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

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| In the Matter of the First Amended Accusation Against:<br><br>**ARIEL ALEXANDER CORTES, M.D.,**<br>**7805 Highland Village Place G103**<br>**San Diego, CA 92129,**<br><br>**Physician's and Surgeon's Certificate No. A 63637,**<br><br>Respondent. | Case No. 8002016026128<br><br>**DEFAULT DECISION AND ORDER**<br><br>[Gov. Code, §11520] |

## FINDINGS OF FACT

1. On or about September 12, 2019, Kimberly Kirchmeyer, in her official capacity as, at the time, Executive Director of the Medical Board of California, Department of Consumer Affairs, filed Accusation No. 8002016026128 against Ariel Alexander Cortes, M.D. (Respondent) before the Medical Board of California (Board).

2. On or about December 6, 2019, Christine J. Lally (Complainant), in her official capacity as Interim Executive Director of the Board, filed a First Amended Accusation No. 8002016026128 against Respondent before the Board.

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3. On or about October 10, 1997, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 63637 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2021, unless renewed. A Certificate of Licensure for Respondent, including his address of record with the Board, is included in the accompanying *Evidence Packet in Support of Default Decision and Order* (*Evidence Packet*) as Exhibit (Exh.) A, which is hereby incorporated by reference.

4. On or about September 12, 2019, an employee of the Board, served by certified mail a copy of Accusation No. 8002016026128, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 7805 Highland Village Place, G103, San Diego, CA 92129. The Accusation, related documents, and Declaration of Service are included in the accompanying *Evidence Packet* as Exh. B, which is hereby incorporated by reference.

5. On or about October 21, 2019, the Accusation, related documents, and Declaration of Service were returned by the U.S. Postal Service (USPS) marked "RETURN TO SENDER"; "ATTEMPTED – NOT KNOWN"; and "UNABLE TO FORWARD." The returned envelope and enclosed documents are included in the accompanying *Evidence Packet* as Exh. C, which is hereby incorporated by reference.

6. On or about October 1, 2019, Complainant served an Accusation Courtesy Notice of Default on Respondent via first-class and certified mail at his address of record with the Board, and another address believed to have been associated at one time with Respondent (the Alternate Address). The Accusation Courtesy Notice of Default included copies of the Accusation, related documents, and Declaration of Service described in Finding of Fact 4, above. The Accusation Courtesy Notice of Default and its Declaration of Service are included in the accompanying *Evidence Packet* as Exh. D, and are hereby incorporated by reference.

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7. On or about October 4, 2019, the copy of the Accusation Courtesy Notice of Default that Complainant served on Respondent via certified mail at his address of record with the Board was delivered by the USPS. (See Declaration of Deputy Attorney General Giovanni F. Mejia [DAG Mejia Decl.], ¶ 5, which is included in the *Evidence Packet* attached hereto as Exh. E.)

8. On or about October 28, 2019, the copy of the Accusation Courtesy Notice of Default that Complainant served on Respondent via certified mail to the Alternate Address was returned to Complainant marked "RETURN TO SENDER"; "UNCLAIMED"; and "UNABLE TO FORWARD." The returned Accusation Courtesy Notice of Default and Envelope are included in the *Evidence Packet* as Exh. F, which is hereby incorporated by reference.

9. On or about December 6, 2019, Complainant served on Respondent by certified mail a copy of First Amended Accusation No. 8002016026128, Supplemental Statement to Respondent, Request for Discovery, Notice of Defense and Government Code sections 11507.5, 11507.6, and 11507.7 to the Alternate Address and 7805 Highland Village Place, San Diego, CA 92129 (7805 Highland).[1] The First Amended Accusation, related documents, and Declaration of Service are included in the accompanying *Evidence Packet* as Exh. G, which is hereby incorporated by reference.

10. On or about December 13, 2019, the Board received a certified mail return receipt for the copy of the First Amended Accusation, related documents, and Declaration of Service served on Respondent at 7805 Highland, signed by an unknown person, acknowledging receipt of the documents. The certified mail return receipt is included in the accompanying *Evidence Packet* as Exh. H, which is incorporated herein by reference.

11. On or about December 23, 2019, the copy of the First Amended Accusation, related documents, and Declaration of Service that Complainant attempted to serve on Respondent at the Alternate Address was returned to the Board. (See Exh. E, DAG Mejia Decl., ¶¶ 6-7.)

12. On or about January 2, 2020, Complainant served a First Amended Accusation Courtesy Notice of Default on Respondent via first-class and certified mail at his address of record with the Board and the Alternate Address. The First Amended Accusation Courtesy Notice

[1] I.e., Respondent's address of record without the "G103" unit or room identifier.

of Default included copies of the First Amended Accusation, related documents and Declaration of Service described in Finding of Fact 9, above. The First Amended Accusation Courtesy Notice of Default and Declaration of Service are included in the accompanying *Evidence Packet* as Exh. I, which is hereby incorporated by reference.

13. On or about January 9, 2020, Complainant received a certified mail return receipt for the copy of the First Amended Accusation Courtesy Notice of Default served on Respondent by certified mail at his address of record with the Board, signed by what appears to be "Sher Henry," an unknown person, acknowledging receipt of the documents. The certified mail return receipt is included in the accompanying *Evidence Packet* as Exh. J, which is hereby incorporated by reference.

14. As of April 17, 2020, the USPS had not successfully delivered the copy of the First Amended Accusation Courtesy Notice of Default Complainant attempted to serve on Respondent at the Alternate Address. (See Exh. E, DAG Mejia Decl., ¶ 8.)

15. Service of the Accusation and the First Amended Accusation was effective as a matter of law under the provisions of Government Code sections 11505, subdivision (c), and 11507.

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

> (a) Within 15 days after service of the accusation...the respondent may file with the agency a notice of defense...
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> ...
>
> (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.

17. Respondent failed to file a Notice of Defense within 15 days after service upon him of the Accusation or the First Amended Accusation, and therefore waived his right to a hearing on the merits of Accusation and First Amended Accusation No. 8002016026128. (See Exh. E, DAG Mejia Decl., ¶ 4.)

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18. To date, Respondent has failed to file *any* Notice of Defense to the Accusation or the First Amended Accusation. (See Exh. E, DAG Mejia Decl., ¶ 4.)

19. 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.

20. 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 Exhibits A through L in the accompanying *Evidence Packet*, finds that the charges and allegations in First Amended Accusation No. 8002016026128, and each of them, separately and severally, are true and correct.

21. Section 2227, subdivision (a) of the Business and Professions Code[2] states:

> 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:
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> (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.
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> (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.

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[2] Unless noted otherwise, all code references hereinafter refer to the Business and Professions Code.

22. Section 2234 of the Code states, in pertinent part:

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.

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23. Section 2242, subdivision (a) of the Code states:

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

24. Section 725, subdivision (a) of the Code states:

Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

25. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

26. 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.

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

27. Respondent has subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, subdivision (b) of the Code in that he committed gross negligence, as more particularly described hereinafter:

***Patient A***[3]

28. On multiple occasions in or around February 2013 to July 2017, Respondent rendered medical care and treatment to Patient A, whose medical history includes, but is not limited to, chronic low back pain, obesity, anxiety, high cholesterol, and hip pain. (Declaration of Kristin S. Peña, M.D. [Dr. Peña Decl.], ¶ 8, included the *Evidence Packet* attached hereto as Exh. K.)

