

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2023-005

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In the Matter of)
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TZVETAN TZVETANOV, M.D.)
_____)

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges Tzvetan Tzvetanov, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 19-036.

Biographical Information

1. The Respondent graduated from the Charles University Faculty of Medicine in Prague in 1988 and completed an internal medicine residency at Pinnacle Health System Polyclinic Hospital in Harrisburg Pennsylvania from 1995 to 1998. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 204641 since September 13, 2000 and previously in New Hampshire until 2016, Maine until 2012, and Pennsylvania until 1999. The Respondent is board certified in internal medicine.

Factual Allegations

1. From 2000 until 2018 the Respondent maintained an independent private internal medicine practice in North Andover with privileges at Holy Family Hospital in Methuen and Lawrence General Hospital in Lawrence.

2. In approximately 2013 the Respondent transitioned from paper medical records to the Athena electronic health record (EHR) system at the suggestion and with the assistance of Steward Health Care.

3. On or about September 14, 2016 the Office of Medicaid commenced a retrospective utilization and peer review of member services from the Respondent for the period from July 1, 2014 through June 30, 2015.

4. Effective March 2, 2018 the Office of Medicaid suspended the Respondent from participating in MassHealth and terminated his contract pursuant to 130 CMR 450.238 and 130 CMR 450.240 after findings of issues with quality of care and medical record documentation.

Patient A

5. In 2008 the Respondent began treating Patient A, then a fifty-six (56) year old male, for multiple chronic medical problems and persistent chronic pain.

6. From 2013 through 2014 the Respondent breached the standard of care for the management and documentation of Patient A's atrial fibrillation through unexplained high-risk anticoagulants and insufficient thromboembolism prevention.

7. From 2013 through 2014 the Respondent breached the standard of care in the treatment and documentation of Patient A's chronic pain syndrome through serial narcotic and opioid pain medications without cause or explanation.

Patient B

8. In 2000 the Respondent began treating Patient B, then a forty-two (42) year old male, for multiple chronic medical problems, including poorly controlled diabetes and persistent chronic pain.

9. From 2014 through 2015 the Respondent breached the standard of care in the maintenance of Patient B's medication list by neglecting to reconcile major updates in treatment plans with the medication list with high risk cardiac and diabetic conditions.

10. From 2014 through 2015 the Respondent breached the standard of care in the documentation of Patient B's complex pain management through lack of clarification and rationale for evolving narcotic and non-narcotic pain interventions.

11. From 2014 through 2018 the Respondent breached the standard of care in the documentation of Patient B's routine office visits in the electronic health record including failing to clarify chief complaints, detail a history of present illness, and conclude and reflect in the assessment and plan.

12. From 2013 through 2016 the Respondent breached the standard of care in the accurate documentation of Patient B's home glucose readings by repeatedly using templated, inaccurate, and contradictory information.

13. From 2014 through 2016 the Respondent breached the standard of care in the documentation and management of Patient B's poorly controlled diabetes in serial failures to address chronic elevated A1c readings and inconsistent updates to Patient B's medication lists.

14. In 2014 the Respondent breached the standard of care in the management and documentation of Patient B's dyspnea, a life-threatening symptom for patients with chronic medical issues.

15. From 2014 through 2015 the Respondent breached the standard of care in the documentation and evaluation of Patient B's chronic abnormal liver blood tests by year of failing to discuss, conduct medical workup, or deliberate potential etiologies.

16. From 2014 through 2015 the Respondent breached the standard of care in management of Patient B's testosterone replacement therapy by failing to initiate or maintain regular prostate cancer surveillance or communicate and document risks.

Patient C

17. In 2014 the Respondent began treating Patient C, then a fifty-five (55) year old male, for multiple chronic medical problems.

18. Between 2014 and 2016 the Respondent breached the standard of care in the documentation and evaluation of Patient C's hematuria by failing to consider or evaluate the ureters and bladder, refer Patient C to urology, or document any communication with Patient C about the risks and causes of hematuria.

