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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Delbert Leondous Beiler, M.D.** **1020 Oswald Road** **Yuba City, CA 95991** **Physician's and Surgeon's Certificate No. A 26354,** Respondent.	Case No. 800-2016-025580 **DEFAULT DECISION AND ORDER**

FINDINGS OF FACT

1. On or about August 27, 2019, Complainant Kimberly Kirchmeyer, in her official capacity as the Executive Director of the Medical Board (Board) of California, Department of Consumer Affairs, filed Accusation No. 800-2016-025580 against Delbert Leondous Beiler, M.D. (Respondent) before the Board. A true and correct copy of the Accusation No. 800-2016-025580 is attached as **Exhibit 1** in the separate accompanying "Default Decision Evidence Packet".[1]

[1] The Exhibits referred to herein, which are true and correct copies of the originals, are contained in the separate accompanying "Default Decision Evidence Packet."

2. On or about October 31, 1974, the Medical Board issued Physician's and Surgeon's Certificate No. A 26354 to Delbert Leondous Beiler, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in the Accusation and expired on August 31, 2017, and has not been renewed. A certified copy of Respondent's Certificate of Licensure is attached as **Exhibit 2** in the separate accompanying Default Decision Evidence Packet.

3. On or about August 27, 2019, an employee of the Complainant Agency served by Certified and First Class Mail a copy of the Accusation No. 800-2016-025580, Statement to Respondent, Request for Discovery, Notice of Defense (two copies), and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 1020 Oswald Road, Yuba City, CA 95991.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

5. On or about October 11, 2019, a courtesy notice of default was sent to Respondent explaining that failure to file a Notice of Defense will result in the entry of a Default Decision against his license without any hearing. On or about October 18, 2019, Deputy Attorney General Jannsen Tan called Respondent to follow up on the Notice of Defense. Respondent stated that he does not contest the default and understands that his medical license will be revoked without a hearing. A true and correct copy of Courtesy Notice of Default and the Declaration of Deputy Attorney General Jannsen Tan is attached as **Exhibit 3** in the separate accompanying Default Decision Evidence Packet.

6. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

7. The Statement to Respondent informed him that he was required to file a Notice of Defense within 15 days after receipt of the Accusation. Respondent has failed to file a Notice of

Defense within 15 days after service upon him of the Accusation, and therefore waived his right to a hearing on the merits of Accusation No. 800-2016-025580. To date, neither Deputy Attorney General Jannsen Tan nor the Board has received a Notice of Defense from Respondent. (Declaration of Supervising Deputy Attorney General Jannsen Tan)

8. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

9. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in Exhibit 1 through 4, finds that the allegations in Accusation No. 800-2016-025580 are true.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Delbert Leondous Beiler, M.D has subjected his Physician's and Surgeon's Certificate No. A 26354 to discipline.

2. Pursuant to its authority under Government Code section 11520, and based on the evidence before it, the Board hereby finds that the charges and allegations in Accusation No. 800-2016-025580, and the Findings of Fact contained in paragraphs 1 through 80 above, and each of them, separately and severally, are true and correct.

3. The Board has jurisdiction to adjudicate this case by default.

4. The Board is authorized to revoke Respondent's Physician's and Surgeon's Certificate Number A 26354 based upon the following violations alleged in the Accusation:

A. Violation of Business and Professions Code Section 2234, subdivision (b) and (c), in that Respondent committed gross negligence and repeated negligent acts in the care and treatment of Patient A when Respondent prescribed large amount of opioids without adequate documentation; Respondent failed to document Patient A's pain level, characteristics, timing, degree of pain, and how it affected Patient A's life; Respondent failed to document for prior

history of substance abuse and failed to document instituting urine screens; Respondent failed to document a plan, work up, or consultation.

B. Violation of Business and Professions Code Section 2234, subdivision (b) and (c), in that Respondent committed gross negligence and repeated negligent acts in the care and treatment of Patient B when Respondent prescribed large amounts of opioids without adequate documentation; Respondent failed to document Patient B's pain level, characteristics, timing, degree of pain, and how it affected Patient B's life; Respondent failed to document prior history of substance abuse, and failed to institute urine screens; Respondent failed to document a plan, work up, or consultation. Respondent also prescribed alprazolam together with oxycodone and hydrocodone and Respondent prescribed a large starting dose for alprazolam.