29. In or around February 2013 to July 2017, Respondent prescribed high doses of opioid or opiate medications to Patient A for lower back pain including, but not limited to, oxycodone[4] or tramadol.[5] During all or most of this period, Respondent's per-day prescribing of opiate medications to Patient A consisted of at least 225 morphine milligram equivalents (MME). (Exh. K, Dr. Peña Decl., ¶ 9.)

30. In the period in or around February 2013 to July 2017 during which Respondent prescribed high doses of opioids or opiates to Patient A, Respondent failed to adequately establish or document an underlying disease process or diagnosis for Patient A's purported back pain. (Exh. K, Dr. Peña Decl., ¶ 10.)

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[3] Patient's identities were withheld from Accusation No. 8002016026128 and the instant Default Decision and Order to preserve patient confidentiality.

[4] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Tramadol is a Schedule IV controlled substance pursuant to Code of Federal Regulations, title 21, section 1308.14, subdivision (b), paragraph (3), and is a dangerous drug as defined by Business and Professions Code section 4022.

31. In the period in or around February 2013 to July 2017 during which Respondent prescribed high doses of opioids or opiates to Patient A, Respondent failed to adequately consider treatment alternatives including, but not limited to, referral to an orthopedic surgeon or neurosurgeon, injections, physical therapy, or non-opiate pain medications. (Exh. K, Dr. Peña Decl., ¶ 11.)

32. In the period in or around February 2013 to July 2017 during which Respondent prescribed high doses of opioids or opiates to Patient A, Respondent failed to adequately assess, reevaluate or document Patient A's pain levels, pain locations, associated symptoms, provoking or palliating factors, medication side effects, or ability to function. (Exh. K, Dr. Peña Decl., ¶ 12.)

33. In the period in or around February 2013 to July 2017 during which Respondent prescribed high doses of opioids or opiates to Patient A, Respondent failed to adequately screen or otherwise evaluate Patient A for any symptoms of opioid use disorder. (Exh. K, Dr. Peña Decl., ¶ 13.)

34. In or around January 2014 to June 2017, Respondent prescribed high doses of alprazolam[6] (Xanax), a benzodiazepine, to Patient A for anxiety. For all or most of this period, Respondent prescribed approximately 4 mg per day of alprazolam to Patient A. (Exh. K, Dr. Peña Decl., ¶ 14.)

35. In the period in or around January 2014 to July 2017 during which Respondent prescribed high doses of alprazolam to Patient A, Respondent failed to adequately counsel, or document counseling, Patient A regarding the risks of high-dose, long-term benzodiazepine use, or benzodiazepine use in combination with opioids or opiates. (Exh. K, Dr. Peña Decl., ¶ 15.)

36. In the period in or around February 2013 to July 2017 during which Respondent prescribed controlled substances to Patient A, Respondent ordered and reviewed only one toxicology drug screen for Patient A in or around July 2017. The toxicology drug screen yielded a positive result for methamphetamines. (Exh. K, Dr. Peña Decl., ¶ 16.)

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[6] Alprazolam 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.

37. In the period in or around February 2013 to July 2017 during which Respondent prescribed controlled substances to Patient A, Respondent reviewed or documented reviewing the CURES database for controlled substance prescriptions filled by Patient A on only one occasion in or around June 2017. (Exh. K, Dr. Peña Decl., ¶ 17.)

38. In the period in or around February 2013 to May 2017 during which Respondent prescribed controlled substances to Patient A including, but not limited to, opioids, opiates or benzodiazepines, Respondent failed to adequately counsel or document counseling Patient A regarding the risks of chronic opioids or opiates, the risk of concomitant benzodiazepine and opioid or opiate use, or the risk of addiction with such medications. (Exh. K, Dr. Peña Decl., ¶ 18.)

39. In or around February 2013 to July 2017, Respondent committed gross negligence in his care and treatment of Patient A including, but not limited to:

(a) Failing to adequately monitor Patient A's controlled substance medications.

(b) Improperly prescribing high doses of controlled-substance opioids or opiates to Patient A.

(See Exh. K, Dr. Peña Decl., ¶ 19.)

***Patient B***

40. On or about March 23, 2015, Patient B presented to Respondent for medical care and treatment with a history of ailments including, but not limited to, anxiety, depression, and heroin[7] dependence or addiction. (Exh. K, Dr. Peña Decl., ¶ 21.)

41. In his treatment note for the appointment with Patient B on or about March 23, 2015, Respondent documented that Patient B had used heroin that day and had last taken methadone in January 2015. (Exh. K, Dr. Peña Decl., ¶ 22.)

42. On or about March 23, 2015, and on multiple occasions thereafter through as late as in or around April 2017, Respondent issued a high-dose methadone prescription to Patient B of

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[7] Heroin is a Schedule I controlled substance pursuant to Health and Safety Code section 11054, subdivision (c).

approximately 80 mg per day, equivalent to approximately 960 MME, to treat Patient B's heroin dependence or addiction. (Exh. K, Dr. Peña Decl., ¶ 23.)

43. At all times relevant to Respondent's prescribing of methadone to Patient B for heroin dependence or addiction in or around March 2015 to April 2017, Respondent was not duly registered with the U.S. Drug Enforcement Agency (DEA) or the California Department of Health Care Services (DHCS) to prescribe methadone as a part of a narcotic treatment program. (See U.S. Department of Justice, Drug Enforcement Administration, Certification of Registration History, included in the *Evidence Packet* attached hereto as Exh. L; see also Exh. K, Dr. Peña Decl., ¶ 24.)

44. At all times relevant Respondent's care and treatment of Patient B in or around March 2015 to April 2017, methadone was a Schedule II controlled substance pursuant to section 812 of the federal Controlled Substances Act (21 U.S.C., §§ 801 et seq.) and Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

45. Prior to prescribing methadone to Patient B, Respondent failed to order or review a toxicology drug screen for Patient B, or obtain or document an adequate history of Patient B's frequency and duration of heroin use. (Exh. K, Dr. Peña Decl., ¶ 25.)

46. During the course of Respondent's prescribing of methadone to Patient B in or around March 2015 to April 2017, Respondent failed to adequately offer treatment alternatives to Patient B including, but not limited to, buprenorphine[8] or Vivitrol,[9] or referral to other healthcare providers for the prescribing of such drugs. (Exh. K, Dr. Peña Decl., ¶ 26.)

47. On multiple occasions during the course of Respondent's care and treatment of Patient B for heroin dependence or addiction in or around March 2015 to April 2017, Respondent

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[8] Buprenorphine is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Vivitrol is a brand name for naltrexone, a medication primarily used to manage alcohol or opioid dependence and a dangerous drug pursuant to Business and Professions Code section 4022.

prescribed controlled substances other than methadone to Patient B including, but not limited to, Adderall[10] and multiple benzodiazepines. (Exh. K, Dr. Peña Decl., ¶ 27.)

48. On multiple occasions in or around March 2015 to January 2016, Respondent concurrently prescribed methadone and citalopram, a non-controlled medication, to Patient B for anxiety. (Exh. K, Dr. Peña Decl., ¶ 28.)

49. During the course of Respondent's concurrent prescribing of methadone and citalopram to Patient B in or around March 2015 to January 2016, Respondent failed to adequately counsel, or document counseling, Patient B regarding the risks of taking high doses of methadone concurrently with citalopram. (Exh. K, Dr. Peña Decl., ¶ 29.)

