COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2139

IN RE: THE APPLICATION TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY FILED BY BRIGG W. BARSNESS, M.D., LICENSE NO. 58873, N64 W23110 MAIN STREET, SUSSEX, WISCONSIN 53089

AGREED ORDER

Come now the Kentucky Board of Medical Licensure ("the Board") and Brigg W. Barsness, M.D. ("the applicant"), and, based upon their mutual desire to grant the applicant a license to practice medicine in the Commonwealth of Kentucky, subject to conditions set forth herein, hereby ENTER INTO the following **AGREED ORDER**:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order:

1. At all relevant times, Brigg W. Barsness, M.D. was an applicant for a medical license within the Commonwealth of Kentucky.
2. The applicant's medical specialty is Family Medicine.
3. On or about December 22, 2022, the applicant submitted an application for a license to practice medicine in the Commonwealth of Kentucky.
4. The applicant answered "yes" to Question 3, Category 1 of the application, which asked, "Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?"

5. However, the applicant answered "no" to Question 9, Category 1 of the application, which asked, "Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?"

6. On or about April 16, 2014, the Wisconsin Medical Examining Board ("Wisconsin Board") issued a Final Decision and Order ("Final Order") limiting the applicant's medicine and surgery license. The findings of fact are as follows:

> Respondent began treating Patient A, a woman [...], on September 17, 2010. Patient A had a history of chronic back pain following a motor vehicle collision at age 16, and was under the care of a pain specialist, from whom she received morphine 30 mg BID, and oxycodone-acetaminophen 10 mg/650 mg, PRN. Patient A had been diagnosed with sarcoidosis, and was using fluticasone/salmeterol (Advair®) and albuterol. She also reported having gastroesophageal reflux disease (GERD), for which she took omeprazole. Due to concerns Patient A expressed about concentration and focus at school (where she was studying to be a nurse), irritability and depression, and after considering Patient A's treatment history, Respondent prescribed alprazolam and bupropion.
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> On October 15, 2010, Patient A reported alprazolam was helping but bupropion caused insomnia and worsened irritability, so desvenlafaxine (Pristiq®) was prescribed. On November 17, 2010, Patient A reported that the desvenlafaxine was working well; she expressed a desire to stop smoking so Respondent prescribed varenicline (Chantix®). Patient A reported past issues with sleeping while on varenicline so a prescription for zolpidem was also given, in addition to the alprazolam and desvenlafaxine. These prescriptions were continued on December 21, 2010.
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> At her next office visit on March 25, 2011, Patient A said she couldn't concentrate or focus, was concerned that she had ADD, and had lost her job. Lisdexamfetamine (Vyvanse®) 3Q mg QD was added to her regimen to treat ADD, with the possibility of increasing or decreasing the dose, depending on response. At her next office visit on April 12, 2011, Patient A reported that the medication was helpful, but that she needed a second pill at midday; her prescribed dosage was increased to 30 mg BID. At her next appointment, May 13, 2011, Patient A stated the Lisdexamfetamine was making her jittery after the second dose, so Lisdexamfetamine was continued in the morning with amphetamine/dextroamphetamine (Adderall®) IR 10 mg for the afternoon. At the next office visit, June 13,

2011, Patient A reported that the amphetamine/dextroamphetamine was ineffective, and that she had resumed taking Lisdexamfetamine twice a day. At the next office visit, July 15, 2011, Patient A reported that the Lisdexamfetamine had been effective and all of her prescriptions were renewed. On November 29, 2011, Patient A identified worsened insomnia, so the Lisdexamfetamine was stopped and amphetamine/ dextroamphetamine IR 20 mg, TID, was prescribed, with a new trial of zolpidem.

