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**STATE OF MINNESOTA
IN COURT OF APPEALS
A17-1571**

In the Matter of Sharon Beth Johnson,
APRN-CNP, RN RN License No. 197878-8
APRN License No. 3516.

**Filed July 16, 2018
Affirmed
Peterson, Judge**

Minnesota Board of Nursing
File No. OAH-8-0904-34212

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Considered and decided by Peterson, Presiding Judge; Kirk, Judge; and Jesson, Judge.

UNPUBLISHED OPINION

PETERSON, Judge

Relator challenges the revocation of her registered nurse (RN) license for a minimum of 15 years based on her inappropriate prescription of controlled substances. Relator asserts that (1) the decision to revoke her RN license was arbitrary and capricious because her conduct in prescribing medications as an advanced practice registered nurse

(APRN) is not dispositive of her ability to practice as an RN, and (2) the 15-year revocation is disproportionate to the claimed violations and is not supported by substantial evidence. We affirm.

FACTS

Respondent Minnesota Board of Nursing (the board) licensed relator Sharon Beth Johnson to practice as an RN and as a certified nurse practitioner (CNP) in 2010 and as an APRN in 2015.¹ Previously she was licensed in Iowa and Tennessee. From 1993 until 2016, Johnson worked in clinical, cardiovascular, and neuroscience care. In March 2016, Johnson began working at a pain clinic treating patients with chronic pain. In June 2016, Johnson stopped working at the pain clinic, but she resumed working there in August 2016. In September 2016, Johnson opened her own pain-management clinic, Metro MN Pain Center, which specialized in treating patients with chronic pain.

Before opening Metro MN, Johnson's experience in pain management consisted of a clinical rotation with a primary-care physician who specialized in pain management and working with a physician and an RN at the pain clinic where she worked in 2016. Both the physician and the RN who she worked with at the pain clinic were disciplined by their licensing boards for controlled-substance violations. The RN was convicted in federal court of a felony controlled-substance crime for prescribing oxycodone without a legitimate medical reason.

¹ In 2015, a statutory amendment required CNPs to obtain an APRN license. Minn. Stat. § 148.211, subd. 1a (2016).

About 250 patients from the pain clinic where Johnson had worked began seeing Johnson at Metro MN after the pain clinic closed due to the criminal charges. By November 2016, Johnson was treating more than 300 patients and stopped accepting new patients. Johnson charged \$300 cash for an initial appointment and \$200 cash for follow-up appointments. Johnson accepted only cash payments, even from patients who had health insurance.

Between September 30, 2016, and April 2, 2017, the board received ten complaints about Johnson's operation of Metro MN from pharmacies and healthcare professionals. Following a preliminary investigation, a review panel of the board found probable cause that Johnson had inappropriately prescribed controlled substances and that her continued practice posed an imminent risk of harm. The panel temporarily suspended her APRN license and initiated a contested-case proceeding.

The panel sought discipline on seven grounds. Two of the grounds were specifically based on Johnson's APRN practice, (1) failing to conform to standards of acceptable and prevailing advanced practice registered nursing and (2) violating federal controlled-substance laws. The other five grounds were (1) engaging in unprofessional conduct, (2) engaging in unethical conduct, (3) improperly managing patient records, (4) knowingly providing false or misleading information directly related to the care of a patient, and (5) "[e]ngaging in abusive or fraudulent billing practices." The hearing notice contained 23 pages of detailed factual allegations supporting the disciplinary grounds.

An evidentiary hearing was held before an administrative law judge (ALJ). The ALJ issued a recommended order, which the board adopted.

The board found that Johnson prescribed controlled substances to 369 patients in November 2016 and that she prescribed very high doses of opioids to 123 of those patients. The dosage of pain-relieving medications is measured in units of morphine milligram equivalents (MMEs). A dose of less than 36 MME per day has a relatively low risk of abuse and addiction. The Centers for Disease Control and Prevention (CDC) advises healthcare providers to use “extra precautions” when prescribing 50 MMEs per day of opioids and to “[a]void or carefully justify” prescribing 90 MMEs per day.² Heather Bell, MD, submitted a report noting that more than 80% of Johnson’s patients were prescribed more than 90 MMEs per day and opining that Johnson “started opioid naïve patients on higher doses than would be considered appropriate and did not conduct timely follow-up or monitoring of these patients,” putting them at risk of addiction or overdose. In November 2016, Johnson prescribed “86 patients over 200 MME per day,” “23 patients between 300 and 400 MME per day,” “8 patients between 400 and 500 MME per day,” “5 patients over 500 MME per day,” and “1 patient 705 MME per day.”