C. Violation of Business and Professions Code Section 2234, subdivision (b) and (c), in that Respondent committed gross negligence and repeated negligent acts in the care and treatment of Patient C when Respondent prescribed large amount of opioids without adequate documentation, radiological studies, and/or consultation; Respondent failed to document Patient C's pain level, characteristics, timing, degree of pain, and how it affected Patient C's life; Respondent failed to document prior history of substance abuse and failed to institute urine screens. Respondent failed to document a plan, work up, or consultation. Respondent also continued to prescribe high doses of two powerful opioids without addressing that they were not being used as per the prescription. Respondent also prescribed amphetamines without adequate documentation.

D. Violation of Business and Professions Code Section 2234, subdivision (b) and (c), in that Respondent committed gross negligence and repeated negligent acts in the care and treatment of Patient D when Respondent prescribed large amount of opioids without adequate documentation, radiological studies, and/or consultation; Respondent failed to document Patient D's pain level, characteristics, timing, degree of pain, and how it affected Patient D's life; Respondent failed to document prior history of substances abuse and failed to institute urine screens; Respondent failed to document a plan, work up, or consultation. Respondent also prescribed and/or increased two strong opioids without adequate documentation.

E. Violation of Business and Professions Code Section 2234, subdivision (c), in that Respondent committed repeated negligent acts in the care and treatment of Patient C when Respondent failed to document appropriate history and reasons for prescribing high doses of opioids to Patient C and failed to document Patient C's alcohol and drug history.

F. Violation of Business and Professions Code Section 2234, subdivision (c), in that Respondent committed repeated negligent acts in the care and treatment of Patient D when Respondent prescribed amphetamines to Patient D without sufficient documentation; Respondent failed to monitor Patient D's diabetes.

G. Violation of Business and Professions Code Section 2234, subdivision (c), in that Respondent committed repeated negligent acts in the care and treatment of Patient E when Respondent failed to document an appropriate medical indication for the high doses of opioids; Respondent disregarded other provider's diagnoses without explanation.

H. Violation of Business and Professions Code Section 725, in that Respondent excessively prescribed controlled substances and dangerous drugs to Patients A, B, C, D, and E.

I. Violation of Business and Professions Code Section 2242, in that Respondent prescribed controlled substances and dangerous drugs to Patients A, B, C, D, and E.

J. Violation of Business and Professions Code Section 2266, in that Respondent failed to maintain adequate and accurate medical records relating to his care and treatment of Patients A, B, C, D, and E.

K. Violation of Business and Professions Code section 2234 in that Respondent engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.

L. Violation of Business and Professions Code Section 822 in that Respondent's ability to practice medicine safely is impaired because he is mentally or physical ill affecting competency.

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ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. A 26354, heretofore issued to Respondent Delbert Leondous Beiler, M.D., is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on February 12, 2020.

It is so ORDERED January 13, 2020

FOR THE MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DELBERT LEONDOUS BEILER, M.D.** **1020 Oswald Road** **Yuba City, CA 95991** **Physician's and Surgeon's Certificate No. A 26354,** Respondent.	Case No. 800-2016-025580 **ACCUSATION**

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 31, 1974, the Medical Board issued Physician's and Surgeon's Certificate No. A 26354 to Delbert Leondous Beiler, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on August 31, 2017, and has not been renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

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(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d)(1) For purposes of this section and Section 2241.5, addict means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

7. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

8. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

9. Section 118 of the Code states:

> (a) The withdrawal of an application for a license after it has been filed with a board in the department shall not, unless the board has consented in writing to such withdrawal, deprive the board of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground.
>
> (b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.
>
> (c) As used in this section, >board= includes an individual who is authorized by any provision of this code to issue, suspend, or revoke a license, and "license" includes "certificate," "registration," and "permit."

10. Section 820 of the Code states:

> Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licentiate and may be received as direct evidence in proceedings conducted pursuant to Section 822.

11. Section 822 of the Code states:

> If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:
>
> (a) Revoking the licentiate's certificate or license.
>
> (b) Suspending the licentiate's right to practice.
>
> (c) Placing the licentiate on probation.
>
> (d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

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The licensing section shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

PERTINENT DRUG INFORMATION

12. Alprazolam – Generic name for the drug Xanax. Alprazolam is a short-acting benzodiazepine used to treat anxiety, and is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14. Alprazolam is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057(d).

