BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS

IN MEDICINE AND SURGERY

IN THE MATTER OF:  

DAVID IZENBERG, D.O.
Holder of License No. 2253

For the practice of osteopathic medicine in the State of Arizona

)  
)  
) Case No.: DO-17-0148A
) ORDER FOR SUSPENSION OF LICENSE (STAYED) AND RESTRICTION OF PRACTICE

On June 5, 2017, the Arizona Board of Osteopathic Examiners ("Board"), received a complaint against David Izenberg D.O. (herein after "Respondent"), filed by the father of patient N.P. On November 18, 2017, Dr. Izenberg appeared before the Board for an Investigative Hearing and was represented by counsel, Mr. Steve Myers.

After hearing testimony from Respondent, the complainant, various witnesses and considering the documents and evidence submitted, the Board voted to enter the following Findings of Fact, Conclusions of Law and Order for Suspension.

JURISDICTIONAL STATEMENTS

1. The Board is empowered, pursuant to A.R.S. § 32-1800 et seq., to regulate the practice of osteopathic medicine in the State of Arizona, and the conduct of the persons licensed, registered, or permitted to practice osteopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 2253 issued by the Board for the practice of osteopathic medicine in the State of Arizona.

FINDINGS OF FACT

3. On October 1, 2008, N.P., a 25 year old male was first seen by Respondent. A handwritten progress note did not include a physical exam. It noted the patient had bipolar
disorder, had lost a brother to suicide, and takes Xanax “per psych back east.” The rest of the note was not legible. Respondent prescribed Xanax 2mg #50.

4. The next office visit was on September 18, 2014, and the patient was now 31 years old. He listed his current medications as Xanax 2mg, oxycodone 10mg and Adderall 30mg. The patient admitted he had been self-medicating with alcohol for his insomnia but usually took Xanax. He complained of anxiety, ADD, back pain, bipolar disorder and insomnia. No examination of the patient’s back was noted. Respondent prescribed Xanax 2mg #120, Adderall 30mg #60 and oxycodone 10mg #90. Respondent advised he would obtain N.P.’s previous medical records from Colorado.


6. On April 9, 2015, Respondent saw N.P. and noted N.P.’s brother reported N.P. was supplementing with alcohol for his back pain. Respondent increased the oxycodone prescription to 15mg, #150, and continued the Xanax and Adderall.

7. The medications were refilled on May 13, 2015. On June 11, 2015, N.P. returned to Respondent and the medications were refilled. On July 9, 2015, N.P. called for early refills. During an office visit on August 5, 2015, the progress notes indicate that N.P. noted his back was really bothering him as he had run out of pain medication because he “knocked his bottle over a week ago.” A UDS completed that day was inconsistent in that it was positive for Xanax but negative for oxycodone or Adderall. It was positive for alcohol and THC. The medications were refilled.

8. On September 9, 2015, the patient’s brother called asking when the scripts would be ready. Dr. Goldberg took the call and noted he would not write for Xanax for over 3 days and would need an MRI and x-rays for the oxycodone. X-rays of the lumbar spine were
done on September 9, 2015. The medications were refilled. An MRI was completed on October 2, 2015.

9. On October 6, 2015, the medications were refilled. On October 7, 2015, N.P. saw Respondent and the test results were reviewed. A disc extrusion was noted at L4-5. The patient was not interested in surgical intervention so they would try an inversion table.

10. The patient’s medications were refilled on November 4 and December 2, 2015.

11. The patient returned on January 7, 2016 and Respondent noted the CSPMP was fine. The medications were refilled.

12. The medications were refilled on February 3, March 2, and March 24, 2016. On March 15, 2016, Respondent completed a disability form for N.P.

13. On July 20, 2016, N.P. noted his mood swings were worse. Respondent prescribed Seroquel XR 50mg. N.P. was to increase the dosage from 100mg and then 150mg and return in three months. On August 10, 2016, the patient returned and reported he was on Seroquel XR 150mg.

14. A CSPMP report of June 26, 2017 indicates the last prescriptions from Respondent were filled on September 16, 2016. N.P was found in his apartment unresponsive and dead by Chandler Police on January 16, 2017.

15. Respondent failed to treat this patient for pain in accordance with the community standard of care. Respondent failed to complete a physical exam of the patient, did not require drug screenings at proper intervals, did not document regular pharmacy audits, nor require diagnostic testing.

16. A UDS was run once for N.P. and the findings were inconsistent with the medications being prescribed. This was not discussed with the patient, or if it was, it was not documented in the medical record.
17. Diagnostic testing was lacking, there was no controlled substance agreement, and there were indications of possible diversion that were not addressed with N.P. Opioids and benzodiazepines were prescribed without an appropriate diagnosis.

CONCLUSIONS OF LAW

18. The conduct and circumstances described above, constitute a violation of A.R.S. §32-1854 (6), engaging in the practice of medicine in a manner that harms or may harm a patient or that the Board determines falls below the community standard.

19. The conduct and circumstances described above, constitute a violation of A.R.S. §32-1854 (21) Failing or refusing to establish and maintain adequate records on a patient as follows:

   (a) If the patient is an adult, for at least six years after the last date the licensee provided the patient with medical or health care services.