Patient A returned to care on February 28, 2012, and reported doing well with amphetamine and dextroamphetamine XR, 20 mg in the morning and 10 mg IR, 3 to 4 times daily thereafter- There is no documentation in the chart regarding how this change came about. Respondent then prescribed amphetamine/dextroamphetamine XR, 20 mg, #30, and amphetamine salt combination, 10 mg, #120. At her next office visit, on May 3, 2012, Patient A again complained of insomnia, and expressed concern that she might have Obsessive Compulsive Disorder. Respondent referred her to psychiatry, and prescribed amphetamine salt combination 10 mg, BID.

On June 18, 2012, Patient A had her next appointment with Respondent, and had not yet met with psychiatry, but had an appointment in August. Patient A reported having stopped amphetamine/dextroamphetamine and desvenlafaxine on her own, and experienced significant difficulty; she then resumed the desvenlafaxine. Respondent charted: "2. Psychiatric concerns. I do think it is time to initiate Lamictal to see if this is helpful as a mood stabilizer. I do recommend that she keep her appointment with Dr. [psychiatrist]. We will see if we can set her up with a female counselor. She is otherwise to continue Adderall and Xanax. Will continue with Pristiq at this time as well. Pristiq may be kindling her mania. 3. Insomnia. Ambien has been helpful. Will continue this medication." Respondent prescribed lamotrigine (Lamictal®) 100 mg, #30, with instructions to take one tablet daily. Respondent, in response to an inquiry from the Board, wrote "[the patient] and I were concerned about the potential for Bipolar Affective Disorder as an explanation for her irritability, reaction to past medications and other psychiatric concerns. The decision was made to trial Lamictal as a mood stabilizer until she was able to meet with her psychiatrist."

In fact, lamotrigine is a medication which must be started at a low dose, and then gradually increased: 25 mg for 2 weeks, then 50 mg for 2 weeks, then 100 mg for 1 week, then 200 mg. There is also a black box warning for this medication concerning the risk of Stevens Johnson syndrome and toxic epidermal necrolysis; there is no indication in the chart that Patient A was informed of this risk, or about what to do if she experienced a rash.

Patient A took the medication as prescribed, and became extremely lethargic on June 19, 2012 requiring hospitalization.

The Board finds that Patient A had a complex polypharmacy with a psychiatric overlay. Respondent is a family physician and should not have been prescribing multiple psychiatric medications. He incorrectly dosed lamotrigine for the patient, causing harm, and failed to document informed consent. Instead, Respondent should have called Patient A's psychiatrist and asked for her to be seen sooner. If Patient A could not be seen sooner by the psychiatrist, Patient A should have been told to wait until the psychiatric appointment.

On September 15, 2010, Patient B, a woman [...], established care with Respondent. Patient B reported a history of migraine headaches every other week, low back pain into her right hip and down the leg, irregular periods and endometriosis (for which she is followed by a gynecologist), depression and anxiety (for which she was seeing a psychiatrist, who prescribed alprazolam 0.5 mg, 5 times per day), acid reflux, low vitamin D, and fibromyalgia. She reported her pain as 5 on a scale of 0 to 10. Patient B reported that she did not drink alcohol, or use tobacco. Her medications included cyclobenzaprine 5 mg, take 1 or 2 TID PRN, and a-hydrocodone 5 mg product, take one or 2 QD. Respondent added topiramate (Topamax:®) 25 mg, HS, to increase by 25 mg weekly until maximum dose of 200 mg daily is reached.

Patient B returned to care on October 18, 2010. She reported that the topiramate was not helpful\ and caused confusion. Patient B further reported that in the past she had not tolerated duloxetine, pregabalin, or amitriptyline. She reported no migraines since her previous visit. Respondent added temazepam 15 mg, take one or 2 every evening PRN, for insomnia.

On November 10, 2010, Patient B requested a refill of her hydrocodone, via telephone. Respondent authorized hydrocodone acetaminophen 5/500 mg TID, #90, no refills.

Patient B returned to care on November 19, 2010, with a report of continuing chronic low back pain. Patient B reported not having tried physical therapy recently, and that the cyclobenzaprine, hydrocodone-acetaminophen, alprazolam, and temazepam have all been helpful. Respondent referred Patient B to physical therapy, and continued all of her medications.