50. In or around March 2015 to April 2017, Respondent prescribed a high dose, approximately 8 mg per day, of benzodiazepines including, but not limited to, clonazepam,[11] lorazepam,[12] or alprazolam, to Patient B for anxiety or depression. (Exh. K, Dr. Peña Decl., ¶ 30.)

51. During the course of Respondent's prescribing of benzodiazepines to Patient B in or around March 2015 to April 2017, Respondent failed to adequately assess or document Patient B's anxiety symptoms or incidences of panic attacks. (Exh. K, Dr. Peña Decl., ¶ 31.)

52. During the course of Respondent's prescribing of benzodiazepines to Patient B in or around March 2015 to April 2017, Respondent failed to adequately counsel, or document counseling, Patient B regarding the risks of benzodiazepine medications. (Exh. K, Dr. Peña Decl., ¶ 32.)

53. During the course of Respondent's prescribing of benzodiazepines to Patient B in or around March 2015 to April 2017, Respondent failed to attempt to reduce Patient B's benzodiazepine doses during periods in which he also prescribed other non-benzodiazepine

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[10] Adderall is a brand name for dextroamphetamine/amphetamine or mixed amphetamine salts, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a stimulant medication commonly used to treat Attention Deficit Disorder.

[11] Clonazepam, also known as Klonopin or Clonopin, 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. It is an anti-anxiety medication in the benzodiazepine family.

[12] Lorazepam, also known as Ativan, 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.

medications to Patient B for anxiety or depression including, but not limited to, citalopram or gabapentin. (Exh. K, Dr. Peña Decl., ¶ 33.)

54. On or about November 11, 2016, and on multiple occasions thereafter through as late as in or around April 2017, Respondent prescribed Adderall to Patient B for depression. On multiple such occasions, Respondent also concurrently prescribed methadone or a benzodiazepine to Patient B. (Exh. K, Dr. Peña Decl., ¶ 34.)

55. During the course of Respondent's prescribing of Adderall to Patient B in or around November 2016 to April 2017, Respondent failed to adequately counsel, or document counseling, Patient B regarding the risks of taking high doses of methadone concurrently with Adderall. (Exh. K, Dr. Peña Decl., ¶ 35.)

56. During the course of Respondent's prescribing of Adderall to Patient B in or around November 2016 to April 2017, Respondent failed to adequately assess Patient B's response to Adderall therapy, or Patient B's symptoms of depression and their severity. (Exh. K, Dr. Peña Decl., ¶ 36.)

57. During the course of Respondent's prescribing of Adderall to Patient B in or around November 2016 to April 2017, Respondent failed to adequately consider treatment alternatives safer than Adderall for depression including, but not limited to, serotonin norepinephrine reuptake inhibitors ("SNRIs"), selective serotonin reuptake inhibitors ("SSRIs"), bupropion, Cytomel or Abilify. (Exh. K, Dr. Peña Decl., ¶ 37.)

58. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent only reviewed, or documented reviewing, one CURES report, on or about July 30, 2016, for controlled substance prescriptions filled by Patient B. (Exh. K, Dr. Peña Decl., ¶ 38.)

59. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent failed to order and review any toxicology drug screens for Patient B. (Exh. K, Dr. Peña Decl., ¶ 39.)

60. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent failed to refer or offer to refer Patient B to a psychiatrist,

Narcotics Anonymous, a narcotic treatment program, or another appropriate mental health or addiction treatment provider. (Exh. K, Dr. Peña Decl., ¶ 40.)

61. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent failed to order or review any electrocardiograms (ECGs) for Patient B. (Exh. K, Dr. Peña Decl., ¶ 41.)

62. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent failed to adequately counsel, or document counseling, Patient B regarding the risks of chronic opiates or opioids, benzodiazepines, concomitant use of methadone and citalopram or Adderall, concomitant use of methadone with benzodiazepines or alcohol, or use of controlled substances by a patient with a history of drug dependence or addiction. (Exh. K, Dr. Peña Decl., ¶ 42.)

63. Respondent committed gross negligence in his care and treatment of Patient B including, but not limited to:

(a) Prescribing methadone to Patient B as treatment for heroin dependence or addiction without holding one or more required state or federal registrations.

(b) Improper dosing of methadone for heroin dependence or addiction treatment.

(c) Improper treatment of a patient with heroin dependence or addiction.

(d) Inadequate monitoring of controlled substances in a patient with a history of substance abuse.

(See Exh. K, Dr. Peña Decl., ¶ 43.)

***Patient C***

64. On or about March 17, 2014, Patient C presented to Respondent for medical care and treatment with a history of symptoms or ailments including, but not limited to, difficulty concentrating at work. (Exh. K, Dr. Peña Decl., ¶ 46.)

65. In his progress note for the medical appointment with Patient C on or about March 17, 2014, Respondent documented that Patient C reported that he had been taking Adderall that he had been getting from his sister. (Exh. K, Dr. Peña Decl., ¶ 47.)

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66. In his progress note for the medical appointment with Patient C on or about March 17, 2014, Respondent documented a diagnosis of Attention Deficit Disorder (ADD). (Exh. K, Dr. Peña Decl., ¶ 48.)

67. On or about March 17, 2014, and on multiple occasions thereafter through as late as in or around February 2017, Respondent prescribed approximately 90 mg per day of short-acting Adderall to Patient C for ADD. (Exh. K, Dr. Peña Decl., ¶ 49.)

68. During the course of Respondent's care and treatment of Patient C for ADD in or around March 2014 to February 2017, Respondent improperly diagnosed Patient C with ADD including, but not limited to, failing to adequately confirm the presence of one or more underlying symptoms of ADD, or consider alternative diagnoses such as hypothyroidism, anemia, or drug-seeking behavior. (Exh. K, Dr. Peña Decl., ¶ 50.)

69. During the course of Respondent's care and treatment of Patient C for ADD in or around March 2014 to February 2017, Respondent improperly treated Patient C for ADD including, but not limited to, failing to adequately evaluate Patient C's specific symptoms or response to therapy, or consider treatment alternatives to short-acting Adderall with less abuse potential. (Exh. K, Dr. Peña Decl., ¶ 51.)

70. On or about January 21, 2015, Patient C presented to Respondent for a medical appointment with complaints of, among other things, lower back pain, upper back pain and right ankle pain. Patient C subsequently presented to Respondent with similar complaints on multiple occasions through as late as in or around February 2017. (Exh. K, Dr. Peña Decl., ¶ 52.)

71. In his progress note for the appointment with Patient C on or about January 21, 2015, Respondent documented that Patient C stated that he was taking 90 mg of oxycodone per day, prescribed by another healthcare provider, after a motor vehicle accident three years prior. (Exh. K, Dr. Peña Decl., ¶ 53.)

72. On or about January 21, 2015, and on multiple occasions thereafter through as late as in or around February 2017, Respondent prescribed a high dose of oxycodone, approximately 90 mg (135 MME) per day, to Patient C for pain. (Exh. K, Dr. Peña Decl., ¶ 54.)

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73. Prior to prescribing oxycodone to Patient C on or about January 21, 2015, Respondent failed to take adequate steps to confirm Patient C's reported history of prior oxycodone use including, but not limited to, reviewing prior prescription bottles, obtaining and reviewing a patient Controlled Substance Utilization Review and Evaluation System (CURES) report, or ordering and reviewing a toxicology screening. (Exh. K, Dr. Peña Decl., ¶ 55.)

