SETTLEMENT AGREEMENT BETWEEN THE MISSOURI STATE BOARD OF REGISTRATION FOR THE HEALING ARTS AND SALVADOR CENICEROS, MD

COMES NOW Salvador Ceniceros, MD, ("Licensee") and the Missouri State Board of Registration for the Healing Arts ("the Board") and enter into this agreement for the purpose of resolving the issue of whether Licensee's physician and surgeon's license is subject to discipline. Licensee and the Board jointly stipulate and agree that a final disposition of this matter may be effectuated as described below pursuant to section 621.045, RSMo.[1]

1. Licensee acknowledges that he understands the various rights and privileges afforded to him by law, including the right to a hearing of the charges; the right to appear and be represented by legal counsel; the right to have all charges against him proven upon the record by competent and substantial evidence; the right to cross-examine any witnesses appearing at the hearing; the right to present evidence on his own behalf; the right to a decision based upon the record concerning the charges pending against him; and the right to present evidence in mitigation of discipline at a hearing before the Board. Having been advised of these rights provided to him by operation of law, Licensee knowingly and voluntarily waives each and every one of these rights, freely enters into this agreement and agrees to abide by the terms of this document as they pertain to him.
2. Licensee acknowledges that he may, at the time this agreement is effective or within fifteen (15) days thereafter, submit this agreement to the Administrative Hearing Commission to determine whether the facts agreed to by the parties constitute grounds to discipline Licensee's license.
3. Licensee acknowledges that he has been advised of his right to consult legal counsel in this matter.
4. The parties stipulate and agree that the discipline agreed to by the Board and Licensee in the consent order in Part III is based only on the agreement set out in Parts I and II herein. Licensee understands that the Board may take further action against him based on facts or conduct not specifically mentioned in this document that is either presently known to the Board or later discovered.

[1] All statutory references are to the Revised Statutes of Missouri Cumulative Supplement (2018), unless otherwise stated.

5. Licensee understands and agrees that the Board will maintain this agreement as an open record as required by Chapters 324, 334 and 610, RSMo, and it will report this agreement to the National Practitioner Data Bank ("NPDB") and the Federation of State Medical Boards ("FSMB").

I. JOINT STIPULATION OF FACTS

Based upon the foregoing, the Board and Licensee herein jointly stipulate and agree to the following:

6. The Board is an agency of the State of Missouri created and established pursuant to section 334.120, RSMo for the purpose of executing and enforcing the provisions of Chapter 334, RSMo.

7. Licensee is licensed by the Board as a physician and surgeon, license number 2010006881, which was first issued on March 1, 2010. Licensee's license lapsed on January 31, 2021, but it was current and active at all times relevant herein. Licensee left the practice of medicine.

Patient 1

8. Patient 1 was a 46-year-old female when she was seen by Licensee between February 1, 2015 and August 1, 2015.

9. Licensee was seeing Patient 1 for bipolar disorder and alcohol/polysubstance dependency.

10. During the above-referenced period, Licensee jointly with another provider prescribed Patient 1 alprazolam (benzodiazepine/anti-anxiety medication, schedule IV), diazepam (benzodiazepine/anti-anxiety medication, schedule IV), fentanyl (opiate/narcotic painkiller, schedule II), oxycodone (opiate/narcotic painkiller, schedule II), triazolam (sedative & benzodiazepine, schedule IV), zolpidem (sedative, schedule IV) and belsomra (sedative).

11. On occasions, Patient 1 had a total morphine equivalent dose of 200 MME/day.

12. There were refills of prescriptions of alprazolam, oxycodone and belsomra that were not supported by Patient 1's chart.

13. From February 2, 2015, to May 5, 2015, Licensee prescribed Patient 1 with fentanyl and oxycodone, opiate painkillers, and the records do not identify or document the nature and intensity of Patient 1's pain, or the effect of the pain on her physician and psychological function.

