COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2048

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOSEPH W. RICHARDSON, M.D., LICENSE NO. 24023, 229 DESHA ROAD, LEXINGTON, KENTUCKY 40502

# SECOND AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, and Joseph W. Richardson, M.D. (hereafter "the licensee"), and, based upon their mutual desire to fully and finally resolve the pending investigation without an evidentiary hearing, hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER**:

## STIPULATIONS OF FACT

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

1. At all relevant times, Joseph W. Richardson, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is emergency medicine.
3. On or about August 16, 2021, the Board requested that the Office of Inspector General review and analyze the licensee's prescribing records after it received an anonymous grievance raising concerns that the licensee was excessively prescribing for an emergency medicine specialist and for conditions presented.
4. On or about September 30, 2021, OIG reported that a review of the licensee's KASPER data for the period of August 28, 2020 through August 28, 2021 raised the following concerns:

- Higher MME than peers (40 MED daily level compared to 28 MED for other emergency medicine physicians) which can greatly increase the risk of opioid overdose;

- Analysis of day supply per opioid prescription indicated that the licensee is close to peers at 2.4 days' supply; however, strength and/or quantity was higher that peers based on average MME;

- Numerous patients were prescribed opioids while concurrently on medication for opioid use disorder (although it was noted that this may be typical for emergency medicine patient population and the licensee may have documented that no other treatment options were available); and

- The licensee may not be compliant with KASPER query requirements as set forth in the Board's regulations.

Based on the above, OIG identified twelve (12) patient charts illustrative of these concerns for further Board review.

5. On or about January 10, 2022, a Board consultant completed a review of the charts, half being from the licensee's emergency department-based practice at St. Joseph Health and the other half being from his treatment of friends outside of his emergency department-based practice locations (including "free house calls").

6. Regarding the licensee's emergency medicine patients, the consultant noted that no patient encounter had prescribed use of pain medication other than a Class II controlled substance and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices in the Commonwealth of Kentucky, stating, in part,

> ...[the licensee's] morphine equivalent dosing is static without attempt to minimize dosing amount or individualize dosing to the patient or patient encounter. He stays within prescribing standards for length of treatment but exceeds typical dosing. ...
>
> ... [N]o other pain control prescriptions were given that were not a controlled substance. The prevailing medical practice for pain control has changed in Kentucky. Given the opioid epidemic, other modalities for treatment of acute pain are utilized. If a controlled substance is

> deemed necessary, it is a deliberate decision with recognition of the habit forming, addictive nature of controlled substances so that the medication is used minimally, and with a review of patient's controlled substance use during the previous year.

7. In regard to the licensee's non-emergency department patients, the consultant noted multiple, ongoing prescribing of controlled substances on a consistent and regular basis; KASPER was not queried in accordance with Board regulations; some patients were prescribed over a period of years with only one documented physical examination; and medical records were not documented or maintained in accordance with acceptable practices. The consultant found that the licensee departed from or failed to conform to acceptable and prevailing medical practices in the Commonwealth of Kentucky, stating, in part,

> Dr. Richardson's medical practice deviates from 201 KAR 9:260. This is demonstrated on most of the patient documentation provided with KASPER review being sparse to nonexistent, the primary use of controlled substances for the treatment of chronic pain and psychiatric conditions, and the refilling of these medications without appropriate reexamination or evaluation for changes in treatment management.