13. Amphetamine Salts – Generic name for the drug Adderall, which is a combination drug containing four salts of the two enantiomers of amphetamine, a Central Nervous System (CNS) stimulant of the phenethylamine class. Adderall is used to treat attention deficit hyperactivity disorder and narcolepsy but can be used recreationally as an aphrodisiac and euphoriant. Adderall is habit forming. Amphetamine Salts are a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12(d) and a dangerous drug pursuant to Business and Professions Code section 4022.

14. Hydrocodone bitartrate with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e). On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163, Code of Federal Regulations Title 21 section 1308.12. Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

15. Morphine Sulfate – Generic name for the drugs Kadian, MS Contin, and MorphaBond ER. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in

opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. MS dissolves readily in water and body fluids, creating an immediate release. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Oxycodone – Generic name for Oxycontin, Roxicodone, and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short acting opioid analgesic used to treat moderate to severe pain. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

17. Carisoprodol – Generic name for Soma, is a centrally acting skeletal muscle relaxant. Effective January 11, 2012, it was reclassified from a non controlled substance to a Federal Schedule IV controlled substance pursuant to Controlled Substances Act. It is a dangerous drug pursuant to Business and Professions Code section 4022.

18. Lorazepam - Generic name for Ativan, is a benzodiazepine drug used to treat anxiety disorders. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

CAUSE FOR REVOCATION
(Mental or Physical Impairment)

19. Respondent's Physician's and Surgeon's Certificate No. 26354 is subject to action under section 822 of the Code in that his ability to practice medicine safely is impaired because he is mentally ill or physically ill affecting competency, as more particularly alleged hereinafter.

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20. On or about March 26, 2019, Health Quality Investigations Unit Investigator Aaron Barnett called Respondent to inform him that a complaint was received by the Board. Respondent told Investigator Barnett that "he had to retire." He stated that he developed congestive heart failure. Respondent added that he cannot walk any distance because of his knees and back. Respondent stated that he gets confused sometimes and does not intend to return to practice. He used to have a sharp memory, but now he forgets things.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

21. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of Patients A, B, C, D, and E[1]. The circumstances are as follows:

22. Respondent is a physician and surgeon who at all times alleged in this Accusation, practiced in Gridley, California.

Patient A

23. During the period of October 10, 2013 to March 11, 2017, Respondent prescribed oxycodone 30 mg at 180 tablets (started June 2016), alprazolam 0.5 mg at 90 tablets (started October 2015), and Norco 325mg/10 mg at 180 tablets (started October 2013 to June 2016).

24. Patient A was at the time a 19-year-old male who first saw Respondent on October 10, 2013. Respondent documented: "Meloxicam was ineffective, wants MS Contin (Morphine). Declined this. Had cold sore." Under the examination portion of his clinic note, Respondent failed to document his examination and scribbled a line across the space in lieu of any particulars. Under the psych portion of his clinic note, Respondent documented "oriented x 3." Respondent's assessment was: "Post-op chronic pain of R leg/ankle," and in the Plan he prescribed gabapentin[2] and Norco 10-325 mg. (opioid plus Tylenol, at higher strength) 1-2 tablets every 4 hours if needed for severe pain, and asks patient to return in 2 weeks." Respondent failed to document

[1] Patient names and information have been removed to protect patient confidentiality. Conduct alleged to have occurred before April 1, 2012, is for informational purposes only.

[2] Gabapentin, brand name Neurontin, among others, is an anticonvulsant medication used to treat partial seizures, neuropathic pain, hot flashes, and restless leg syndrome.

that Patient A had surgery to remove retained hardware from his prior tibial fracture on August 7, 2013 performed by another provider. Respondent failed to take into account that his prescription of Norco was considerably higher than what had been previously dispensed.

25. On or about November 22, 2013, Respondent saw Patient A for a follow-up visit. Patient A at this point had already refilled another 180 tablets of Norco. Respondent documented "leg better with Norco." In the objective section of the note, Respondent documented extremities were checked off and there was one partially legible line which says something about "tender to palpation". In the assessment portion, Respondent documented "R leg pain following Surgery." Respondent wrote the plan was: Norco 10-325 1 tablet 4 times a day prn severe pain. For at least the next few months subsequent to this visit, Patient A was consistently filling about 200 Norco every 3 weeks or so, or almost 10 tablets a day.