74. During the course of Respondent's prescribing of oxycodone to Patient C for pain in or around January 2015 to February 2017, Respondent documented normal physical evaluations of Patient C and failed to conduct or document a sufficiently thorough neurological examination. (Exh. K, Dr. Peña Decl., ¶ 56.)

75. During the course of Respondent's prescribing of oxycodone to Patient C for pain in or around January 2015 to February 2017, Respondent failed to adequately assess or document any affects of Patient C's reported pain on his functioning. (Exh. K, Dr. Peña Decl., ¶ 57.)

76. During the course of Respondent's prescribing of oxycodone to Patient C for pain in or around January 2015 to February 2017, Respondent failed to order and review any diagnostic testing, such as an x-ray or MRI, or recommend evaluation by a specialist, such as an orthopedic surgeon or physical therapist. (Exh. K, Dr. Peña Decl., ¶ 58.)

77. During the course of Respondent's prescribing of oxycodone to Patient C for pain in or around January 2015 to February 2017, Respondent failed to offer, or document offering, safer treatment alternatives including, but not limited to, anti-inflammatories. (Exh. K, Dr. Peña Decl., ¶ 59.)

78. During the course of Respondent's prescribing of oxycodone to Patient C for pain in or around January 2015 to February 2017, Respondent failed to adequately counsel, or document counseling, Patient C regarding the risks of oxycodone. (Exh. K, Dr. Peña Decl., ¶ 60.)

79. During the course of Respondent's treatment of Patient C in or around March 2014 to February 2017, Respondent failed to order and review any toxicology drug screens for Patient C. (Exh. K, Dr. Peña Decl., ¶ 61.)

80. During the course of Respondent's care and treatment of Patient C in or around March 2014 to February 2017, Respondent reviewed CURES for controlled substance

prescriptions filled by Patient C on only one occasion, on or about March 17, 2014. (Exh. K, Dr. Peña Decl., ¶ 62.)

81. On multiple occasions during the course of Respondent's care and treatment of Patient C in or around March 2014 to February 2017, Respondent failed to adequately and accurately document details regarding Patient C's back pain, subjective reports of a complaint, or physical examination. (Exh. K, Dr. Peña Decl., ¶ 63.)

82. In or around March 2014 to February 2017, Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to:

(a) Improperly evaluating and treating Patient C's reported chronic back pain.

(b) Improperly prescribing high-dose opioids or opiates to Patient C.

(c) Inadequately monitoring Patient C's use of controlled substances.

(See Exh. K, Dr. Peña Decl., ¶ 64.)

***Patient D***

83. On multiple occasions in or around 2006[13] to April 2017, Respondent rendered medical care or treatment to Patient D, whose medical history includes, but is not limited to, pain, muscle spasms, anxiety, depression, paroxysmal supraventricular tachycardia, and alcoholism. (Exh. K, Dr. Peña Decl., ¶ 66.)

84. On multiple occasions in or around October 2013 to August 2015, Respondent prescribed approximately 20 mg (30 MME) per day of short-acting oxycodone to Patient D for chronic pain. (Exh. K, Dr. Peña Decl., ¶ 67.)

85. On multiple occasions in or around September 2015 to November 2016, Respondent prescribed approximately 40 mg (60 MME) per day of short-acting oxycodone to Patient D for chronic pain. (Exh. K, Dr. Peña Decl., ¶ 68.)

86. On multiple occasions in or around January 2017 to September 2017, Respondent prescribed approximately 120 mg (180 MME) per day of short-acting oxycodone to Patient D for chronic pain. (Exh. K, Dr. Peña Decl., ¶ 69.)

[13] Any acts or omissions by Respondent found to have occurred more than seven years prior to the date of filing of Accusation No. 8002016026128 are not set forth as a basis for discipline against Respondent's license, but rather are set forth for informational purposes only.

87. On multiple occasions in or around October 2017 to December 2017, Respondent prescribed short-acting oxycodone to Patient D ranging from 150 mg (225 MME) to 180 mg (270 MME) per day for chronic pain. (Exh. K, Dr. Peña Decl., ¶ 70.)

88. On multiple occasions in or around November 2013 to November 2016, Respondent prescribed approximately 80 mg (80 MME) per day of short-acting hydrocodone[14] to Patient D for chronic pain. (Exh. K, Dr. Peña Decl., ¶ 71.)

89. On multiple occasions in or around January 2017 to September 2017, Respondent prescribed approximately 40 mg (40 MME) per day of short-acting hydrocodone to Patient D for chronic pain. (Exh. K, Dr. Peña Decl., ¶ 72.)

90. On multiple occasions in or around March 2016 to October 2017, Respondent prescribed approximately 16 mg (64 MME) per day of short-acting hydromorphone[15] to Patient D for chronic pain. (Exh. K, Dr. Peña Decl., ¶ 73.)

91. In or around March 2016 to December 2017, Respondent concomitantly prescribed to Patient D at least two, and as many as three, different short-acting opioid or opiate medications in doses cumulatively exceeding 200 MME per day. (Exh. K, Dr. Peña Decl., ¶ 74.)

92. Respondent documented, on or about January 13, 2017, that Patient D was planning to see a pain management specialist. However, Respondent increased his prescribing of opioid or opiate medications on or after this date, and failed to document the outcome of any corresponding pain consultation or any follow-up regarding Patient D's plan to see a pain specialist. (Exh. K, Dr. Peña Decl., ¶ 75.)

93. In the period in or around March 2016 to December 2017 during which Respondent prescribed high doses of multiple short-acting opioids or opiates to Patient D, Patient D continued to complain of worsening pain. However, Respondent failed to adequately consider treatment alternatives including, but not limited to, physical therapy, transcutaneous electrical nerve

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[14] Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[15] Hydromorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

stimulation (TENS) treatment, surgical intervention, or safer medications. (Exh. K, Dr. Peña Decl., ¶ 76.)

94. In the period in or around March 2016 to December 2017 during which Respondent prescribed high doses of multiple short-acting opioids or opiates to Patient D, Patient D continued to complain of worsening pain. However, Respondent failed to refer Patient D to an orthopedic or spine surgeon. (Exh. K, Dr. Peña Decl., ¶ 77.)

95. On multiple occasions in or around November 2013 to December 2017, Respondent prescribed approximately 5 mg per day of diazepam,[16] a benzodiazepine, to Patient D for anxiety or insomnia. (Exh. K, Dr. Peña Decl., ¶ 78.)

96. On multiple occasions in or around July 2014 to December 2017, Respondent prescribed approximately 0.5 mg, or more, per day of alprazolam, a benzodiazepine, to Patient D for anxiety. (Exh. K, Dr. Peña Decl., ¶ 79.)

97. In the period in or around November 2013 to December 2017 during which Respondent prescribed benzodiazepines to Patient D, Respondent failed to adequately evaluate or document details of Patient D's reported anxiety or insomnia. (Exh. K, Dr. Peña Decl., ¶ 80.)

98. In the period in or around November 2013 to December 2017 during which Respondent prescribed benzodiazepines to Patient D for anxiety or insomnia, Respondent failed to adequately consider safer treatment alternatives. (Exh. K, Dr. Peña Decl., ¶ 81.)

99. In the period in or around November 2013 to December 2017 during which Respondent prescribed benzodiazepines to Patient D for anxiety or insomnia, Respondent failed to offer Patient D a referral to a mental health provider. (Exh. K, Dr. Peña Decl., ¶ 82.)