8. In or around February 2022, the licensee responded to the consultant's report, stating, in part,

> It appears that I have not been completely compliant with Kentucky's prescription laws. In the previous twelve months I worked over 250 twelve-hour shifts and cared for over 6000 patients, all during the Covid-19 pandemic. Per Kasper, I requested over 1000 Kasper reports. Clearly, I am aware of the law and make every attempt to follow it. … I do have a handful of long-time patients who I care for outside of the ER. Yes, I do give them more than 3-days worth of whatever medications I deem necessary to address their individual problems. … None of these patients are ever charged for my services either in money or in kind. I have performed Kasper reports on each of these patients, albeit not as frequently as I should have. While I did ask each of them if they received medications from other prescribers, I took them at their word when they responded no. A recent review of their Kasper reports prove that my faith in their honesty was well founded (again, I've known and cared for these people, some for over 30 years), but still I have not been 100% compliant with the law. …

9. Upon consideration of the licensee's response, the Board consultant stated

> … Dr. Richardson's deficiencies were not simply "secretarial." The clinical decision to prescribe controlled substances is medically complex and not merely about documentation. The clinical decision, including reviewing prior use of controlled substances, is akin to reviewing prior records when planning patient care. The clinical decision to use a controlled substance (including dosing and duration) above other medications/therapies is similar to weighing the risks and benefits of a dangerous medical procedure. For patients using chronic controlled substances, the clinical reevaluation is to ensure that the controlled substance is still treatment appropriate. This action is parallel to the medical reassessment and follow up. In Dr. Richardson's case, the documentation was lacking, but more importantly, the clinical component was also deficient. The nonadherence to 201 KAR 9:260 only served to codify that element.

10. On or about March 17, 2022, the licensee appeared before the Panel and stated that he had retired from the practice of emergency medicine; he intends only to provide free primary care to his established non-emergency department patients.

11. On or about March 21, 2022, the licensee entered into an Agreed Order, in lieu of the issuance of a Complaint and Emergency Order of Restriction.

12. Pursuant to the Agreed Order, the licensee was to contact LifeGuard to schedule an individualized clinical skills assessment, in the specialty of primary care, for the earliest available date.

13. After various delays, in or around October 2022, the licensee submitted to a clinical skills assessment at LifeGuard.

14. On or about December 16, 2022, LifeGuard issued its Final Report. Pertinent findings from the Report are as follows:

    - The licensee met the minimum standards in the area of family medicine but would greatly benefit from education remediation to strengthen his knowledge base.

    - An independent and credentials external peer physician reviewer was unable to use the customary tool for the licensee's medical record

documentation review because there was such minimal documentation that it did not apply. None of the "encounters" reviewed by LifeGuard meet the standard of care. The licensee is seriously under documenting on patients who he seems to be treating over a significant amount of time. If he intends to act as a primary care MD, he will need an EMR that helps him document the appropriate information with far more detail.

- Specific to the assessment of the licensee's knowledge of prescribing opioids and other controlled substances and related clinical decision-making, the licensee was administered the MCQ knowledge examination (which utilizes state and federal guidelines for prescribing, treatment and care, as well as state specific statues and regulations). The licensee's knowledge-tested performance yielded a score of 79%, falling below the performance threshold established by LifeGuard of 85%.

- The licensee showed knowledge of the standard of care regarding pain management and was able to address the most salient issues surrounding the treatment of patients with opiates but he does not have a repeatable method for treating opiate patients. It would be helpful for the licensee to have an EMR that would prompt him to cover such issues as aggravating and relieving factors, pain quality and VAS. Having risk assessment tools that he could track through an EMR would be helpful.

- The licensee's oral analysis of four cases in family medicine were correctly diagnosed and worked up. However, if he is to resume practice doing primary care and not ED, he should be aware of this difference in approach and alter his habits accordingly.

- The licensee did not appear to acknowledge the boundaries of professionalism regarding documenting his medical activities and communicating with the patient's established primary care provider.

15. LifeGuard surmised in its Recommendations and Remediation Plan that while the licensee appears to have a sufficient level of medical knowledge, his approach to patient care is highly problematic. Therefore, the team of evaluators recommended that Dr. Richardson pursue one of two options with regards to continued treatment of his private patients including as follows:

- Dr. Richardson should not continue his practice of serving merely as a vehicle to write prescriptions for a select group of chosen individuals. This is poor medical practice and these patients should be referred to a standard medical office practice where they can receive care (including prescriptions) in the context of comprehensive primary care.

