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8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12
13 In the Matter of the Accusation Against:

Case No. 800-2016-025580

14 **Delbert Leondous Beiler, M.D.**
15 **1020 Oswald Road**
Yuba City, CA 95991

DEFAULT DECISION AND ORDER

16 **Physician's and Surgeon's Certificate**
17 **No. A 26354,**

18 Respondent.

19
20 **FINDINGS OF FACT**

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

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28 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."

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

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

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

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

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

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

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

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

4 (Declaration of Supervising Deputy Attorney General Jannsen Tan)

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

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

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

13 DETERMINATION OF ISSUES

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

16 2. Pursuant to its authority under Government Code section 11520, and based on the
17 evidence before it, the Board hereby finds that the charges and allegations in Accusation No. 800-
18 2016-025580, and the Findings of Fact contained in paragraphs 1 through 80 above, and each of
19 them, separately and severally, are true and correct.

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

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

23 A. Violation of Business and Professions Code Section 2234, subdivision (b) and
24 (c), in that Respondent committed gross negligence and repeated negligent acts in the care and
25 treatment of Patient A when Respondent prescribed large amount of opioids without adequate
26 documentation; Respondent failed to document Patient A's pain level, characteristics, timing,
27 degree of pain, and how it affected Patient A's life; Respondent failed to document for prior
28

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

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

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

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

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

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

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

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

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

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

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

24 L. Violation of Business and Professions Code Section 822 in that Respondent's
25 ability to practice medicine safely is impaired because he is mentally or physical ill affecting
26 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

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Aug 27 20 19
BY D. Richards ANALYST

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14 **DELBERT LEONDOUS BEILER, M.D.**
1020 Oswald Road
Yuba City, CA 95991
15
16 **Physician's and Surgeon's Certificate**
No. A 26354,
17
18 **Respondent.**

Case No. 800-2016-025580

ACCUSATION

19 **PARTIES**

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

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

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1 **JURISDICTION**

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

5 4. Section 2227 of the Code states:

6 (a) A licensee whose matter has been heard by an administrative law judge of
7 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
8 Code, or whose default has been entered, and who is found guilty, or who has entered
9 into a stipulation for disciplinary action with the board, may, in accordance with the
10 provisions of this chapter:

11 (1) Have his or her license revoked upon order of the board.

12 (2) Have his or her right to practice suspended for a period not to exceed one
13 year upon order of the board.

14 (3) Be placed on probation and be required to pay the costs of probation
15 monitoring upon order of the board.

16 (4) Be publicly reprimanded by the board. The public reprimand may include a
17 requirement that the licensee complete relevant educational courses approved by the
18 board.

19 (5) Have any other action taken in relation to discipline as part of an order of
20 probation, as the board or an administrative law judge may deem proper.

21 (b) Any matter heard pursuant to subdivision (a), except for warning letters,
22 medical review or advisory conferences, professional competency examinations,
23 continuing education activities, and cost reimbursement associated therewith that are
24 agreed to with the board and successfully completed by the licensee, or other matters
25 made confidential or privileged by existing law, is deemed public, and shall be made
26 available to the public by the board pursuant to Section 803.1.

27 **STATUTORY PROVISIONS**

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

3 (2) When the standard of care requires a change in the diagnosis, act, or
4 omission that constitutes the negligent act described in paragraph (1), including, but
5 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.

6 (d) Incompetence.

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

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

11 (g) The practice of medicine from this state into another state or country
12 without meeting the legal requirements of that state or country for the practice of
13 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.

14 (h) The repeated failure by a certificate holder, in the absence of good cause, to
15 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.

16 6. Section 2241 of the Code states:

17 (a) A physician and surgeon may prescribe, dispense, or administer prescription
18 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.

19 (b) A physician and surgeon may prescribe, dispense, or administer prescription
20 drugs or prescription controlled substances to an addict for purposes of maintenance
21 on, or detoxification from, prescription drugs or controlled substances only as set
22 forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and
23 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.

24 (c) Notwithstanding subdivision (a), prescription drugs or controlled substances
25 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:

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

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

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

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

8 (A) Impaired control over drug use.

9 (B) Compulsive use.

10 (C) Continued use despite harm.

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

14 7. Section 2242 of the Code states:

15 (a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section
16 4022 without an appropriate prior examination and a medical indication, constitutes
17 unprofessional conduct.

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

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

26 (2) The licensee transmitted the order for the drugs to a registered nurse or to a
27 licensed vocational nurse in an inpatient facility, and if both of the following
28 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.

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

7 16. Oxycodone – Generic name for Oxycontin, Roxicodone, and Oxecta. Oxycodone has
8 a high risk for addiction and dependence. It can cause respiratory distress and death when taken
9 in high doses or when combined with other substances, especially alcohol. Oxycodone is a short
10 acting opioid analgesic used to treat moderate to severe pain. Oxycodone is a Schedule II
11 controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12.

12 Oxycodone is a dangerous drug pursuant to California Business and Professions Code section
13 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code
14 section 11055(b).

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

19 18. Lorazepam - Generic name for Ativan, is a benzodiazepine drug used to treat anxiety
20 disorders. It is a Schedule IV controlled substance pursuant to Health and Safety Code section
21 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section
22 4022.