26. On or about January 9, 2014, Respondent saw Patient A for a follow-up visit. Respondent's documentation for past history, family history and vital signs are written in by template. During this visit, Respondent documented: "states he is trying to stop smoker (sic). Leg pain same chronical (sic)." Respondent failed to perform and/or document a physical examination and discussion about the level of his pain, functioning, problems with the medication, potential treatment, tests and referrals to deal with the pain.

27. On or about August 22, 2014, Patient A reported that 180 Norco tablets were stolen. Respondent documented 15 minutes of counsel regarding safe storage of medications, and refills.

28. On or about January 26, 2015, Respondent documented that Patient A needed to refill Norco and that "[Patient A] swears on gm (presumably grandmother's) grave that he is not selling Norco." Respondent failed to perform a drug screen. Respondent failed to enter into a pain medication contract with Patient A.

29. On March 19, 2015, Respondent documented that Patient A's medication was stolen, and that a police report was on hand.

30. On or about June 20, 2016, Respondent switched Patient A's Norco prescription to oxycodone 30 mg 3 times daily. Patient A claimed the Norco was causing him nausea and not adequately helping the pain, and Patient A suggested this medication. Respondent also prescribed

Xanax. Respondent's prescriptions for oxycodone continue until January 2017, and for Xanax to March 2017.

31. Respondent also documented back pain referenced as spinal stenosis, which is not sufficiently documented.

32. Respondent committed gross negligence in his care and treatment of Patient A which included, but was not limited to, the following:

A. Respondent prescribed large amount of opioids without adequate documentation. Respondent failed to document Patient A's pain level, characteristics, timing, degree of pain, and how it affected Patient A's life. Respondent failed to document prior history of substance abuse and failed to institute urine screens. Respondent failed to document a plan, work up, or consultation.

Patient B

33. Patient B was a 40-year-old male who first saw Respondent on February 7, 2014. He presented with a chief complaint of "Needs pain medicine." Respondent documented the history of present illness as "old FB right knee. 4 surg on knee." Respondent subsequently documented that Patient B has had 4 previous surgeries to right knee, but Respondent failed to further detail the degree and particularities of the pain. Respondent failed to perform and/or document a physical exam, except the vital signs which are drawn into the note. Respondent documented his assessment as pain in joint and lower leg, hypertension and obesity. Respondent failed to document a plan, and document what he prescribed. Respondent prescribed Norco 325/10 at 180 tablets during this visit, but Respondent failed to document the prescription.

34. On or about March 13, 2014, Respondent saw Patient B for a follow-up visit. Respondent failed to perform and/or document a physical examination. Respondent documented that Patient B was taking Norco, but failed to document the amount prescribed.

35. On or about April 7, 2014, Respondent saw Patient B for a follow-up visit. Respondent documented "increasing pain in the hands and feet in addition to the knee pain." Respondent also documented that Patient B had undergone two surgeries. Respondent failed to perform and/or document a physical examination.

36. The X-ray report dated May 23, 2014 showed moderate degenerative changes, chondrocalcinosis, effusion, and findings of old ligament repair. Respondent injected Patient B's knees with cortisone-like medication on or about May 22, 2014, June 19, 2014, and September 18, 2014.

37. On or about January 30, 2015, Respondent documented in his note that Patient B reported his knee pain to be an 8 out of 10. Patient B also reported that Norco was not effective. Respondent prescribed another narcotic, oxycodone 30mg 1 every 4 hours per his note, 180 tablets. Respondent did not discontinue Norco. Respondent refilled Patient B's Norco until September 29, 2015.

38. On or about January 30, 2015, Respondent documented in his note that he referred Patient B to orthopedic surgery. On or about March 6, 2015, Patient B called Respondent's office stating he had not received any referral.

39. On or about September 29, 2015, Respondent documented that Patient B's knees were hurting. Respondent also documented Chronic Obstructive Pulmonary Disease (COPD), but provided no evidence for it. Respondent also prescribed topiramate[3] to treat COPD.

40. On or about December 22, 2015, Respondent documented a physical examination, but failed to mention findings on Patient B's knees. Respondent documented a referral to orthopedics.