14. On June 23, 2015, after Patient 1 expressed to Licensee her desire to come off of a Suboxone prescription she received through another provider, Licensee decided to refer Patient 1 to a third provider for pain management. The patient's chart does not reflect any consultation with the new pain management specialist.
15. Licensee did not always sufficiently assess risk and address harms in Patient 1 nor exhibit increased vigilance despite Patient 1's history of polysubstance dependency, and despite the fact that Licensee prescribed Patient 1 a combination of benzodiazepine and opioids, which poses an increased risk of death in patients taking these medications concurrently.
16. The medical records do not show drug screens for Patient 1; however, Licensee maintains that that those screens were always completed.
17. Licensee continued to prescribe Patient 1 controlled substances despite the absence of recorded urinary drug screens. Licensee repeatedly provided Patient 1 with alprazolam (Xanax) despite noting in the medical records that Patient 1 "overtook them and ran out early."
18. During the course of care, Licensee did not sufficiently evaluate underlying or coexisting diseases or conditions or history in this patient.
19. During the course of care, Licensee did not always document progress towards treatment objectives, improvement in patient's pain intensity or improvement of physical and/or psychosocial function.
20. During the course of care, Licensee did not always sufficiently consider alternative medications, utilize the lowest possible dosage, and/or sufficiently assess benefits and harms in prescribing pain medications with this patient.
21. Licensee failed to keep complete and accurate ongoing records of the diagnosis and treatment plan of Patient 1, in violation of Section 334.107(1), RSMo.
22. Licensee's aforesaid actions and inactions constitute a violation of Sections 334.100.2(4)(l), 334.100.2(5), 334.097 and 334.107, RSMo and are cause for discipline.

Patient 2

23. Patient 2 was a 41-year-old male when he was seen by Licensee between April 1, 2015, and October 1, 2015.

24. Licensee was seeing Patient 2 for schizophrenia.

25. During the above-referenced period, Licensee jointly with another provider prescribed Patient 2 alprazolam (benzodiazepine/anti-anxiety medication, schedule IV), diazepam (benzodiazepine/anti-anxiety medication, schedule IV), hydromorphone (opiate/narcotic painkiller, schedule II), fentanyl (opiate/narcotic painkiller, schedule II), oxycodone (opiate/narcotic painkiller, schedule II) and eszopiclone (sedative).

26. There were refills of prescriptions of alprazolam and oxycodone to Patient 2 that were not supported by Patient 2's chart.

27. On occasion, Patient 2 had a total morphine equivalent dose over 200 MME/day.

28. Licensee's prescribing was atypical and potentially harmful in that he prescribed three short acting medications.

29. During the above-referenced period, Licensee prescribed Patient 2 multiple opioids of various doses, and the medical records do not adequately identify or document the nature and intensity of Patient 2's pain, or the effect of the pain on his physical and psychological function.

30. Over the above-referenced time period, the medical records only document that Licensee saw Patient 2 four (4) times.

31. During the course of care, the medical records do not document that Licensee always determined progress towards treatment objectives, improvement in patient's pain intensity or improvement of physical and/or psychosocial function.

32. During the course of care, Licensee did not always sufficiently consider alternative medications, utilize the lowest possible dosage, and/or sufficiently assess benefits and harms in prescribing pain medications with this patient.

33. Licensee did not exhibit increased vigilance despite the fact that he prescribed Patient 2 a combination of benzodiazepine and opioids, which poses an increased risk of death in patients taking these medications concurrently.

34. The medical records do not show drug screens in Patient 2's records to ensure patient compliance with prescriptions or to prevent diversion of controlled substances; however, Licensee maintains that that those screens were always completed

35. Licensee continued to prescribe Patient 2 controlled substances despite the absence of recorded urinary drug screens.

36. Licensee failed to keep complete and accurate ongoing records of the diagnosis and treatment plan of Patient 2, in violation of section 334.107(1), RSMo.

37. Licensee's aforesaid actions and inactions constitute a violation of Sections 334.100.2(4)(l), 334.100.2(5), 334.097 and 334.107, RSMo and are cause for discipline.

Patient 3

38. Patient 3 was a 55-year-old male when he was seen by Licensee between August 3, 2015, and February 3, 2016.

39. Licensee was seeing Patient 3 for depression, anxiety, and pseudobulbar affect (PBA).

40. During the above-referenced period, Licensee jointly with another provider prescribed Patient 3 alprazolam (benzodiazepine/anti-anxiety medication, schedule IV), fentanyl (opiate/narcotic painkiller, schedule II), oxycodone (opiate/narcotic painkiller, schedule II), and Belsomra (sedative).

41. There were refills of prescriptions of alprazolam and Belsomra to Patient 3 that were not supported by Patient 3's chart.

42. On occasion, Patient 3 had a total morphine equivalent dose of 200 MME/day.

43. During the above-referenced period, Licensee prescribed multiple opioids of various doses to Patient 3 and the records do not reflect Licensee identifying or documenting the nature and intensity of Patient 3's pain, underlying or coexisting diseases or conditions, or the effect of the pain on his physical and psychological function.

44. Over this time period, the records only show that Licensee saw Patient 3 twice. Licensee did not always conduct sufficient physical examinations on Patient 3, nor did he sufficiently evaluate the underlying or co-existing diseases or conditions and history of Patient 3.