Patient B missed a scheduled appointment on December 5, 2010, but telephoned on December 8, 2010, for a refill of her hydrocodone. Respondent authorized an additional one month supply.

Patient B returned to care on December 30, 2010, reporting increased migraine headaches. Patient B stated that she had not yet been to physical

therapy. Her medications were continued, together with a new prescription for sumatriptan 100 mg. Respondent noted, among other things: "5. Anxiety. We will continue Xanax. Potentially other medications such as Lexapro may be of benefit." There is no notation of any escitalopram (Lexapro®) samples being dispensed, or a prescription issued, for escitalopram.

On January 13, 2011, Patient B telephoned, reporting that she had received samples of escitalopram 10 mg, and that her left eye had swollen and developed yellow drainage. Patient B was referred to urgent care.

Patient B missed a scheduled appointment on January 24, 2012.

Patient B returned to care on January 26, 2011. The intake note states: "Last in on December 30, 1010. Here today for a one-month follow-up on Lexapro samples." Patient B reported that the escitalopram had been helpful for her anxiety, she had not yet been able to do physical therapy, and that the sumatriptan made her migraine headaches worse. Respondent noted, among other things: "1. Depression/anxiety. We will continue the Lexapro 10 mg. We will see if we can get this approved with her insurance. She is provided with 2 more samples today." Respondent also prescribed rizatriptan for migraine headaches.

Patient B telephoned the clinic on February 9, 2011, reporting that her insurance company would not cover escitalopram until she tried other medications. She reported that Respondent also gave her citalopram (Celexa®), but that this medication was causing worse anxiety and heart palpitations. There is no notation anywhere in the chart of any dispensing of citalopram.

Patient B returned to care on March 11, 2011, reporting pain in her hands and up into her arms. Respondent referred her to rule out or treat carpal tunnel syndrome, and charted that he increased her hydrocodone product to the 7.5 mg strength. He also prescribed amitriptyline 25 mg HS for fibromyalgia. He noted that Patient B's insurance had approved the escitalopram, and that she was taking this together with the alprazolam, cyclobenzaprine, and temazepam. Notwithstanding the narrative note, the medication list for this visit shows that the patient was prescribed hydrocodone-acetaminophen 10 mg/325 mg, take one every 6 hours PRN, #60.

On March 23, 2011, Patient B telephoned Respondent's office and requested a refill of her hydrocodone. Respondent authorized 60 tablets, with the same instructions, of the 10 mg strength.

Patient B returned to care on March 25, 2011. Patient B reported that her arm pain had resolved when she stopped the escitalopram, so she did not follow up with the referral. Patient B reported using the hydrocodone product more frequently as a result of pain from strep throat. Respondent charted, among other things: "2. Bilateral arm pain. I am uncertain why Lexapro would supposedly worsened these symptoms. There is no family history of anything like serotonin ~syndrome or malignant hyperthermia. I do wonder if this may be some type of odd extrapyramidal affect though she had no changes to her face whatsoever. I do think potentially follow-up with Dr.[...] would be of benefit; however, discontinuing the medication appears to have been helpful alone. 3. Depression/anxiety. I do recommend that she follow-up with Dr. [psychiatrist] as well as he may have a better idea of what the Lexapro side effects were causing. We will not make any changes to medication at present. She will go without this medication. 4. Back pain. We will continue the Vicodin as helpful. I would consider Butrans in the future."

On April 4, 2011, Patient B telephoned Respondent's clinic to request a refill of her hydrocodone product. Respondent authorized an additional 60 tablets with the same dosage instructions.

Patient B returned to care on April 11, 2011. She reported having some pain with writing, but still improved without the escitalopram. Patient B further reported that the hydrocodone-acetaminophen 10/325 was no longer effective for her back pain. Respondent then prescribed oxycodone-acetaminophen 5/325, take one every 6 hours PRN, #30. He also prescribed pregabalin (Lyrica®) 75 mg BID for fibromyalgia.

