negative drug screen

with the patient and documented an appropriate treatment plan in the medical record.

9. Respondent treated Patient A for chronic pain, but the medical record does not make clear the etiology, location, quality, and type of chronic pain.

10. The Investigative Committee determined that Patient A's medical record lacked adequate documentation of Patient A's history, etiology of injuries, and meaningful physical exams prior and during treating Patient A for chronic pain.

11. Respondent treated Patient A for chronic pain, but the medical record does not contain clear documentation of whether there was any change in pain relief or change in physical and psychosocial function. The medical record contains no documentation of other planned treatments or that additional diagnostic tests were considered.

12. Respondent treated Patient A for chronic pain. The medical record reflects that Respondent gave Patient A the Rhode Island Department of Health ("RIDOH") handout titled "Knowing the Risks of Opioid Prescription Pain Medications," which handout addresses some issues related to Patient A's education contemplated by Section 4.4(D) of the Regulations. There medical record contains no evidence that Respondent actually communicated this information to Patient A, however, or that Respondent had a conversation with Patient A, or that Respondent had specifically addressed the risks associated with the prescribed opioid medications in view of Patient A's January 2019 diagnosis of opioid addiction.

13. Respondent prescribed Patient A greater than 50 MME per day of an opioid and co-prescribed benzodiazepines. Notably, Patient A's medical record reflects a past diagnosis of opiate addiction. Any one of these three conditions would trigger the requirement that Patient A additionally be prescribed naloxone. The medical record contains no documentation of Respondent ever prescribing naloxone to Patient A.

14. The Investigative Committee determined that Respondent violated **R.I. Gen. Laws § 5-37-5.1(19)**, which defines "unprofessional conduct" as including, ""*[I]ncompetent, negligent, or willful misconduct in the practice of medicine which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board;*" and the **Rules and Regulations for Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island (216-RICR-20-20-4)** ("Regulations"), specifically, **Section 4.4(A)**, regarding "Patient Evaluation," which provides, "*The practitioner shall obtain, evaluate and document the patient's health history and physical examination in the health record prior to treating for chronic pain,*" and **Section 4.4(B)**, regarding "Documentation of Treatment Plan," which provides, "*Documentation in the medical record for chronic pain shall state the objectives that will be used to determine treatment success and shall include, at a minimum: 1. Any change in pain relief; 2. Any change in physical and psychosocial function; and 3. Additional diagnostic evaluations or other planned treatments;*" and **Section 4.4(D)**, regarding "Patient Education/ Informed Consent," which provides, "*If prescribing opioids, the practitioner will advise patients specifically about adverse risks of taking alcohol or other psychoactive medications (e.g. sedatives and benzodiazepines), tolerance, dependence, overdose or death if acute or long-term use. For those patients in recovery from substance use disorder, education shall be focused on relapse risk factors. This education, which must be documented in the medical record, will be communicated orally or in writing depending on patient preference and shall include as a minimum: 1. Acknowledgement that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and 2. Educate patient regarding safe disposal options for unused portion of a*

controlled substance. 3. Requirement for Conversation: Prior to initiating a prescription for an opioid drug and, upon the second refill and/or upon the third prescription, specifically discuss with the patient who is eighteen (18) years of age or older, or the patient's parent or guardian if the patient is under eighteen (18) years of age: a. The risks of developing a dependence or substance use disorder to the prescription opioid drug and potential of overdose or death; b. The adverse risks of concurrent use of alcohol or other psychoactive medications; c. The risk the medication(s) or underlying medical condition may impair an individual's ability to safely operate any motor vehicle; d. The responsibility to safeguard all mediations; e. If the prescriber deems appropriate, discuss such alternative treatments (including non-opioid medications, as well as non-pharmacologic treatments) as may be available; and f. For patients in recovery from substance use disorder, education shall be focused on relapse risk factors. This discussion shall be noted in the patient's medical record at each applicable visit;" and **Section 4.4(M)**, regarding "Co-prescribing of Naloxone," which provides, "*A prescriber must co-prescribe naloxone when: 1. Prescribing an opioid which individually or in aggregate with other medications is more than or equal to fifty (50) MMEs per day, or document in the medical record why this is not appropriate for the patient. 2. Prescribing any dose of an opioid when a benzodiazepine has been prescribed in the past thirty (30) days, or will be prescribed at the visit. Prescribers shall note medical necessity of the co-prescription of the opioid and the benzodiazepine and explain why the benefit outweighs the risk given the U.S. FDA black box warning. 3. Prescribing any dose of an opioid to a patient with a prior history of opioid use disorder or overdose. Prescribers must not medical necessity of prescribing the opioid and explain why the benefit outweighs the risk given the patient's previous history.*"

Based on the foregoing, the parties agree as follows:

1. Respondent admits to and agrees to remain under the jurisdiction of the Board.

2. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board and is not binding on Respondent until final ratification by the Board.

3. If ratified by the Board, Respondent hereby acknowledges and waives:

a. The right to appear personally or by counsel or both before the Board;

b. The right to produce witnesses and evidence on his behalf at a hearing;

c. The right to cross examine witnesses;

d. The right to have subpoenas issued by the Board;

e. The right to further procedural steps except for those specifically contained herein;

f. Any and all rights of appeal of this Consent Order;

g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review; and

h. Any objection to the fact that this Consent Order will be reported to the National Practitioner Data Bank and Federation of State Medical Boards and posted to the RIDOH public website.

4. Respondent agrees to pay, within 60 days of the ratification of this Consent Order, an administrative fee of $1960.00 for costs associated with investigating the above-referenced complaint. Such payment shall be made by certified check, made payable to "**Rhode Island General Treasurer,**" and sent to Rhode Island Department of Health, 3 Capitol Hill, Room 205, Providence, RI 02908, Attn: Lauren Lasso. Respondent will send notice of compliance with this condition to DOH.PRCompliance@health.ri.gov within 30 days of submitting payment.

5. Respondent hereby agrees to this reprimand on his physician license.

6. Within 90 days of ratification of this Consent Order, Respondent will attend and undergo a competency assessment in his area of medical practice in internal medicine and cardiology arising from the nature of the complaint documented herein, assessed by Lifeguard Services in Harrisburg, Pennsylvania ("Lifeguard"), and will follow Lifeguard's recommendations, which recommendations shall be incorporated by reference within this Consent Order. Respondent shall cause all results from Lifeguard to be forwarded by Lifeguard directly to the Board at DOH.PRCompliance@health.ri.gov.In the event Lifeguard's recommendations do not include such provision or similar acceptable to the Board, Respondent shall, within 90 days of receipt of Lifeguard's recommendations, complete a Board-approved course on controlled substance prescribing, such as the Vanderbilt curriculum. Respondent will send notice of compliance with this condition to DOH.PRCompliance@health.ri.gov within 30 days of completion.If Respondent violates any term of this Consent Order after it is signed and accepted, the Director of RIDOH ("Director") shall have the discretion to impose further disciplinary action, including immediate suspension of Respondent's medical license. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request an administrative hearing within 20 days of the suspension and/or further discipline. The Director shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any term of this Consent Order. The Administrative Hearing Officer may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if the alleged violation is proven by a preponderance of evidence.

[SIGNATURE PAGE FOLLOWS]

Signed this 5 day of Feb, 2020.

Richard Iacobucci

Richard Iacobucci, MD

Ratified by the Board of Medical Licensure and Discipline on the 12th day of February, 2020.

Nicole Alexander-Scott

Nicole Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health
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