45. During the course of care, Licensee did not regularly determine progress towards treatment objectives, improvement in patient's pain intensity or improvement of physical and/or psychosocial function.

46. During the course of care, Licensee did not always sufficiently consider alternative medications, utilize the lowest possible dosage, and/or sufficiently assess benefits and harms in prescribing pain medications with this patient.

47. Licensee did not exhibit increased vigilance despite the fact that he prescribed Patient 3 a combination of benzodiazepine and opioids, which poses an increased risk of death in patients taking these medications concurrently.

48. The medical records do not show drug screens for Patient 3; however, Licensee maintains that those screens were always completed.

49. Licensee continued to prescribe Patient 3 controlled substances despite the absence of recorded urinary drug screens.

50. Licensee failed to keep complete and accurate ongoing records of the diagnosis and treatment plan of Patient 3, in violation of Section 334.107(1), RSMo.

51. Licensee's aforesaid actions and inactions constitute a violation of Sections 334.100.2(4)(l), 334.100.2(5), 334.097 and 334.107, RSMo and are cause for discipline.

Patient 4

52. Patient 4 was a 38-year-old male when he was seen by Respondent between January 28, 2016, and August 1, 2016.

53. Respondent treated Patient 4 for schizophrenia and anxiety.

54. During the above-referenced period, Respondent jointly with another provider prescribed Patient 4 alprazolam (benzodiazepine/anti-anxiety medication, schedule IV), tramadol (opiate/narcotic painkiller, schedule IV) and Eszopiclone (sedative).

55. There were refills of prescriptions of alprazolam and Eszopiclone to Patient 4 that were not supported by Patient 4's chart.

56. Over the above-referenced time period, the medical records show that Respondent saw Patient 4 four (4) times.

57. Respondent did not always conduct sufficient physical examinations on Patient 4; nor did he always sufficiently evaluate the underlying or co-existing diseases or conditions of history of Patient 4.

58. During the course of care, the medical records do not show that Respondent always determined progress towards treatment objectives, improvement in patient's pain intensity or improvement of physical and/or psychosocial function.

59. During the course of care, Respondent did not always sufficiently consider alternative medications, utilize the lowest possible dosage, and/or sufficiently assess benefits and harms in prescribing pain medications with this patient.

60. Respondent did not always exhibit increased vigilance despite the fact that he prescribed Patient 4 a combination of benzodiazepine and opioids, which poses an increased risk of death in patients taking these medications concurrently.

61. Despite noting Patient 4 was opiate dependent during the January 28, 2016, visit, Respondent prescribed Patient 4 with a 10-day supply of 100mg tramadol, an opiate painkiller.

62. On February 1, 2016, Patient 4's urinary drug screens showed that he was positive for hydrocodone, a medication he was not prescribed, while negative for alprazolam (Xanax), a medication he was prescribed.

63. The medical records do not show that Respondent addressed the inconsistent drug screens. He also continued to prescribe Patient 4 alprazolam (Xanax) on or about February 23, 2016, despite the previous negative urine drug screen.

64. Respondent failed to keep complete and accurate ongoing records of the diagnosis and treatment plan of Patient 4, in violation of Section 334.107(1), RSMo.

65. Respondent's aforesaid actions and inactions constitute a violation of Sections 334.100.2(4)(l), 334.100.2(5), 334.097 and 334.107, RSMo and are cause for discipline.

Patient 5

66. Patient 5 was a 49-year-old male when he was seen by Licensee between February 15, 2017, and August 15, 2017.

67. Licensee was seeing Patient 5 with opiate dependence, schizoaffective disorder, generalized anxiety disorder, and insomnia.

68. During the above-referenced period, Licensee jointly with another provider prescribed Patient 5 diazepam (benzodiazepine/anti-anxiety medication, schedule IV), Suboxone (opiate/narcotic painkiller, schedule IV), and zolpidem (sedative).

69. Licensee ordered GeneSight Psychotropic Combinatorial Pharmacogenomic Test ("GeneSight"), a non-FDA approved genetic test, be performed on Patient 5.

70. This test has not been approved by the Food and Drug Administration ("FDA").

71. Patient 5 and Licensee entered into a Pain Management Contract on or about February 15, 2017.

72. In the Pain Management Contract, Patient 5 agreed to random drug testing and to not use street drugs.

73. Patient 5 had a history of using marijuana and continued to use marijuana while he was treated by Licensee for opiate dependency.