On April 18, 2011, Patient B telephoned the clinic and requested a refill of her oxycodone, and a larger quantity. Respondent issued a prescription for 120 tablets.

Patient B returned to care on May 13, 2011, and reported that she had not attempted the pregabalin because she was concerned about side effects which this medication had caused in her mother. The medication list shows the amitriptyline is discontinued, but there is no explanation for this. Respondent issued a prescription for 120 tablets of oxycodone 5/325, to be filled "on or around" May 18, 2011.

On June 3, 2011, Patient B telephoned the clinic and stated that an impacted wisdom tooth was causing problems and that she was in significant pain, taking 2-3 oxycodone at a time. She requested a stronger medication. Patient B was informed not to take her medication in this manner, and to use the emergency room if necessary.

Patient B returned to care on June 15, 2011. Respondent charted "regarding her back pain, this does persist particularly on the right side with radiation into the right leg. We have previously tried to set up referral as well as physical therapy; however she has difficulty with transportation and cannot make these appointments. MRI performed in April showed no significant abnormalities. Patient B's medication list shows that temazepam was discontinued, but there is no explanation for this in the chart. Respondent's plan included: "5. Back pain: we will continue Percocet. She is also provided with samples of Lidoderm." The chart reflects that another prescription for 120 tablets of oxycodone 5/325 was issued.

Patient B returned to care on July 11, 2011, and reported worse back pain. Patient B reported her pain as being 8 on a scale of 0 to 10. Respondent charted: "examination of the back does reveal tenderness at the lumbosacral junction and more to the right side." Respondent's plan included: "1. Back pain. I do think referral to Dr. [physiatrist] [*sic*] would be helpful. There are a number of modalities that would provide relief, including increased physical activity, weight loss and physical therapy. Increasing the amount of Percocet will likely not cause the greatest benefit down the road. I do think Lyrica and other agents would be very helpful. However, her mother has not responded well to Lyrica. We will also trial Butrans 5 mg weekly today to see if this is affordable. Fentanyl is likely too strong at this point." Respondent prescribed buprenorphine 5µg per hour transdermal patch (Butrans®), apply one each week, #4. Additionally, he prescribed oxycodone-acetaminophen (Endocet®) 5/325, take one every 6 hours as needed, #135.

Patient B telephoned Respondent's clinic on August 8, 2011, and requested a refill of her oxycodone. Respondent issued a prescription for another 135 tablets.

On August 29, 2011, Patient B returned to care, and reported that the pain medication had been helpful. She further reported that her mother had advised her against seeing the physiatrist, [*sic*] that she was having headaches 4 or 5 times per month. Patient B reported her pain as a 4 on a scale of 0 to 10. Respondent's plan included: "2. Back pain. We will continue the Endocet 4-5 tablets daily. I do think that trying fentanyl would be of benefit as well. We had tried Butrans last time, but it was not covered by insurance." Respondent then issued prescriptions: fentanyl 25 µg per hour, apply one every 3 days, #10; oxycodone 5/325, take one every 6 hours as needed, #135, refill on or after September 9, 2011.

On September 26, 2011, Patient B telephoned Respondent's clinic and requested a refill of her fentanyl patches. Respondent then prescribed 10 additional patches.

Patient B returned to care on September 29, 2011. She noted that she would meet with her psychiatrist on October 6, and that her fibromyalgia had been worse with the weather. "She has not tolerated nerve tonics well." Patient B reported continuing to take oxycodone, 4 to 5 tablets per day, as well as cyclobenzaprine. The medication list indicates that the fentanyl patches were discontinued because they would not stay on. There is no discussion in the chart about how this can be reconciled with the fact that Patient B requested a refill of these patches, 3 days previously. Patient B reported her pain as a 6 on a scale of 0 to 10 "pretty much everywhere and mostly my lower back." Respondent's plan included: "6. Fibromyalgia: we will continue her current dose of Percocet. She has not had difficulty with escalating doses or early refills. Should she need changes I do think Advanced Pain Management would be very helpful. There is also a physical therapist who specializes in fibromyalgia at the Southside Clinic which would be of significant benefit for her should she be able to arrange transportation." Respondent issued a prescription for oxycodone 5/325, take one tablet for to 5 times daily, one-month supply, #135.