19. Between 2014 and 2016 the Respondent breached the standard of care in the management and documentation of Patient C's obesity by failing to discuss treatment options including referral to nutrition or a formal weight loss program, or bariatric surgery.

20. Between 2015 and 2016 the Respondent breached the standard of care in the management and documentation of Patient C's ongoing reported abdominal pain without documented assessment and planning, and inconsistent and erroneous recording including Patient C, an adult male, "denies possible pregnancy."

21. In 2016 the Respondent breached the standard of care in the evaluation, management, and treatment of Patient C's ongoing full body rash by prescribing an antibiotic without documented justification, failure to consider or make a dermatology referral and document any ongoing assessment and plan as the condition reported to persist for several months.

22. In March 2016 the Respondent breached the standard of care in the documentation and management of Patient C's gout with an insufficient physical examination,

inadequate detail in the record to support the diagnosis, and contraindicated prescriptions in relation to Patient C's chronic renal insufficiency.

23. In March 2016 the Respondent breached the standard of care in the treatment of Patient C's morbid obesity by prescribing phentermine when Patient C's glomerular filtration rate (GFR) was higher than thirty (30) and he had insufficient renal function.

24. In September 2016 the Respondent breached the standard of care in the evaluation, management, and documentation of Patient C's profound hypoxemia, oxygen saturation of 80%, by failing to refer Patient C for emergency care.

25. Between 2014 and 2016 the Respondent breached the standard of care in maintaining an accurate ongoing medication list through inaccuracies and disconnection from the assessments and plans and with documented medical decision making.

26. Between 2014 and 2016 the Respondent breached the standard of care in the documentation of routine office visits by failing to accurately record details, generate appropriate care plan for issues identified in the history of present illnesses, or raise and address present and other issues in the assessment and plan or other parts of the electronic health record.

Patient D

27. In 2003 the Respondent began treating Patient D, then a forty-nine (49) year old male, for multiple chronic medical problems and persistent chronic pain.

28. From 2012 through 2015 the Respondent breached the standard of care in the management and documentation of substantial changes in Patient D's chronic hypertension.

29. From 2014 through 2018 the Respondent breached the standard of care in the evaluation, management, and documentation of Patient D's atrial fibrillation through failure to assess and document risk of thromboembolism and use of anticoagulation therapies.

30. From 2014 through 2018 the Respondent breached the standard of care in the management and documentation of Patient D's poorly controlled diabetes through the failure to consistently and accurately monitor glycemic control, use of inaccurate and templated home glucose readings contradictory to A1c results, and delayed, subtherapeutic, and inappropriate medication selections, and lack of referral to a diabetes specialist.

31. There is no evidence that the health of any of the four patients was adversely affected or otherwise compromised by the aforementioned circumstances.

Legal Basis for Proposed Relief

A. The Respondent engaged in conduct which places into question the Respondent's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions in violation of G.L. c. 112 §5, eighth par. (c) and 243 CMR 1.03(5)(a)(3).

B. The Respondent failed to maintain a medical record for each patient that is complete, timely, legible, and adequate to enable a licensee or any other health care provider to provide proper diagnosis and treatment in violation of 243 CMR 1.03(5)(a)(11), to wit: 243 CMR 2.07(13)(a).

C. The Respondent engaged in conduct that undermines the public confidence in the integrity of the medical profession. *See Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982); *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979).

The Board has jurisdiction over this matter pursuant to G.L. c. 112, §§ 5, 61 and 62. This adjudicatory proceeding will be conducted in accordance with the provisions of G.L. c. 30A and 801 CMR 1.01.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The Board may also order, in addition to or instead of revocation or suspension, one or more of the following: admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training or other restrictions upon the Respondent's practice of medicine.

Order

Wherefore the Respondent is hereby **ORDERED** to show cause why the Board should not discipline him for the conduct described herein.

By the Board of Registration in Medicine,



Julian N. Robinson, M.D.
Board Chair

Date: 1/5/2023