74. Before placing Patient 5 on Suboxone treatment, the medical records do not reflect that Licensee properly address Patient 5's history of substance abuse or assess Patient 5 for risk of continued substance abuse and/or overdose.

75. Once placed on Suboxone treatment, Patient 5 repeatedly tested positive for eTHC, indicating his continued use of marijuana, which indicates incompliance with the Pain Management Contract he signed with Licensee.

76. The medical records do not demonstrate that Licensee addressed Patient 5's violation of the Pain Management Contract or inconsistent drug screens in any of the following office visits with Patient 5.

77. The medical records do not demonstrate that Licensee properly addressed the inconsistent drug screen results when Patient 5 tested positive for medications not prescribed on February 15, 2017, June 7, 2017, and July 12, 2017, or when Patient 5 tested negative on March 15, 2017, and April 12, 2017, for medications he was prescribed.

78. The medical records do not document that Licensee revised the treatment plan based on the inconsistent drug screens.

79. Patient 5's medical records maintained by Licensee lacked objective support for a diagnosis of schizoaffective disorder, generalized anxiety disorder, and psychophysiologic insomnia, as no objective tests were utilized or documented before Licensee formed the aforementioned diagnoses.

80. Patient 5's medical records maintained by Licensee contained many errors. Specifically, Licensee described Patient 5, a self-reported a heavy smoker, as a "[n]ever smoker." Licensee also referred to Patient, a male, as "she" on more than one occasion.

81. During the course of care, the medical records do not show that Licensee t always determined progress towards treatment objectives, improvement in patient's pain intensity or improvement of physical and/or psychosocial function.

82. During the course of care, Licensee did not always sufficiently consider alternative medications, utilize the lowest possible dosage, and/or sufficiently assess benefits and harms in prescribing pain medications with this patient.

83. Licensee did not always exhibit increased vigilance despite the fact that he prescribed Patient 5 a combination of Suboxone, an opioid, and a long-term benzodiazepine, which poses an increased risk of death in patients taking these medications concurrently.

84. Licensee failed to keep complete and accurate ongoing records of the diagnosis and treatment plan of Patient 5, in violation of Section 334.107(1), RSMo.

85. Licensee's aforesaid actions and inactions constitute a violation of Sections 334.100.2(4)(l), 334.100.2(5), 334.097 and 334.107, RSMo and are cause for discipline.

86. Licensee's treatment of Patients 1-5 consisted of conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public.

87. Licensee also failed to maintain an adequate and complete patient record for Patients 1-5 in that Licensee's records failed to adequately document the identification of Patients 1-5 including name, birthday, address, and telephone number, the date or dates the patients were seen, current status, including the reason for the visit, observation of pertinent physical findings, objective assessment and clinical impression of diagnosis, plan for care and treatment, or additional consultations or diagnostic/confirmatory testing, if necessary, and any informed consent for office procedures.

88. Licensee's treatment of Patients 1-5 was a failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by a member of Licensee's profession, in the performance of Licensee's functions or duties as a physician. The above constitutes repeated negligence in the performance of the functions of duties of Licensee's profession.

89. The above is cause to discipline Licensee's license pursuant to sections 334.100.2(4)(l), 334.100.2(5), 334.097, and 334.107, RSMo.

90. Licensee left the practice of medicine, did not renew his license in 2021 and desires to surrender his license.

91. Licensee does not intent to practice medicine again and, therefore, wishes to surrender his license.

92. Licensee understands that his surrender is reportable discipline.

II. JOINT CONCLUSIONS OF LAW

93. Cause exists to discipline Licensee's license pursuant to sections 334.100.2(4)(l), 334.100.2(5), 334.097, and 334.107, RSMo. which state:

> 334.100.2 The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered the person's certificate of registration or authority, permit or license for any one or any combination of the following causes:
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(4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including, but not limited to, the following:

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(l) Failing to furnish details of a patient's medical records to other treating physicians or hospitals upon proper request; or failing to comply with any other law relating to medical records

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(5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence in the performance of the functions or duties of any profession licensed or regulated by this chapter. For the purposes of this subdivision, "repeated negligence" means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant's or Respondent's profession;

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334.097. 1. Physicians shall maintain an adequate and complete patient record for each patient and may maintain electronic records provided the record-keeping format is capable of being printed for review by the state board of registration for the healing arts. An adequate and complete patient record shall include documentation of the following information:

(1) Identification of the patient, including name, birthdate, address and telephone number;
(2) The date or dates the patient was seen;
(3) The current status of the patient, including the reason for the visit;
(4) Observation of pertinent physical findings;
(5) Assessment and clinical impression of diagnosis;
(6) Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the patient record the medication and dosage of any medication prescribed, dispensed or administered;
(7) Any informed consent for office procedures.