Patient B telephoned Respondent's clinic on October 31, 2011, and requested a refill of her oxycodone. Respondent issued a prescription for another 135 tablets with the same dosage instructions. Patient B telephoned for another refill on November 28, 2011, and another prescription for 135 tablets was issued.

Patient B returned to care on December 20, 2011, and reported ongoing headaches. Respondent noted that amitriptyline was not helpful, and that Patient B reported being on liquid Roxicet for her pain, having been seen in the emergency department on December 19. She reported her pain as the 6 on a scale of 0 to 10 "my whole body kind of aches." Respondent's plan included: "3. Chronic low back pain. We will continue pain medication as helpful." The chart reflects that a prescription for 135 tablets of oxycodone 5/325 was issued.

On January 20, 2012, Patient B telephoned Respondent's clinic and requested a refill of her oxycodone. Respondent issued a prescription for 135 tablets. On February 17, 2012, Patient B telephoned the clinic and requested a refill of her oxycodone; Respondent issued a prescription for another 135 tablets, and Patient B was informed that she needed to be seen before another prescription would be issued.

On March 2, 2012, Patient B returned to the clinic and reported that her pain was a 6 on a 0 to 10 scale. She further reported that she had an appointment to begin physical therapy the following week, and that her headaches had resolved. Respondent's plan included: "1. Back pain. I do strongly recommend she follow up with physical therapy. This would be the most helpful thing we can try long term. Regarding long-term use of chronic

opioids, this is concerning given her young age. We will see if Nucynta may be a better option. We have prescribed this as 100 mg 4 times daily. Barring that we will continue with Percocet. I do think referral to Advanced Pain Management for potential injection would be helpful." A prescription for tapentadol (Nucynta®) was issued, #120.

Patient B returned to clinic on March 13, 2012, reporting that she had fallen at home on March 8, and experienced the significant pain. She went to the emergency room four days later, and received a ketorolac injection, which was not effective. She reported her pain as a 10 on a scale of 0 to 10. Respondent's plan included: 1. Acute or chronic pain exacerbation. I do think the timing for the injury and the subsequent ER visit our [*sic*] concerning. I do think this is an exacerbation of underlying fibromyalgia. There may be a degree of ankle sprain though she is able to walk without much difficulty. I would recommend that she continue with an Ace wrap as helpful. One is provided to date. I do think physical therapy would be of benefit tomorrow though she is recommended to go easy as she did have this recent fall. I do think fibromyalgia is the primary cause of most of her pain. We discussed other non-narcotic options for treatment of pain though she is not interested at this time given difficulty her mother has had with such treatments. She is most interested in continuing with Percocet. I did discuss that this will likely not be the best long-term intervention as it will become less effective over time. At this time we will continue with this medication though I would be very much interested in trying Savella, Lyrica or Cymbalta again in the future." Respondent then issued a prescription for oxycodone 5/325, #135. There was no charted discussion of the tapentadol.

On April 9, 2012, Patient B telephoned Respondent's clinic for a refill of her oxycodone. Respondent issued another prescription for 135 tablets. On May 4, 2012, Patient B called for a refill of her oxycodone, and Respondent issued another prescription for 135 tablets. There is a note that Patient B should have enough medication to last through May 8, 2012, and that the prescription would not be issued until May 7, 2012.