41. On or about January 22, 2016, Respondent failed to document the orthopedic visit. Respondent continued to prescribe topiramate.

42. During the period of November 9, 2011 to January 10, 2017, Respondent prescribed oxycodone 15 mg to 30 mg at 180 tablets (started January 30, 2015), alprazolam 2 mg at 90 tablets (started August 19, 2016), hydrocodone 325/10 mg at 180 tablets;

43. Respondent committed gross negligence in his care and treatment of Patient B which included, but was not limited to, the following:

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[3] Topiramate, brand name, Topamax is used alone or with other medications to prevent and control seizures and migraine headaches.

A. Respondent prescribed large amounts of opioids without adequate documentation. Respondent failed to document Patient B's pain level, characteristics, timing, degree of pain, and how it affected Patient B's life. Respondent failed to document prior history of substance abuse and failed to institute urine screens. Respondent failed to document a plan, work up, or consultation.

B. Respondent prescribed alprazolam together with oxycodone and hydrocodone.

C. Respondent prescribed a large starting dose for alprazolam.

Patient C

44. Patient C was a 32-year-old male who first saw Respondent on or about September 6, 2013. Respondent documented the purpose of the visit as "Re-Establish Care." Respondent documented that Patient C was still working with a tree service, has lumbar disc disease, ADD (Attention Deficit Disorder), and Chronic Pain Syndrome. In the Plan section, Respondent documented Oxycontin 80mg 2 tabs every 8 hours for severe pain, Norco 10/325 1-2 every 4 hours for moderate pain, and Adderall, 20 mg 3 times daily.

45. On or about October 4, 2013, Respondent documented that Patient C reported that 9 days of Oxycontin were missing from his house after a birthday party. Patient C did not have a police report. Respondent prescribed an early refill of 180 tablets of Oxycontin. Respondent did not list any advice, instruction, or consequence regarding the alleged theft and early refill.

46. During the period of October 28, 2011 to December 2, 2016, Respondent prescribed Oxycontin and Norco. Respondent started Oxycontin at 40 mg, but eventually increased it to 80 mg. after April 10, 2012.

47. On or about November 22, 2013, Respondent documented the reason for the Adderall prescription: "Reason for Rx of ADHD is as kid in school couldn't concentrate and as adult a lot of symptoms, with Adderall focus clear and memory improved." Respondent failed to document a psychiatric evaluation.

48. During the period of December 2013 to April 10, 2014, Respondent failed to adequately document details about Patient C's back injury.

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49. On or about April 10, 2014, Respondent documented ""hard working tree climber with back injury and motocross rider as a child, ADHD, Chronic lumbar pain." Respondent failed to detail the back injury.

50. On or about September 26, 2014, Respondent prescribed 180 tablets of Percocet in addition to the regular heavy doses of opioids Patient C was taking. Respondent subsequently discontinued Percocet, and continued prescribing the Norco and Oxycontin as before.

51. On or about November 21, 2014, Respondent documented that Patient C was going to be out of town for work and needed medication before leaving. Patient C presented his prescription to the pharmacist, and the pharmacist noted that the words "OK to fill, working out of town..." was written on the top portion of the prescription. Respondent's office verified that the prescription presented by Patient C was altered. Respondent continued to prescribe the same large amounts of opioids.

52. On or about December 21, 2015, Patient C visited Dr. S, who suggested Patient C decrease his controlled substance medications. Respondent subsequently noted the different lower doses in his next note, but Respondent failed to lower the dose of the opioids he prescribed to Patient C. Respondent noted doses in his plan that do not concur with the higher doses Patient C was refilling.

53. On or about August 5, 2016, Respondent documents upper back pain and pain down the right leg. However, Respondent failed to perform and/or document a physical examination. Respondent failed to document anything different during this visit to address Patient C's complaint, either diagnostically or therapeutically.

54. On September 2, 2016, Respondent documented that Patient C was getting a steroid injection into right hip, but no mention of symptoms or physical findings that would support the medical indication for the injection.

55. On or about November 4, 2016, Respondent documented a pain management referral but failed to document the results or any follow up on the referral.

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56. On or about December 2, 2016, Respondent documented that meds were discussed and reconciled with the patient, a statement which was just part of the electronic template. The medications in Respondent's list were not the dose Respondent prescribed.