– OR –

a. Dr. Richardson must practice medicine in accordance with acceptable and recognized standards and guidelines for medical care and treatments, inclusive of, but not limited to: Developing appropriate and ongoing physician-patient relationships that go beyond simply writing prescriptions on request;

b. Documenting regular patient visits utilizing the standards and guidelines of medical records documentation, including notation of the patient's past medical history, family history, surgical history, current complaints, medical diagnoses providing a rationale for prescribing medications, developing and maintaining a medication and problem list, and using an appropriate documentation format such as a S.O.A.P note for each patient visit;

c. Addressing all patient complaint and conditions on a regular basis inclusive of preventative maintenance;

d. Utilizing an EHR to provide continuity of documentation and prompts necessary for appropriate documentation. Dr. Richardson would need to demonstrate evidence of EHR implementation and use;

e. Establishing appropriate policies, procedures and protocols for controlled substance prescribing and care;

f. Conducting risk assessments for those patients being prescribed opioids and other medications which have addiction and diversion potential;

g. Ensuring that a KASPER is reviewed and information documented prior to initiating controlled substances, and each time the patient presents for a refill; and

h. Using and documenting urine drug screen and noting inconsistencies and consequences of continued for patient's prescribed controlled substances.

16. LifeGuard further surmised in its Recommendations and Remediation Plan regarding Education Remediation that should the licensee choose to practice primary medicine in a more customary manner as outlined above, additional education remediation is warranted specifically in opioids and controlled substance prescribing and medical record documentation.

17. On January 8, 2023, the licensee wrote the panel and offered his explanation for many of the stated concerns outlined in LifeGuard's Final Report. The licensee

admitted that documentation is not his strong suit, and his lack of documentation posed a serious concern. The licensee further admitted that he took his patients at their word that they did not receive controlled substances from other providers.

18. On January 19, 2023, the licensee appeared before Inquiry Panel B, with counsel, and expressed his plan to continue taking care of his 20 concierge patients. He also expressed a desire to return to emergency medicine by taking some shifts to cover shortages in the ER. He acknowledged that most of his 20 concierge patients have other primary care physicians and/or specialty physicians. He acknowledged that although he had researched and identified an EMR system since he last appeared before the Panel in March 2022, he had not implemented use of an EMR system but had "upped" his charting and has kept charts since April 2022. He also stated that he runs KASPER every time he writes a prescription and utilizes a phone application called Iprescribe to write his prescriptions. He continues to see his patients free of charge.

19. The Board moved to issue a Complaint and Emergency Order of Restriction but first allowed the licensee an opportunity to enter into one of two proposed Amended Agreed Orders in lieu of the issuance of the Complaint and Emergency Order of Restriction.

20. On or about February 2, 2023, the licensee entered into one of the two proposed Amended Agreed Orders and was subject to the following terms and conditions:

    - The licensee SHALL ONLY practice within the specialty of emergency medicine and while physically located within an emergency department of a Kentucky-licensed hospital in the Commonwealth of Kentucky. The licensee shall not practice within any other specialty or any other setting;

    - The licensee SHALL ONLY prescribe, dispense, administer or otherwise professionally utilize controlled substances to persons who are registered patients of the emergency department, during the time the patient is

admitted to the emergency department and, when medically necessary, for a 72-hour period following their discharge from the emergency department. The licensee SHALL NOT prescribe, dispense, or otherwise professionally utilize controlled substances in any other context and/or for any other person(s); and

- The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597

21. On or about July 7, 2023, the Board's investigator, Kevin Payne, reviewed a KASPER Prescriber Report on the licensee from February 1, 2023 through June 15, 2023. His findings included:

    - Patient A had a prescription for Zolpidem #14 for 14 days' supply on May 3, 2023. The same patient had another prescription for Zolpidem #10 for 10 days' supply on June 13, 2023. Both prescriptions exceed the 72-hour prescribing restrictions in the Amended Agreed Order and do not appear to be typical ER prescribing.