100. In the period in or around November 2013 to December 2017 during which Respondent prescribed benzodiazepines to Patient D for anxiety or insomnia, Respondent failed to adequately discuss or document discussing with Patient D the risks of benzodiazepines

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[16] Diazepam 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.

including, without limitation, the risks of taking benzodiazepines with opiates, Soma[17] or alcohol. (Exh. K, Dr. Peña Decl., ¶ 83.)

101. On multiple occasions in or around May 2013 to December 2017, Respondent prescribed Soma to Patient D for pain. (Exh. K, Dr. Peña Decl., ¶ 84.)

102. In the period in or around May 2013 to December 2017 during which Respondent prescribed Soma to Patient D, Respondent failed to adequately establish or document a medical indication for Soma. (Exh. K, Dr. Peña Decl., ¶ 85.)

103. In the period in or around May 2013 to December 2017 during which Respondent prescribed Soma to Patient D, Patient D presented with multiple pertinent risk factors including, but not limited to, use of high-dose opiates and benzodiazepines, and a history of alcohol abuse. (Exh. K, Dr. Peña Decl., ¶ 86.)

104. In the period in or around May 2013 to December 2017 during which Respondent prescribed Soma to Patient D, Respondent failed to adequately counsel Patient D regarding the risks of Soma in conjunction with opiates, benzodiazepines or alcohol. (Exh. K, Dr. Peña Decl., ¶ 87.)

105. On multiple occasions in or around December 2013 to August 2017, Respondent prescribed phentermine[18] or phendimetrazine,[19] controlled-substance stimulants commonly used to suppress appetite and assist patients with weight loss, to Patient D. (Exh. K, Dr. Peña Decl., ¶ 88.)

106. Throughout the course of Respondent's prescribing of phentermine or phendimetrazine to Patient D in or about December 2013 to August 2017, Respondent failed to adequately establish or document a medical indication for the prescribing of phentermine or phendimetrazine to Patient D. (Exh. K, Dr. Peña Decl., ¶ 89.)

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[17] Soma, a brand name for carisoprodol, is a schedule IV controlled substance pursuant to Health and Safety code section 11057, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code section 4022. It is used as a muscle relaxant.

[18] Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a stimulant and an appetite suppressant.

[19] Phendimetrazine is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

107. Throughout the course of Respondent's prescribing of phentermine or phendimetrazine to Patient D in or about December 2013 to August 2017, Respondent failed to adequately consider or discuss with Patient D treatment alternatives including, but not limited to, modifications to her diet, referral to a nutritionist, safer medications, or changes to Patient D's then-existing medication regimen. (Exh. K, Dr. Peña Decl., ¶ 90.)

108. Throughout the course of Respondent's prescribing of phentermine or phendimetrazine to Patient D in or about December 2013 to August 2017, Patient D had one or more documented contraindications for the use of phentermine or phendimetrazine including, but not limited to, paroxysmal supraventricular tachycardia, anxiety, insomnia, chest pain and risk factors for heart disease, and addiction. (Exh. K, Dr. Peña Decl., ¶ 91.)

109. On multiple occasions in or around August 2013 to April 2017, Respondent administered, or ordered the administration of, Depo-Provera to Patient D for contraception or hormone replacement therapy. (Exh. K, Dr. Peña Decl., ¶ 92.)

110. In the period in or around August 2013 to April 2017 during which Respondent administered or ordered the administration of Depo-Provera to Patient D, Respondent failed to adequately counsel, or document counseling, Patient D regarding the risks of Depo-Provera. (Exh. K, Dr. Peña Decl., ¶ 93.)

111. In the period in or around August 2013 to April 2017 during which Respondent administered or ordered the administration of Depo-Provera to Patient D, Respondent failed to adequately monitor Patient D's bone density, bone turnover markers or other osteoporosis indicators. (Exh. K, Dr. Peña Decl., ¶ 94.)

112. Respondent failed to adequately monitor Patient D's liver function during the course of his care and treatment of Patient D following 2015. (Exh. K, Dr. Peña Decl., ¶ 95.)

113. Patient D's medical chart contained a copy of a CURES report dated February 20, 2014. Among other things, the CURES report showed that Patient D had received prescriptions for Suboxone,[20] commonly used to treat opioid dependence, and hydrocodone from

[20] Suboxone is a brand name for buprenorphine and naloxone, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

other healthcare providers. Respondent failed to address or document addressing these discrepancies with Patient D. (Exh. K, Dr. Peña Decl., ¶ 96.)

114. Respondent otherwise failed to review or document reviewing the CURES database for controlled substance prescriptions filled by Patient D throughout the course of his care and treatment of Patient D in or around 2014 to December 2017. (Exh. K, Dr. Peña Decl., ¶ 97.)

115. During the course of Respondent's care and treatment of Patient D in or around May 2013 to December 2017, Respondent only ordered and reviewed a toxicology drug screen for Patient D on, at most, two occasions in or around July or November 2017. (Exh. K, Dr. Peña Decl., ¶ 98.)

116. During the course of Respondent's care and treatment of Patient D in or around May 2013 to December 2017, Respondent failed to adequately screen Patient D for opiate use disorder. (Exh. K, Dr. Peña Decl., ¶ 99.)

117. During the course of Respondent's care and treatment of Patient D in or around May 2013 to December 2017, Respondent failed to adequately obtain or document informed consent from Patient D for treatment with opioids or opiates, stimulants, benzodiazepines, or Soma, or any combination thereof. (Exh. K, Dr. Peña Decl., ¶ 100.)

118. On multiple occasions during the course of Respondent's care and treatment of Patient D in or around October 2012 to December 2017, Respondent generated an illegible or difficult to read progress note for Patient D, or documented contradictory information in a progress note for Patient D. (Exh. K, Dr. Peña Decl., ¶ 101.)

119. In or around October 2013 to December 2017, Respondent committed gross negligence in his care and treatment of Patient D including, but not limited to:

(a) Improperly prescribing multiple high-dose opioids or opiates to Patient D.

(b) Inadequately monitoring Patient D's use of controlled substances.

(c) Improperly prescribing chronic benzodiazepines to Patient D.

(d) Improperly prescribing phentermine or phendimetrazine to Patient D.

(See Exh. K, Dr. Peña Decl., ¶ 102.)

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***Patient G***

120. On or about November 4, 2015, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented diagnoses of a hydrocele and painful scrotum, ordering a urology consultation and a testicular and scrotal ultrasound, and that the patient reported being previously treated with approximately 20 mg of oxycodone every five to six hours for pain control. (Exh. K, Dr. Peña Decl., ¶ 119.)

121. On or about November 4, 2015, Respondent prescribed a high dose of oxycodone, approximately four 20 mg tablets (120 MME) per day, to Patient G for pain. (Exh. K, Dr. Peña Decl., ¶ 120.)

122. On or about December 11, 2015, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G had not obtained an ultrasound or presented to a urologist since the prior appointment. (Exh. K, Dr. Peña Decl., ¶ 121.)

123. On or about December 11, 2015, Respondent documented renewing Patient G's prescription for oxycodone. (Exh. K, Dr. Peña Decl., ¶ 122.)

124. On or about June 1, 2016, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G had not obtained an ultrasound or presented to a urologist since the prior appointment. (Exh. K, Dr. Peña Decl., ¶ 123.)