Patient B returned to care on May 21, 2012, and stated that her back pain had been getting worse for the past 2 months, and that she had been taking 8 to 10 tablets of oxycodone per day. She had not undertaken physical therapy: no explanation for this was charted. Patient B's chart does not reflect a pain level. Respondent noted that Patient B appeared very fatigued and unhappy. His plan included: "1. Back pain. I do discuss with [patient] that taking her pain medication more than prescribed is dangerous and illegal. I do think this is more a symptom of pseudoaddiction in the sense that her pain is incompletely controlled. I do want to give her the benefit of the doubt. We will change to oxycodone 10 mg immediate release, a two-week supply to take up to 4 times daily. I do strongly recommend physical therapy. MRI of the back is reassuring. It does not show any significant red

flags for which surgery would be indicated. I would also be very interested in trying Cymbalta as she is having some dysphoria. I do discuss with [patient] that she needs to take these medications as prescribed; otherwise I cannot continue to prescribe them." Respondent issued a prescription for oxycodone 10 mg QID, #60; duloxetine (Cymbalta®) 30 mg, delayed release, take one daily for one week, and then twice daily thereafter.

Patient B telephoned Respondent's clinic on June 4, 2012, and requested a refill of the "original" formulation. Respondent then prescribed oxycodone 5/325, #135.

Patient B returned to care on June 29, 2012. Respondent charted, in part: "at the previous visit she had been using Percocet inappropriately and we instead tried oxycodone 10 mg. She states that oxycodone 20 mg is equivalent to Percocet 5/325. She is interested in continuing the Percocet, though she would like to increase the dose. She did try the Cymbalta, however, she state that after 4 days this caused some confusion and she is not interested in taking more of it." There is no pain level charted. Respondent's plan included: "chronic pain. We will continue the Percocet, however, we will increase to 7.5/325 with the same dosing #135 months late. I do strongly recommend physical therapy. There are other agents I would like to use again in the future. I am concerned that at her young age of 30, should she continue with these medications that will bode a very poor quality of life in the future." Respondent issued a prescription for oxycodone-acetaminophen 7.5/325mg, #135.

Patient B returned to care on July 28, 2012. Respondent charted: "she states her chronic pain remains fairly well controlled with the Percocet, however, she has had worsening bilateral hand pain for the past 10 days. She had been given splints in the past for carpal tunnel syndrome though she has recently moved and does not know where they are. She states the 3rd and 4th digit of both hands are affected. The right-hand is more affected than the left. She continues to have difficulty with neck pain for which cyclobenzaprine has been helpful at night." There is no record of Patient B's pain level. Respondents plan included: "1. Chronic pain. We will continue with the Percocet for tablets daily, #135. 2. Bilateral hand pain. At present this does appear to be carpal tunnel syndrome. I would recommend she used [*sic*] the splints again. She does not have much difficulty further up the forearm, in the elbow or the upper arm. I do not detect a significant abnormality in the neck aside from muscle tightness. Use of tizanidine may be of benefit which cyclobenzaprine causes too much sedation." Respondent issued prescriptions for oxycodone 7.5/325, #135; and tizanidine 4 mg, TID, #90, one refill.

Patient B returned to care on August 24, 2012. Respondent charted: "she reports her Percocet is not as effective as it had been previously. She is

having difficulty with the way the prescription was written before as they will not provided [*sic*] as a one-month supply and she has run out to [*sic*] days early. She describes ongoing bilateral hand pain, particularly affecting the right, with numbness, and tingling. 2 of the other fingers on the right-hand have also been affect it [*sic*]. She has been having significant pain in the right hip which does radiate around to the front. She has not yet done physical therapy but is looking into options in her new home in Delavan. She describes difficulty sleeping at night secondary to her pain. Tizanidine has been very effective." There is no record of Patient B's pain level. Respondent's plan included: "1. Fibromyalgia. I do think very strongly that Lyrica in addition to her current medications could be very helpful to prevent progression of her disease. I would like to do this again in the future; however, she is not interested at this time. Improved sleep as well as physical therapy would also be strongly recommended. 2. Chronic pain. We will continue the tizanidine. I very much recommend not trying few trans patches though she is not interested at this time. We will increase the Percocet up to 10/325 to take for [*sic*] tablets daily #120. [...] 5 right hip pain. This appears to be trochanteric bursitis which I do think could benefit significantly from injection. She is not interested at this time." There is no explanation for why Patient B rejects Respondent's recommendations. Respondent issued prescriptions for oxycodone/APAP 10/325, take one every 6 hours PRN, #120; and tizanidine 4 mg, TID, #90, 11 refills.