57. During the period of October 28, 2011 to December 2, 2016, Respondent prescribed Adderall at 20mg at 90 tablets (started February 13, 2015), hydrocodone 325/10 mg at 240 tablets, Oxycontin 40 mg to 80 mg at 180 tablets, oxycodone 325/10 mg at 180 tablets, amphetamine salt combo 20 mg at 90 tablets (started April 3, 2013).

58. Respondent committed gross negligence in his care and treatment of Patient C which included, but was not limited to, the following:

A. Respondent prescribed large amount of opioids without adequate documentation, radiological studies, and/or consultation. Respondent failed to document Patient C's pain level, characteristics, timing, degree of pain, and how it affected Patient C's life. Respondent failed to document prior history of substance abuse and failed to institute urine screens. Respondent failed to document a plan, work up, or consultation.

B. Respondent continued to prescribe high doses of two powerful opioids without addressing that they were not being used as per the prescription. Patient C filled both simultaneously at maximum dose for years.

C. Respondent prescribed amphetamines without adequate documentation.

Patient D

59. Patient D was a 38-year-old male, who saw Respondent on May 26, 2014. Respondent documented the visit was to establish care, "incomplete medication list, needs refills. Respondent had previously treated Patient D and prescribed hydrocodone, and Adderall to him from October 22, 2011 to May 20, 2013. HPI simply says "Pain, ADHD." Under medical history, Respondent documented DM (Diabetes Mellitus). Respondent documented that Patient D denied past surgical history or past hospitalizations. There was a list of medications which included Adderall XR 30mg 1 daily, Norco 10-325 1 tablet as needed every 6 hours, and alprazolam (Xanax) 1 mg twice daily. Respondent documented that the medication list was reviewed and reconciled with the patient. Respondent failed to document the description of the

pain or intensity, the history of the pain, the length Patient D had been on these meds, or any prior or current history of alcohol, drugs or addiction. Respondent failed to perform and/or document a physical exam other than vital signs. Respondent failed to check CURES[4], check for prior urine drug screens or request for old records. Respondent also failed to document that he had been treating Patient D before, between October 22, 2011 to May 20, 2013. Respondent renewed Patient D's medication and advised him to follow up in 4 weeks.

60. On or about February 18, 2014, Respondent documented that Patient D's physical exam was normal.

61. During the period of May 26, 2014 to January 10, 2017 Respondent intermittently prescribed hydrocodone at 325/5 mg ranging from 56 to 240 tablets, Adderall 30 mg at 30 tablets, alprazolam 1 mg, at 90 tablets, oxycodone 30 mg at 180 tablets, and mixed amphetamine salts 30 mg, at 30 tablets to Patient D.

62. On or about January 17, 2015, Respondent begins prescribing oxycodone 15mg, a little over 8 tablets a day, in addition to, Patient D's hydrocodone prescription. Respondent failed to document any worsening of Patient D's pain symptoms, and failed to document the prescription for oxycodone. Respondent lists syringomyelia as a diagnosis without any substantiation.

63. On or about February 19, 2015, Respondent documented that Patient D was on oxycodone, but again failed to document the reason for the increase in opioid therapy. In this note, spinal stenosis (which would be very rare in a man this age) and migraine are mentioned, but Respondent failed to substantiate any medical indication as to why the opioid medication had been greatly increased.

64. On or about April 17, 2015, Respondent documented a one page pain management contract in the chart. It is only signed by Patient D. The pain management contract covered

[4] Controlled Substance Utilization Review and Evaluation System (CURES), maintained by the Department of Justice (DOJ), is a platform that tracks all Schedule II – IV controlled substances dispensed to patients in California. Authorized prescribers, pharmacists, law enforcement, and regulatory agencies can view information in CURES.

Adderall, Norco and oxycodone. Drug screens are mentioned in the Agreement, but Respondent failed to order any drug screens.

65. Respondent subsequently increased the oxycodone to 30 mg, in addition to the large doses of hydrocodone and amphetamines without explanation.

66. On or about December 15, 2015, Respondent saw Patient D for an office visit. Respondent documented Patient D's complaint as chronic back pain. Respondent documented an exam showing some back tenderness.