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334.107. Nothing in section 334.106 and this section shall deny the right of the board to deny, revoke or suspend the license of any physician or otherwise discipline any physician who:

(1) Prescribes, administers or dispenses a controlled substance that is nontherapeutic in nature or nontherapeutic in the manner in which it is prescribed, administered or dispensed, or fails to keep complete and accurate ongoing records of the diagnosis and treatment plan;

94. Cause exists for the Board to take disciplinary action against Licensee's license under sections 334.100.2(4)(l), 334.100.2(5), 334.097, and 334.107, RSMo.

III. CONSENT ORDER ON DISCIPLINE

Based on the foregoing, the parties mutually agree and stipulate that the following shall constitute the disciplinary order entered by the Board in this matter under the authority of section 621.110, RSMo. This agreement, including the disciplinary order, will be effective immediately on the date entered and finalized by the Board. The following are the terms of the disciplinary order:

95. In lieu of placing Licensee's license number 2010006881 on probation, the Board hereby accepts Licensee's surrender of his license.

96. Licensee shall, within thirty (30) days after the effective date of this Agreement, return his pocket card and license to the Board if they exist.

97. If Licensee is licensed in other jurisdictions, he shall forward written notice of this disciplinary action to the medical licensing authorities of those jurisdictions within thirty (30) days of the effective date of this agreement. Licensee shall submit a copy of the written notice to the Board contemporaneously with sending it to the relevant licensing authority. If Licensee becomes licensed in any jurisdiction during the course of the disciplinary period, he shall notify the medical licensing authorities in those states of his disciplinary status within fifteen (15) days of obtaining said license. If Licensee is not licensed in other jurisdictions, he shall notify the Board of that fact, in writing, within thirty (30) days of the effective date of this agreement.

98. Licensee shall, within thirty (30) days of the effective date of this agreement, forward written notice of this disciplinary action to all employers, hospitals, nursing homes, out-patient centers, clinics, and any other facility where Licensee practices or has privileges. Licensee shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative. If Licensee obtains privileges or begins practicing with any employer, hospital, nursing home, out-patient center, surgical center, clinic or other facility during the course of the disciplinary period, he shall notify the employer or medical facility of his disciplinary status within

fifteen (15) days of the granting of privileges or beginning of practice. If Licensee does not have an employer, staff privileges or practice at any facility, he shall notify the Board of that fact, in writing, within thirty (30) days of the effective date of this agreement.

99. Licensee shall, within thirty (30) days of the effective date of this agreement, forward written notice of this disciplinary action to any allied health care professionals supervised by Licensee. Licensee shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative. If Licensee begins supervising any allied health care professionals during the course of the disciplinary period, he shall notify them of his disciplinary status within fifteen (15) days of becoming their supervisor. If Licensee does not supervise any allied health professionals, he shall notify the Board of that fact, in writing, within thirty (30) days of the effective date of this agreement.

100. For purposes of this agreement and unless otherwise specified herein, all reports, documentation, evaluations, notices, or other materials Licensee is required to submit to the Board in this agreement shall be forwarded to the State Board of Registration for the Healing Arts, Attention: Enforcement, P.O. Box 4, Jefferson City, Missouri 65102.

101. This agreement does not bind the Board or restrict the remedies available to it concerning any other violation of Chapter 334, RSMo by Licensee not specifically mentioned in this document, either currently known to the Board or later discovered.

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102. Licensee hereby waives and releases the Board, its members, and any of its employees, agents, or attorneys, including any former board members, employees, agents, and attorneys, of, or from, any liability, claim, actions, causes of action, fees, costs and expenses, and compensation, including, but not limited to any claims for attorney's fees and expenses, including any claims pursuant to section 536.087, RSMo, or any claim arising under 42 USC 1983, which may be based upon, arise out of, or relate to any of the matters raised in this agreement, or from the negotiation or execution of this agreement. The parties acknowledge that this paragraph is severable from the remaining portions of this agreement in that it survives in perpetuity even in the event that any court of law deems this agreement or any portion thereof void or unenforceable.

LICENSEE

2/15/2022
Salvador Ceniceros, MD Date
Licensee

2/15/22
Johnny K. Richardson Date
Attorney for Licensee
Missouri Bar No. 28744

BOARD

2/22/22
James Leggett Date
Executive Director

2/15/22
Adam G. Grayson Date
Associate General Counsel
Missouri Bar No. 61976

EFFECTIVE THIS 22nd DAY OF February, 2022.