125. On or about June 1, 2016, Respondent documented renewing Patient G's prescription for oxycodone. (Exh. K, Dr. Peña Decl., ¶ 124.)

126. On or about July 6, 2016, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G had not presented to a urologist since the prior appointment. (Exh. K, Dr. Peña Decl., ¶ 125.)

127. On or about July 6, 2016, Respondent prescribed a higher dose of approximately four 30 mg tablets of oxycodone (180 MME) per day to Patient G. (Exh. K, Dr. Peña Decl., ¶ 126.)

128. On or about July 15, 2016, Respondent reduced the potency of the tablets prescribed to Patient G, back to the 20 mg tablets, following reports from Patient G that the 30 mg tablets were upsetting his stomach and making him vomit. (Exh. K, Dr. Peña Decl., ¶ 127.)

129. On or about August 5, 2016, another healthcare provider affiliated with the medical practice at which Respondent regularly treated Patient G reduced Patient G's oxycodone prescription to approximately four 15 mg tablets (90 MME) per day. (Exh. K, Dr. Peña Decl., ¶ 128.)

130. On or about September 21, 2016, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G reported fair pain control with the decreased oxycodone prescription, and an order for a pain management consultation. (Exh. K, Dr. Peña Decl., ¶ 129.)

131. On or about September 21, 2016, Respondent prescribed approximately four 15 mg tablets of oxycodone (90 MME) per day to Patient G. (Exh. K, Dr. Peña Decl., ¶ 130.)

132. On or about October 7, 2016, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G reported worsening pain, taking up to two 15 mg oxycodone tablets at a time, and that he was starting to run out of oxycodone. Respondent also documented that Patient G and had not presented to a pain management clinic as previously referred. (Exh. K, Dr. Peña Decl., ¶ 131.)

133. In his progress note for the appointment with Patient G on or about October 7, 2016, Respondent documented that CURES did not show any suspicious activity for Patient G. (Exh. K, Dr. Peña Decl., ¶ 132.)

134. In fact, the CURES database listed one or more medications containing a controlled substance, including, but not limited to, tramadol, that a healthcare provider unaffiliated with Respondent had prescribed or dispensed to Patient G in or around November 2015 to October 2016. The CURES database further listed that Patient G had obtained controlled substances from at least four different pharmacies or dispensing physicians during that period. (Exh. K, Dr. Peña Decl., ¶ 133.)

135. On or about October 7, 2016, Respondent prescribed approximately four 30 mg tablets of oxycodone (180 MME) per day to Patient G. (Exh. K, Dr. Peña Decl., ¶ 134.)

136. On or about November 18, 2016, Respondent renewed the prescription to Patient G for approximately four 30 mg tablets of oxycodone (180 MME) per day. (Exh. K, Dr. Peña Decl., ¶ 135.)

137. On or about December 9, 2016, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G was doing well with his current regimen and that Patient G was requesting an early refill for travel. (Exh. K, Dr. Peña Decl., ¶ 136.)

138. In his progress note for the medical appointment with Patient G on or about December 9, 2016, Respondent also documented prescribing a higher dose of approximately five 30 mg tablets of oxycodone (225 MME) per day to Patient G. (Exh. K, Dr. Peña Decl., ¶ 137.)

139. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to review or document the review of any ultrasound, urology consultation or pain management consultation. (Exh. K, Dr. Peña Decl., ¶ 138.)

140. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to adequately confirm his hydrocele diagnosis for Patient G or rule out other causes for scrotal swelling or pain. (Exh. K, Dr. Peña Decl., ¶ 139.)

141. On one or more occasions during the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent prescribed high-dose opioids or opiates to Patient G without adequate medical indication. (Exh. K, Dr. Peña Decl., ¶ 140.)

142. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to adequately consider or document consideration of treatment alternatives to opioid or opiate therapy for a hydrocele. (Exh. K, Dr. Peña Decl., ¶ 141.)

143. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to enter into a controlled substance agreement with Patient G, or otherwise discuss and document the risks of chronic opioid or opiate therapy with Patient G including, but not limited to, addiction, dependence, overdose or respiratory depression. (Exh. K, Dr. Peña Decl., ¶ 142.)

144. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to adequately order or review urine toxicology screenings for Patient G. (Exh. K, Dr. Peña Decl., ¶ 143.)

145. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to adequately assess Patient G's risk for opioid or opiate addiction or dependence. (Exh. K, Dr. Peña Decl., ¶ 144.)

146. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to adequately review the CURES database for controlled substance prescriptions filled by Patient G, or address any CURES entries for a controlled substance prescribed or dispensed by a healthcare provider unaffiliated with Respondent and the use of multiple pharmacies or dispensing physicians. (Exh. K, Dr. Peña Decl., ¶ 145.)

147. Respondent committed gross negligence in his care and treatment of Patient G in that he improperly prescribed high-dose opioids or opiates to Patient G for a hydrocele. (See Exh. K, Dr. Peña Decl., ¶ 146.)

148. Respondent committed gross negligence in his care and treatment of Patient G in that he failed to adequately monitor the prescribing of controlled substances to Patient G. (See Exh. K, Dr. Peña Decl., ¶ 147.)

**SECOND CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

149. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234,

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subdivision (c) of the Code in that he committed repeated negligent acts, as more particularly described hereinafter:

150. Findings of Fact 27 through 148, above, are hereby incorporated by reference as if fully set forth herein.

151. Respondent further committed negligence in his care and treatment of Patient A including, but not limited to:

(a) Improper prescribing of high-dose, chronic benzodiazepines in combination with opioids or opiates.

(b) Failing to obtain or document adequate informed consent from Patient A for opioid, opiate or benzodiazepine medications.

(c) Improper treatment of back pain.

(See Exh. K, Dr. Peña Decl., ¶ 20.)

152. Respondent further committed negligence in his care and treatment of Patient B including, but not limited to:

(a) Improper prescribing of benzodiazepines.

(b) Improper prescribing of methadone and citalopram in combination.

(c) Prescribing Adderall for depression to a patient with a history of drug dependence or addiction without adequate monitoring.

(d) Failing to obtain or document adequate informed consent from Patient B for chronic opioid, opiate, or benzodiazepine medications, or concomitant use of methadone and citalopram or Adderall.

(See Exh. K, Dr. Peña Decl., ¶ 44.)

153. Respondent further committed negligence in his care and treatment of Patient C including, but not limited to:

(a) Improperly diagnosing and treating Patient C for ADD.

(b) Failing to obtain or document adequate informed consent from Patient C for oxycodone treatment.

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(c) Failing to maintain adequate and accurate documentation for Patient C including, but not limited to, failing to adequately and accurately document details regarding the patients' back pain, subjective reports of a complaint, or physical examination.

(See Exh. K, Dr. Peña Decl., ¶ 65.)

154. Respondent further committed negligence in his care and treatment of Patient D including, but not limited to:

(a) Improperly prescribing Soma to Patient D.

(b) Failing to obtain or document adequate informed consent from Patient D for treatment with opioids or opiates, benzodiazepines, or Soma, or any combination thereof.

(c) Improper administration of Depo-provera to Patient D.

(d) Failing to maintain adequate and accurate documentation for Patient D.

(Exh. K, Dr. Peña Decl., ¶ 103.)

***Patient E***

155. On multiple occasions in or around October 2006 to February 2016, Respondent rendered medical care or treatment to Patient E, whose documented medical history includes, but is not limited to, ADD and hypothyroidism. (Exh. K, Dr. Peña Decl., ¶ 104.)