    - Patient B had eight (8) separate prescriptions:

        - 3/1/2023 for Oxycodone 32517.5mg #8 for a 2-day supply;
        - 3/8/2023 for Oxycodone 32517.5mg #8 for a 2-day supply;
        - 3/21/2023 for Amphetamine/Dextroamphetamine (Adderall) #9 for a 3-day supply;
        - 4/18/2023 for Oxycodone 32517.5mg #8 for a 2-day supply;
        - 5/1/2023 for Amphetamine/Dextroamphetamine (Adderall) #9 for a 3-day supply;
        - 5/7/2023 for Amphetamine/Dextroamphetamine (Adderall) #9 for a 3-day supply;
        - 5/12/2023 for Amphetamine/Dextroamphetamine (Adderall) #9 for a 3-day supply; and
        - 6/10/2023 for Methylphenidate 10mg.

    The prescriptions for Adderall and Methylphenidate do not appear to be typical ER prescribing.

22. The licensee was contacted and admitted to prescribing for Patients A and B. He was clear to state that he saw Patient A in the ER. He also admitted that the

prescriptions were for a 14- and 10-day supply, exceeding the 72-hour prescribing restriction. He stated that this patient was referred to Dr. Christopher Durham in Lexington.

23. The licensee stated that he cared for Patient B for years but referred him to Dr. Durham after he entered into the Amended Agreed Order. The licensee stated that he prescribed several prescriptions for ADHD because Patient B could not get an appointment to see Dr. Durham for several months, and the licensee did not want to see him go through withdrawal while he waited for the appointment. The licensee did not see Patient B in the ER.

24. On July 20, 2023, the licensee was present and appeared before the Board. He admitted that he violated the terms of the Amended Agreed Order but justified the violations as best for his patients. He stated that he is not presently working in the Emergency Room. He discussed his future plans, which he stated do not include clinical work. However, he did express a desire to keep his license so that he could still prescribe should he "get a call in the middle of the night."

25. The licensee agreed to enter into this Second Amended Agreed Order, in lieu of the issuance of a Complaint and Emergency Order of Restriction.

## STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee engaged in conduct which violates the provisions of KRS 311.595(9) [as illustrated by KRS 311.597(4)], (12), and

(13). Accordingly, there are legal grounds for the parties to enter into this Second Amended Agreed Order.

3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this matter without an evidentiary hearing by entering into an informal resolution such as this Second Amended Agreed Order.

## SECOND AMENDED AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to resolve the pending matter without an evidentiary hearing, the parties hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER:**

1. The license to practice medicine within the Commonwealth of Kentucky held by Joseph W. Richardson, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Second Amended Agreed Order.

2. During the effective period of this Second Amended Agreed Order, the licensee's medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:

    a. The licensee SHALL NOT prescribe, dispense, administer, or otherwise professionally utilize controlled substances;

    b. The licensee SHALL ONLY practice within the specialty of emergency medicine and while physically located within an emergency department of a Kentucky-licensed hospital in the Commonwealth of Kentucky. The licensee shall not practice within any other specialty or any other setting; and

    c. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. As an express condition for the entry of this Second Amended Agreed Order in lieu of a Complaint and Emergency Order of Restriction, each party understands and agrees that the Board will never consider any petition for termination or modification of this Second Amended Agreed Order. Any communication by the licensee and/or his agents to the Board attempting to revive this matter or modify or terminate the terms set forth in this Second Amended Agreed Order will be returned without being provided or forwarded to any Board member.

4. The licensee expressly agrees that if he should violate any term or condition of this Second Amended Agreed Order, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that the licensee has violated any term or condition of this Second Amended Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Second Amended Agreed Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Second Amended Agreed Order.

5. The licensee understands and agrees that any violation of the terms of this Second Amended Agreed Order would provide a legal basis for additional disciplinary action, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 26TH day of July, 2023.

FOR THE LICENSEE:

JOSEPH W. RICHARDSON, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

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