67. On or about January 8, 2016, Patient D saw another provider, Dr. W., as Respondent was out. In his note, Dr. W. stated that Patient D was not able to go to physical therapy because he was not able to afford it. In the diagnoses he documented chronic pain due to trauma. He stated that "narcotics use counseling done, he was advised of the need to go to a detox program." Respondent, in the next visits, made no mention of the findings of Dr. W.

68. On or about May 24, 2016, Respondent ordered labs for Patient D's diabetes. Respondent documented diabetes Type 1 and then changed it to Type 2 within the same note. Respondent failed to discuss the results of the lab result in the subsequent notes. Respondent failed to document Patient D's actual sugar measurements.

69. During the period of June 2016 to December 30, 2016, Respondent's documentation was similar to each other, with no new findings.

70. Respondent committed gross negligence in his care and treatment of Patient D which included, but was not limited to, the following:

A. Respondent prescribed large amount of opioids without adequate documentation, radiological studies, and/or consultation. Respondent failed to document Patient D's pain level, characteristics, timing, degree of pain, and how it affected Patient D's life. Respondent failed to document prior history of substance abuse and failed to institute urine screens. Respondent failed to document a plan, work up, or consultation.

B. Respondent prescribed and/or increased two strong opioids without adequate documentation.

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SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

71. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patients A, B, C, D, and E, as more particularly alleged hereinafter. Paragraphs 19 through 70, above, are hereby incorporated by reference and realleged as if fully set forth herein.

Patient C

72. Respondent failed to adequately document appropriate history and reasons for prescribing high doses of opioids to Patient C and failed to document Patient C's alcohol and drug history.

Patient D

73. Respondent prescribed amphetamines to Patient D without sufficient documentation. Respondent also failed to monitor Patient D's diabetes.

Patient E

74. Patient E was a 42-year-old male who has already been on large doses of opioids prior to seeing Respondent. Respondent saw Patient E on or about January 8, 2014 for a clinic visit. Respondent documented that Patient E has chronic lumbar pain with stenosis, and is taking Oxycontin 80mg once every 12 hours (2 per day), Norco 10-325 1 tablet as needed every 6 hours (4 per day), and lorazepam (Ativan-sedative) 2mg at bedtime. However, Respondent's records were incorrect. At the time of the visit, Patient E's medication was Oxycontin 80mg 9 per day, Norco 6 per day, and Soma 350 mg 3 per day. Respondent failed to adequately document Patient E's pain, his past history of treatment, and/or substance abuse history, if any. Respondent also failed to document the presence of a recognized medical condition for the continued use of the controlled substances.

75. On or about February 21, 2014, Respondent corrected his record to reflect Oxycontin 1-3 every 8 hours.

76. During the period of October 25, 2011 to February 17, 2017, Respondent prescribed lorazepam 2 mg at 90 tablets, Oxycontin 40 mg at 270 - 540 tablets (later increased to 80 mg),

Hydrocodone 325/10 mg at 186 tablets, and alprazolam 1 mg, at 90 tablets (added September 2014). During this period, Respondent failed to document an appropriate medical indication for the high doses of opioids. Respondent disregarded other provider's diagnoses without explanation.

THIRD CAUSE FOR DISCIPLINE
(Excessive Prescribing)

77. Respondent is further subject to disciplinary action under sections 2227, 2234 and 725, in that he has excessively prescribed controlled substances and dangerous drugs to Patients A, B, C, D, and E, as more particularly alleged hereinafter. Paragraphs 19 through 76, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE
(Prescribing Controlled Substances Without Appropriate Examination or Medical Indication)

78. Respondent is further subject to disciplinary action under sections 2227, 2234 and 2242, in that he has prescribed controlled substances and dangerous drugs to Patients A, B, C, D, and E, as more particularly alleged hereinafter. Paragraphs 19 through 76, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)

79.. Respondent's license is subject to disciplinary action under section 2266, of the Code, in that he failed to maintain adequate and accurate medical records relating to his care and treatment of Patients A, B, C, D, and E, as more particularly alleged hereinafter. Paragraphs 19 through 76, are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

80.. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as

more particularly alleged in paragraphs 19 through 76, above, which are hereby realleged and incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 26354, issued to Delbert Leondous Beiler, M.D.;

2. Revoking, suspending or denying approval of Delbert Leondous Beiler, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Delbert Leondous Beiler, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: August 27, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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