156. On or about September 26, 2012, and on multiple occasions thereafter through as late as in or around February 2016, Respondent prescribed to Patient E a high dose of short-acting Adderall, approximately 120 mg per day, for ADD. (Exh. K, Dr. Peña Decl., ¶ 105.)

157. On at least three occasions, on or about July 30, 2014, April 10, 2015, and October 23, 2015, Respondent concurrently prescribed at least 30 mg per day of extended-release Adderall to Patient E in addition to approximately 120 mg per day of short-acting Adderall. (Exh. K, Dr. Peña Decl., ¶ 106.)

158. During the course of Respondent's prescribing of Adderall to Patient E in or around September 2012 to February 2016, Respondent failed to adequately order and review toxicology drug screens of Patient E, or review the CURES database for controlled substance prescriptions filled by Patient E. (Exh. K, Dr. Peña Decl., ¶ 107.)

159. During the course of Respondent's prescribing of Adderall to Patient E in or around September 2012 to February 2016, Respondent routinely documented normal heart rates and blood pressures for Patient E. (Exh. K, Dr. Peña Decl., ¶ 108.)

160. During the course of Respondent's prescribing of Adderall to Patient E in or around September 2012 to February 2016, Respondent failed to adequately assess, reevaluate or document Patient E's symptoms of ADD. (Exh. K, Dr. Peña Decl., ¶ 109.)

161. In or around September 26, 2012 to February 2016, Respondent committed negligence in his care and treatment of Patient E including failing to adequately monitor his treatment of Patient E for ADD. (See Exh. K, Dr. Peña Decl., ¶ 110.)

***Patient F***

162. On multiple occasions in or around December 2012 to December 2016, Respondent rendered medical care and treatment to Patient F, whose medical history includes, but is not limited to, peripheral neuropathy, anxiety, depression, shoulder pain, knee pain, and opioid dependence. (Exh. K, Dr. Peña Decl., ¶ 111.)

163. On multiple occasions in or around June 2014 to November 2014, Respondent prescribed approximately 3 mg per day of lorazepam, a benzodiazepine, to Patient F for anxiety. (Exh. K, Dr. Peña Decl., ¶ 112.)

164. On multiple occasions in or around December 2014 to August 2017, Respondent prescribed approximately 1 to 2 mg per day of clonazepam, a benzodiazepine, to Patient F for anxiety. (Exh. K, Dr. Peña Decl., ¶ 113.)

165. On or about January 23, 2015, and on multiple occasions thereafter through as late as on or about August 23, 2017, Respondent prescribed approximately 30 mg per day of temazepam,[21] a benzodiazepine, to Patient F for insomnia. (Exh. K, Dr. Peña Decl., ¶ 114.)

166. In the period in or around June 2014 to August 2017 during which Respondent prescribed one or more benzodiazepines to Patient F, Respondent also concomitantly prescribed

[21] Temazepam 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.

multiple opioid or opiate medications to Patient F including, but not limited to, oxycodone, OxyContin (long-acting oxycodone), fentanyl,[22] or Suboxone. (Exh. K, Dr. Peña Decl., ¶ 115.)

167. In the period in or around June 2014 to August 2017 during which Respondent prescribed one or more benzodiazepines to Patient F, Respondent failed to adequately counsel or document counseling Patient F regarding the risks of benzodiazepines taken in combination with opioid or opiate medications. (Exh. K, Dr. Peña Decl., ¶ 116.)

168. In the period in or around June 2014 to August 2017 during which Respondent prescribed one or more benzodiazepines to Patient F, Respondent failed to refer or offer to refer Patient F for psychiatric evaluation or treatment. (Exh. K, Dr. Peña Decl., ¶ 117.)

169. In or around December 2012 to December 2016, Respondent committed negligence in his care and treatment of Patient F including improperly prescribing chronic benzodiazepines concomitantly with opioids or opiates to Patient F. (See Exh. K, Dr. Peña Decl., ¶ 118.)

**THIRD CAUSE FOR DISCIPLINE**

**(Incompetence)**

170. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, subdivision (d) of the Code in that his care and treatment of Patient B exhibited incompetence regarding the care and treatment of a patient with a substance abuse disorder, as more particularly described in Findings of Fact 40 through 63 and 152, above, which are hereby incorporated by reference as if fully set forth herein. (See Exh. K, Dr. Peña Decl., ¶ 45.)

**FOURTH CAUSE FOR DISCIPLINE**

**(Prescribing, Dispensing, or Furnishing of a Dangerous Drug Without an Appropriate Prior Examination and Medical Indication)**

171. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, as defined by section 2242, subdivision (a), of the Code in that he prescribed, dispensed, or

[22] Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

furnished a dangerous drug on one or more occasions without an appropriate prior examination and medical indication as more particularly described in Findings of Fact 27 to 169, above, which are hereby incorporated by reference as if fully set forth herein.

**FIFTH CAUSE FOR DISCIPLINE**

**(Repeated Acts of Clearly Excessive Prescribing)**

172. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, as defined by section 725, subdivision (a), of the Code in that he committed repeated acts of clearly excessive prescribing, furnishing, dispensing or administering of a drug or treatment as more particularly described in Findings of Fact 27 to 169, above, which are hereby incorporated by reference as if fully set forth herein.

**SIXTH CAUSE FOR DISCIPLINE**

**(Violation of Federal or State Statute or Regulation Regulating Dangerous Drugs or Controlled Substances)**

173. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, as defined by section 2238, of the Code in that he violated one or more federal or state statutes or regulations regulating dangerous drugs or controlled substances by prescribing methadone to a patient for heroin dependence or addiction without one or more required state or federal registrations as more particularly described in Findings of Fact 40 through 63 and 152, above, which are hereby incorporated by reference as if fully set forth herein.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Records)**

174. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code in that he failed to maintain adequate and accurate records relating to the provision of services to one or more patients as more particularly described in

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Findings of Fact 64 through 119, and 153 through 154, above, which are hereby incorporated by reference as if fully set forth herein.

**EIGHTH CAUSE FOR DISCIPLINE**

**(Violating One or More Provisions of the Medical Practice Act)**

175. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, subdivision (a) of the Code in that he violated or attempted to violate, directly or indirectly, any provision of the Medical Practice Act as more particularly described in Findings of Fact to 27 through 174, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

**DETERMINATION OF ISSUES**

1. Pursuant to California Government Code section 11520, the Board hereby takes this action based upon Respondent's express admissions or upon other evidence contained in the accompanying *Evidence Packet* filed herewith.

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 First Amended Accusation No. 8002016026128, and the Findings of Fact in paragraphs 1 through 175, above, and each of them, severally and separately, are true and correct.

3. Pursuant to its authority under Government Code section 11520 and Business and Professions Code section 2227, and based on the evidence before it, the Findings of Fact in paragraphs 1 through 177, above, and the Determination of Issues 1 and 2, above, the Board hereby finds that Respondent Ariel Alexander Cortes, M.D. has subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action in that:

(a) Respondent committed gross negligence in violation of section 2234, subdivision (b) of the Code;

(b) Respondent committed repeated negligent acts in violation of section 2234, subdivision (c) of the Code;

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(c) Respondent exhibited incompetence in violation of section 2234, subdivision (d) of the Code;

(d) Respondent prescribed, dispensed, or furnished one or more dangerous drugs without an appropriate prior examination and medical indication in violation of sections 2234 and 2242, subdivision (a) of the Code;

(e) Respondent committed repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs in violation of sections 2234 and 725, subdivision (a) of the Code;

(f) Respondent committed one or more violations of a federal or state statute or regulation regulating dangerous drugs or controlled substances in violation of sections 2234 and 2238 of the Code;

(g) Respondent failed to maintain adequate and accurate records relating to the provision of services to his patients in violation of sections 2234 and 2266 of the Code; and

(h) Respondent violated one or more provisions of the Medical Practice Act in violation of section 2234, subdivision (a) of the Code.