Patient B then returned to care on September 17, 2012. Respondent charted, in part: "regarding her chronic pain, she does think the increase in Percocet has been helping. She states that this will help for approximately 4 hours. She has had significant difficulty with sleep at night second to her pain. She is not using the new trans patch. She does continue to take tizanidine which has been helpful. She will be following up with her psychiatrist again later this month. She continues to have difficulty with right hip pain but declines injection ... Respondent's plan included: "l. Chronic pain. We will refill the Percocet #120 to take 4 times daily. I do think Butrans would be very helpful though she is not interested in taking it. I do again think that Lyrica could be helpful as well. I do strongly recommend follow up with physical therapy. [...] 3. Right hip pain. I do think that trochanteric bursitis injection would be very helpful. She is not interested." No reason is charted for Patient B's rejection of Respondent's recommendations. Respondent issued prescriptions for oxycodone 10/325, take one every 6 hours as needed, #120; and diazepam 10 mg, take one nightly as needed for anxiety, #30.

The Board finds that at no time did Respondent require Patient B to sign a medication argument, conduct a urine drug screen, conduct a pill count, consult with collateral sources, or take any recognized steps to avoid diversion. Respondent's chart is inadequate to support this level of opioid prescribing, fails to establish functional goals and monitor progress towards

such goals, and fails to demonstrate that alternatives to opioid therapy were adequately tried.

7. Pursuant to the Final Order, the Wisconsin Board required the applicant to complete extensive continuing education on the topic of prescribing psychotropic medications, prescribing controlled substances, medical documentation and five (5) hours in informed consent including its documentation.
8. On or about August 8, 2014, the applicant entered into a Consent Order with the Department of Financial and Professional Regulation of the State of Illinois, Division of Professional Regulation ("the Illinois Department") related to the Wisconsin Board's action. The Illinois Department reprimanded the applicant.
9. On or about September 11, 2014, the Wisconsin Board found that the applicant had successfully completed the Board-ordered education and returned his license to full, unrestricted status.
10. The applicant was given notice of the Board meeting on December 14, 2023. The applicant did not appear. The Board voted to grant the applicant's application, contingent upon the applicant entering into this Agreed Order.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order:

1. By submitting his application for medical license to the Board, the applicant's medical license is subject to regulation and discipline by the Board.
2. KRS 311.571 provides that the Board may deny licensure to an applicant without a prior evidentiary hearing upon a finding that the applicant has violated any provision of KRS 311.595 or 311.597 or is otherwise unfit to practice.

3. Based upon the Stipulations of Fact, the applicant has engaged in conduct which violates the provisions of KRS 311.595 (17). Accordingly, there are legal grounds for the parties to enter into this Agreed Order.
4. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending matter by entering into an informal resolution such as this Agreed Order.

AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, as an express condition of the Board approving Dr. Brigg W. Barsness' Application for License to Practice Medicine in the Commonwealth of Kentucky, the parties hereby ENTER INTO the following **AGREED ORDER:**

1. The applicant is hereby FINED One Thousand Dollars ($1,000.00).
2. Upon verified payment of the above fine, the applicant will be issued a Kentucky Medical License.

SO AGREED on this 3rd day of January, 2024.

FOR THE APPLICANT:

BRIGG BARSNESS, M.D.

COUNSEL FOR THE APPLICANT
(IF APPLICABLE)

FOR THE BOARD:

WILLIAM C. THORNBURY, JR., M.D.
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