Benzodiazepines are controlled substances with a high risk of abuse, diversion, and overdose. Their properties include sedation, anxiety relief, and muscle relaxation. The board found that “there are significant risks of over-sedation, depressing a patient’s respiratory system, and death, when opioids are used in conjunction with benzodiazepines”

² Johnson argues that CDC guidelines are not evidence of the standard of care. But at the hearing before the ALJ, Johnson acknowledged that the CDC guidelines are “designed to help practitioners inform their practice decisions.” There was also expert evidence that the CDC guidelines inform and summarize standards of practice. The board, therefore, did not err in relying on the CDC guidelines as evidence of the standard of care.

and that the CDC “urges clinicians to ‘avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.’” In November 2016, Johnson prescribed opioids with benzodiazepines to 125 patients. Johnson prescribed benzodiazepines to increase the effectiveness of pain medication and to treat symptoms occurring with pain, such as anxiety or sleeplessness.

Promethazine-codeine cough syrup is often diverted for use as a recreational drug. The board found that “individuals began seeking [Johnson] out for promethazine-codeine cough syrup prescriptions,” and “as a result, [Johnson’s] prescriptions for promethazine-codeine syrup more than tripled between June and October 2016.” Johnson prescribed promethazine-codeine cough syrup to treat asthma even though it is not an appropriate treatment for asthma and can be harmful to asthma patients because it suppresses protective reflexes.

The board made detailed, specific findings on Johnson’s treatment of six patients. For example, Johnson assessed M.H. at a low risk of addiction and prescribed her increasing amounts of oxycodone but failed to account for her “history of drug-seeking behavior, drug abuse, and bipolar disorder.” In April 2016, Johnson prescribed M.H. 255 MMEs of oxycodone per day. Johnson also prescribed M.H. a high dosage of an anti-anxiety medication, but M.H.’s patient records did not show that Johnson assessed M.H. for anxiety. Between April and August 2016, Johnson increased M.H.’s oxycodone prescription from 255 MMEs per day to 360 MMEs per day, but the patient records did not state a rationale for the increase. Between May and November 2016, Johnson wrote

monthly oxycodone prescriptions for M.H. in amounts exceeding a 30-day supply without conducting pill counts.

Johnson's conduct with the other five patients included prescribing D.H. high doses of oxycodone despite a lack of medical support for his claimed injury and a diagnosis of opioid dependency, starting S.P. at a high dose of oxycodone without rationale and doubling the dosage within 30 days without rationale, double-filling C.H.'s oxycodone prescription and doubling his prescription for an anti-anxiety medication without rationale, issuing T.M. an early oxycodone prescription without rationale, and prescribing high doses of oxycodone to A.E. without medical support for his claimed pain.

The board concluded that Johnson (1) "engaged in inappropriate and harmful prescribing of controlled substances," (2) "diagnosed patients on the basis of the patients' representations to her, many of which were contradicted by available medical records," (3) "failed to identify common risk factors for opioid addiction," (4) "failed to accurately or reasonably assess her patients' risk of later opioid addiction," (5) "failed to undertake protocols, including pill counts, that would guard against abuse," (6) "disregarded patient misconduct," (7) "failed to institute plans for tapering . . . patients off of opioid medications," (8) "failed to document necessary patient evaluations," (9) "failed to undertake appropriate assessments," (10) "failed to conduct sufficient assessments," (11) made "numerous errors and misstatements" in documentation, and (12) "engaged in abusive billing practices." The board revoked Johnson's APRN and RN licenses and ordered that she not be allowed to "apply for any level of nursing relicensure for a minimum of fifteen years."

This appeal followed. On appeal, Johnson challenges the revocation of her RN license but does not challenge the revocation of her APRN license.

D E C I S I O N

“[D]ecisions of administrative agencies enjoy a presumption of correctness, and deference should be shown by courts to the agencies’ expertise and their special knowledge in the field[s] of their technical training, education, and experience.” *Reserve Mining Co. v. Herbst*, 256 N.W.2d 808, 824 (Minn. 1977). But an appellate court reviewing an agency decision may reverse or modify “the decision if the substantial rights of the petitioners may have been prejudiced” because the administrative decision was (1) based on unlawful procedure, (2) affected by an error of law, (3) not supported by substantial evidence in view of the entire record, or (4) arbitrary or capricious. Minn. Stat. § 14.69 (2016). “The relator has the burden of proof when challenging an agency decision” *Minn. Ctr. for Envtl. Advocacy v. Minn. Pollution Control Agency*, 660 N.W.2d 427, 433 (Minn. 2003).

“In reviewing an agency’s decision on a legal issue, this court is not bound by the agency’s ruling.” *In re Revocation of the Family Child Care License of Burke*, 666 N.W.2d 724, 726 (Minn. App. 2003). “A reviewing court must defer to the agency’s fact-finding process and be careful not to substitute its findings for those of the agency.” *Id.* A reviewing court does not retry facts or make credibility determinations and must defer to an agency’s credibility determinations. *In re Appeal of Rocheleau*, 686 N.W.2d 882, 891 (Minn. App. 2004), *review denied* (Minn. Dec. 22, 2004).

I.

Johnson argues that the board acted arbitrarily and capriciously by revoking her RN license because her violations concerned prescribing medication, which is an APRN function.