23 **CAUSE FOR REVOCATION**
24 **(Mental or Physical Impairment)**

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

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1 that Patient A had surgery to remove retained hardware from his prior tibial fracture on August 7,
2 2013 performed by another provider. Respondent failed to take into account that his prescription
3 of Norco was considerably higher than what had been previously dispensed.

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

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

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

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

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

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

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

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

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

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

12 **Patient B**

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

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

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

1 36. The X-ray report dated May 23, 2014 showed moderate degenerative changes,
2 chondrocalcinosis, effusion, and findings of old ligament repair. Respondent injected Patient B's
3 knees with cortisone-like medication on or about May 22, 2014, June 19, 2014, and September
4 18, 2014.

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

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

13 39. On or about September 29, 2015, Respondent documented that Patient B's knees
14 were hurting. Respondent also documented Chronic Obstructive Pulmonary Disease (COPD), but
15 provided no evidence for it. Respondent also prescribed topiramate³ to treat COPD.

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

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

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

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

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

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

6 B. Respondent prescribed alprazolam together with oxycodone and hydrocodone.

7 C. Respondent prescribed a large starting dose for alprazolam.

8 **Patient C**

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

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

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

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

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

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

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

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

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

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

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

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

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28 ///

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

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

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

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

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

18 C. Respondent prescribed amphetamines without adequate documentation.

19 **Patient D**

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

1 pain or intensity, the history of the pain, the length Patient D had been on these meds, or any prior
2 or current history of alcohol, drugs or addiction. Respondent failed to perform and/or document a
3 physical exam other than vital signs. Respondent failed to check CURES⁴, check for prior urine
4 drug screens or request for old records. Respondent also failed to document that he had been
5 treating Patient D before, between October 22, 2011 to May 20, 2013. Respondent renewed
6 Patient D's medication and advised him to follow up in 4 weeks.

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

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

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

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

23 64. On or about April 17, 2015, Respondent documented a one page pain management
24 contract in the chart. It is only signed by Patient D. The pain management contract covered
25

26
27 ⁴ Controlled Substance Utilization Review and Evaluation System (CURES), maintained
28 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.

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

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

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

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

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

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

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

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

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

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SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

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2
3 71. Respondent's license is subject to disciplinary action under section 2234, subdivision
4 (c), of the Code, in that he committed repeated negligent acts during the care and treatment of
5 Patients A, B, C, D, and E, as more particularly alleged hereinafter. Paragraphs 19 through 70,
6 above, are hereby incorporated by reference and realleged as if fully set forth herein.

7 **Patient C**

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

11 **Patient D**

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

14 **Patient E**

15 74. Patient E was a 42-year-old male who has already been on large doses of opioids
16 prior to seeing Respondent. Respondent saw Patient E on or about January 8, 2014 for a clinic
17 visit. Respondent documented that Patient E has chronic lumbar pain with stenosis, and is taking
18 Oxycontin 80mg once every 12 hours (2 per day), Norco 10-325 1 tablet as needed every 6 hours
19 (4 per day), and lorazepam (Ativan-sedative) 2mg at bedtime. However, Respondent's records
20 were incorrect. At the time of the visit, Patient E's medication was Oxycontin 80mg 9 per day,
21 Norco 6 per day, and Soma 350 mg 3 per day. Respondent failed to adequately document Patient
22 E's pain, his past history of treatment, and/or substance abuse history, if any. Respondent also
23 failed to document the presence of a recognized medical condition for the continued use of the
24 controlled substances.

25 75. On or about February 21, 2014, Respondent corrected his record to reflect Oxycontin
26 1-3 every 8 hours.

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

1 Hydrocodone 325/10 mg at 186 tablets, and alprazolam 1 mg, at 90 tablets (added September
2 2014). During this period, Respondent failed to document an appropriate medical indication for
3 the high doses of opioids. Respondent disregarded other provider's diagnoses without
4 explanation.

5 **THIRD CAUSE FOR DISCIPLINE**
6 **(Excessive Prescribing)**

7 77. Respondent is further subject to disciplinary action under sections 2227, 2234 and
8 725, in that he has excessively prescribed controlled substances and dangerous drugs to Patients
9 A, B, C, D, and E, as more particularly alleged hereinafter. Paragraphs 19 through 76, are hereby
10 incorporated by reference and realleged as if fully set forth herein.

11 **FOURTH CAUSE FOR DISCIPLINE**
12 **(Prescribing Controlled Substances Without Appropriate Examination or Medical**
13 **Indication)**

14 78. Respondent is further subject to disciplinary action under sections 2227, 2234 and
15 2242, in that he has prescribed controlled substances and dangerous drugs to Patients A, B, C, D,
16 and E, as more particularly alleged hereinafter. Paragraphs 19 through 76, above, are hereby
17 incorporated by reference and realleged as if fully set forth herein.

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

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

24 **SIXTH CAUSE FOR DISCIPLINE**
25 **(General Unprofessional Conduct)**

26 80.. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
27 defined by section 2234, of the Code, in that he has engaged in conduct which breaches the rules
28 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

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

3 **PRAYER**

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


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

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

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

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

13
14 DATED: August 27, 2019


15 KIMBERLY KIRCHMEYER
16 Executive Director
17 Medical Board of California
18 Department of Consumer Affairs
19 State of California
20 *Complainant*

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