   (b) If the patient is a child, either for at least three years after the child's eighteenth birthday or for at least six years after the last date the licensee provided that patient with medical or health care services, whichever date occurs later.

20. The conduct and circumstances described above, constitute a violation of A.R.S. §32-1854 (36), Prescribing or dispensing controlled substances or prescription-only medications without establishing and maintaining adequate patient records.

21. The conduct and circumstances described above, constitute a violation of A.R.S. §32-1854 (38), Any conduct or practice that endangers a patient's or the public's health or may reasonably be expected to do so.
22. The conduct and circumstances described above, constitute a violation of A.R.S. §32-1854 (48), Prescribing, dispensing or furnishing a prescription medication or a prescription-only device to a person if the licensee has not conducted a physical or mental health status examination of that person or has not previously established a physician-patient relationship.

ORDER

Pursuant to the authority vested in the Board,

IT IS HEREBY ORDERED that David Izenberg, D.O, holder of osteopathic medical License number 2253 is placed on SUSPENSION (Stayed) for a period of twelve (12) months from the effective date of the Order. The suspension will be reconsidered pending the results of the evaluation and compliance with any recommendations in case no. Do-16-0133A..

IT IS HEREBY FURTHER ORDERED that David Izenberg, D.O., holder of osteopathic medical License number 2253 shall comply with the following terms:

1. Respondent’s practice is restricted in that beginning the effective date of this order Respondent is restricted from prescribing or dispensing Class 2, 3, or 4 controlled substances (including Suboxone and Subutex). Respondent is also prohibited from providing or issuing a written certification for medical marijuana as defined in A.R.S. §36-2801 (18) until further order of the Board.

2. The Board re-affirms its decision in Case No. DO-16-0133A, a Consent Agreement, in which Respondent agreed to undergo a physician practice assessment by the Physician Assessment and Clinical Education Program (“PACE”), at the University of San Diego (619-543-6770/www.paceprogram.ucsd.edu) or a practice assessment through The Center For Personalized Education for Physicians (“CPEP”) in Denver, Colorado (303-577-3232 or www.cpepdoc.org), or an equivalent program that has been pre-approved by the Board’s Executive Director, unless otherwise ordered by the Board. The evaluation shall be completed
pursuant to the terms of the order in Case No. DO-16-0133A. Respondent shall ensure that the results from the practice assessment are sent to the Board.

3. Further, Respondent is required to comply with all recommendations made pursuant to the assessment and failure to do so is a violation of the Order issued in Case. No. Do-16-0133 and may result in the lifting of the stay in Case No. DO-17-0148A.

4. **Costs:** Respondent shall bear all costs incurred regarding compliance with this Order.

5. **Obey All Laws:** Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in the State of Arizona.

6. **Ceasing Practice in the State of Arizona:** In the event that Respondent ceases to practice medicine in the State of Arizona, by moving out of state, failing to renew his license, or maintaining an Arizona license but ceasing to practice clinical medicine or administrative medicine requiring licensure, Respondent shall notify the Board that he has ceased practicing in Arizona, in writing, within 10 days of ceasing to practice. In its sole discretion, the Board may stay the terms of this Order until such time as the Respondent resumes the practice of medicine in Arizona, or may take other action to resolve the findings of fact and conclusions of law contained in this Consent Agreement and Order for Probation.

7. **Failure to Comply / Violation:** Respondent's failure to comply with the requirements of this Order shall constitute an allegation of unprofessional conduct as defined at A.R.S. § 32-1854(25) and proven violations may be grounds for further disciplinary action (e.g., suspension or revocation of license), including the lifting of the stayed suspension.

Issued this 27th Day of March, 2018.

Arizona Board of Osteopathic Examiners
In Medicine and Surgery

[Signature]

Rachel Shepherd, Interim Executive Director
NOTICE OF RIGHT TO REQUEST REVIEW OR REHEARING

Any party may request a rehearing or review of this matter pursuant to A.R.S. § 41-1092.09. The motion for rehearing or review must be filed with the Arizona Board of Osteopathic Examiners within thirty (30) days. If a party files a motion for review or rehearing, that motion must be based on at least one of the eight grounds for review or rehearing that are allowed under A.A.C. R4-22-106(D). Failure to file a motion for rehearing or review within 30 days has the effect of prohibiting judicial review of the Board’s decision. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a motion for rehearing or review is not filed, the Board’s Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Original “Order for Suspension of License (Stayed) and Restriction of Practice” filed this 21st day of March, 2018 with:

Arizona Board of Osteopathic Examiners
In Medicine and Surgery
1740 W. Adams St. Ste 2410
Phoenix AZ 85007

Copy of the “Order for Suspension of License (Stayed) and Restriction of Practice” sent by regular US Mail and email this 21st day of March, 2018 to:

Steve Myers, D.O.
One Renaissance Square
2 North Central Avenue, Suite 1450
Phoenix, AZ 85004

Copies of this “Order for Suspension of License (Stayed) and Restriction of Practice” sent this 21st day of March, 2018 to:
David Izenberg, D.O.
5252 E. Main St.
Mesa, AZ 85205

AND

Jeanne Galvin, AAG
Office of the Attorney General SGD/LES
15 South 15th Ave.
Phoenix AZ 85007