[A]n agency ruling is arbitrary and capricious if the agency (a) relied on factors not intended by the legislature; (b) entirely failed to consider an important aspect of the problem; (c) offered an explanation that runs counter to the evidence; or (d) the decision is so implausible that it could not be explained as a difference in view or the result of the agency's expertise.

Citizens Advocating Responsible Dev. v. Kandiyohi Cty. Bd. of Comm'rs, 713 N.W.2d 817, 832 (Minn. 2006). Also, an agency decision is arbitrary or capricious if the decision is based on whim or is devoid of articulated reasons. *CUP Foods, Inc. v. City of Minneapolis*, 633 N.W.2d 557, 565 (Minn. App. 2001), *review denied* (Minn. Nov. 13, 2001).

Under the Minnesota Nurse Practice Act, the functions of an RN include

- (1) providing a comprehensive assessment of the health status of a patient through the collection, analysis, and synthesis of data used to establish a health status baseline and plan of care, and address changes in a patient's condition;
- (2) collaborating with the health care team to develop and coordinate an integrated plan of care;
- (3) developing nursing interventions to be integrated with the plan of care;
- (4) implementing nursing care through the execution of independent nursing interventions; . . .
- (7) providing safe and effective nursing care; . . . [and]
- (11) collaborating and coordinating with other health care professionals in the management and implementation of care within and across care settings and communities[.]

Minn. Stat. § 148.171, subd. 15 (2016); *see also* Minn. Stat. § 148.171, subd. 20 (2016) (stating that a “registered nurse” is “an individual licensed by the board to practice professional nursing”).

The RN functions addressed by the board’s findings and conclusions include conducting assessments for medical conditions and addiction risk, developing treatment plans, documentation, and instituting adequate safeguards for monitoring patients for controlled-substance abuse and diversion. Specifically, Johnson failed to properly assess patients for risk of opioid addiction and diagnosed patients with conditions that they did not have, sometimes in order to prescribe them controlled substances. She failed to develop treatment plans for her patients and did not maintain proper patient records. Johnson failed to properly monitor patients for controlled-substance abuse and diversion; she failed to conduct pill counts, initiate toxicology screens, and monitor prescriptions to guard against patients filling prescriptions at multiple pharmacies to avoid detection of substance abuse. Johnson used patient agreements, in which patients agreed to conditions to guard against controlled-substance abuse, but she did not enforce the terms of the agreements. Because Johnson failed to perform functions of an RN that are identified in section 148.171, subdivision 15, the board did not act arbitrarily or capriciously in revoking her RN license. *See* Minn. Stat. § 148.261, subd. 1(1) (2016) (stating that failure to meet the requirements of section 148.171 is grounds for license revocation).

II.

Johnson argues that the discipline imposed by the board is not supported by substantial evidence. But “the assessment of penalties and sanctions by an administrative

agency is not a factual finding but the exercise of a discretionary grant of power.” *In re License of Haugen*, 278 N.W.2d 75, 80 n.10 (Minn. 1979). “A reviewing court, therefore, may not interfere with the penalties or sanctions imposed by an agency decision unless a clear abuse of discretion is shown by the party opposing the decision.” *In re Qwest’s Wholesale Service Quality Standards*, 678 N.W.2d 58, 65 (Minn. App. 2004) (quotation omitted). Professional boards are given such discretion because they are “uniquely suited” to identify violations of professional standards and assess discipline. *See In re Proposed Disciplinary Action Against Dentist License of Schultz*, 375 N.W.2d 509, 514 (Minn. App. 1985).

Boards and commissions . . . are appointed because of their special expertise regarding the standards of their own professions. When a professional person must be disciplined for breaching these standards, the nature and duration of the discipline is best determined by his or her fellow professionals, who are in a superior position to evaluate the breaches of trust and unprofessional conduct.

Padilla v. Minn. State Bd. of Med. Exam’rs, 382 N.W.2d 876, 886–87 (Minn. App. 1986).

Johnson also argues that the 15-year revocation of her RN license is disproportionate to her violations. The board made 184 findings of fact and 22 conclusions of law based on three days of testimony and thousands of pages of exhibits. The testimony was taken from Johnson, witnesses to her nursing practices, and experts on nursing practices. The exhibits included Johnson’s patient records, pharmacy prescription records, controlled-substance prescription reports, expert reports, complaints received by the board against Johnson, criminal complaints filed against Johnson’s patients, pain-management practice guides, and articles regarding the opioid epidemic. Based on the record evidence

and the authority cited by Johnson, we conclude that the board did not clearly abuse its discretion in revoking Johnson's RN license for a minimum of 15 years.

Johnson also argues that she should not be prohibited from applying for licensed practical nurse (LPN) licensure in Minnesota. The board's order prohibits Johnson from "apply[ing] for any level of nursing relicensure for a minimum of fifteen years." We agree with the board's construction of its order as applying only to relicensure. Because Johnson was never licensed as an LPN, the order does not prohibit her from applying for an LPN license.

Affirmed.