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## ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. A 63637, heretofore issued to Respondent Ariel Alexander Cortes, M.D., is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent Ariel Alexander Cortes, M.D. 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 June 5, 2020 at 5:00 P.m.

It is so ORDERED May 7, 2020

FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

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| In the Matter of the First Amended Accusation Against:<br><br>**Ariel Alexander Cortes, M.D.**<br>**7805 Highland Village Place G103**<br>**San Diego, CA 92129**<br><br>**Physician's and Surgeon's Certificate No. A 63637,**<br><br>Respondent. | Case No. 8002016026128<br><br>**FIRST AMENDED ACCUSATION** |

## PARTIES

1. Christine J. Lally (Complainant) brings this First Amended Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 10, 1997, the Medical Board issued Physician's and Surgeon's Certificate Number A 63637 to Ariel Alexander Cortes, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2021, unless renewed.

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## JURISDICTION

3. This First Amended 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, subdivision (a) of the Code states:

> 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:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (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.
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> (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.

5. Section 2234 of the Code states, in pertinent part:

> 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:
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> (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.
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> (b) Gross negligence.
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> (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.

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6. Section 2242, subdivision (a) of the Code states:

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

7. Section 725, subdivision (a) of the Code states:

Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

8. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

9. 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.

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

10. Respondent has subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, subdivision (b) of the Code in that he committed gross negligence. The circumstances are as follows:

***Patient A***

11. On multiple occasions in or around February 2013 to July 2017, Respondent rendered medical care and treatment to "Patient A,"[1] whose medical history includes, but is not limited to, chronic low back pain, obesity, anxiety, high cholesterol, and hip pain.

[1] Patient identities are withheld from the instant accusation to preserve patient confidentiality. Patient identities are known to Respondent or will be disclosed by Complainant upon receipt of a duly issued request for discovery.

12. In or around February 2013 to July 2017, Respondent prescribed high doses of opioid or opiate medications to Patient A for lower back pain including, but not limited to, oxycodone[2] or tramadol.[3] During all or most of this period, Respondent's per-day prescribing of opiate medications to Patient A consisted of at least 225 morphine milligram equivalents (MME).

13. In the period in or around February 2013 to July 2017 during which Respondent prescribed high doses of opioids or opiates to Patient A, Respondent failed to adequately establish or document an underlying disease process or diagnosis for Patient A's purported back pain.

14. In the period in or around February 2013 to July 2017 during which Respondent prescribed high doses of opioids or opiates to Patient A, Respondent failed to adequately consider treatment alternatives including, but not limited to, referral to an orthopedic surgeon or neurosurgeon, injections, physical therapy, or non-opiate pain medications.

15. In the period in or around February 2013 to July 2017 during which Respondent prescribed high doses of opioids or opiates to Patient A, Respondent failed to adequately assess, reevaluate or document Patient A's pain levels, pain locations, associated symptoms, provoking or palliating factors, medication side effects, or ability to function.

16. In the period in or around February 2013 to July 2017 during which Respondent prescribed high doses of opioids or opiates to Patient A, Respondent failed to adequately screen or otherwise evaluate Patient A for any symptoms of opioid use disorder.

17. In or around January 2014 to June 2017, Respondent prescribed high doses of alprazolam[4] (Xanax), a benzodiazepine, to Patient A for anxiety. For all or most of this period, Respondent prescribed approximately 4 mg per day of alprazolam to Patient A.

18. In the period in or around January 2014 to July 2017 during which Respondent prescribed high doses of alprazolam to Patient A, Respondent failed to adequately counsel, or

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[2] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Tramadol is a Schedule IV controlled substance pursuant to Code of Federal Regulations, title 21, section 1308.14, subdivision (b), paragraph (3), and is a dangerous drug as defined by Business and Professions Code section 4022.

[4] Alprazolam 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.

document counseling, Patient A regarding the risks of high-dose, long-term benzodiazepine use, or benzodiazepine use in combination with opioids or opiates.

19. In the period in or around February 2013 to July 2017 during which Respondent prescribed controlled substances to Patient A, Respondent ordered and reviewed only one toxicology drug screen for Patient A in or around July 2017. The toxicology drug screen yielded a positive result for methamphetamines.

20. In the period in or around February 2013 to July 2017 during which Respondent prescribed controlled substances to Patient A, Respondent reviewed or documented reviewing the CURES database for controlled substance prescriptions filled by Patient A on only one occasion in or around June 2017.

21. In the period in or around February 2013 to May 2017 during which Respondent prescribed controlled substances to Patient A including, but not limited to, opioids, opiates or benzodiazepines, Respondent failed to adequately counsel or document counseling Patient A regarding the risks of chronic opioids or opiates, the risk of concomitant benzodiazepine and opioid or opiate use, or the risk of addiction with such medications.

22. Respondent committed gross negligence in his care and treatment of Patient A including, but not limited to:

(a) Failing to adequately monitor Patient A's controlled substance medications.

(b) Improperly prescribing high doses of controlled-substance opioids or opiates to Patient A.

***Patient B***

23. On or about March 23, 2015, "Patient B" presented to Respondent for medical care and treatment with a history of ailments including, but not limited to, anxiety, depression, and heroin[5] dependence or addiction.

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[5] Heroin is a Schedule I controlled substance pursuant to Health and Safety Code section 11054, subdivision (c).

24. In his treatment note for the appointment with Patient B on or about March 23, 2015, Respondent documented that Patient B engaged in occasional alcohol use, had used heroin that day and had last taken methadone in January 2015.

25. On or about March 23, 2015, and on multiple occasions thereafter through as late as in or around April 2017, Respondent issued a high-dose methadone prescription to Patient B of approximately 80 mg per day, equivalent to approximately 960 MME, to treat Patient B's heroin dependence or addiction.

26. At all times relevant to Respondent's prescribing of methadone to Patient B for heroin dependence or addiction in or around March 2015 to April 2017, Respondent was not duly registered with the U.S. Drug Enforcement Agency (DEA) or the California Department of Health Care Services (DHCS) to prescribe methadone as a part of a narcotic treatment program.

27. At all times relevant Respondent's care and treatment of Patient B in or around March 2015 to April 2017, methadone was a Schedule II controlled substance pursuant to section 812 of the federal Controlled Substances Act (21 U.S.C., §§ 801 et seq.) and Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

28. Prior to prescribing methadone to Patient B, Respondent failed to order or review a toxicology drug screen for Patient B, or obtain or document an adequate history of Patient B's frequency and duration of heroin use.

29. During the course of Respondent's prescribing of methadone to Patient B in or around March 2015 to April 2017, Respondent failed to adequately offer treatment alternatives to Patient B including, but not limited to, buprenorphine[6] or Vivitrol,[7] or referral to other healthcare providers for the prescribing of such drugs.

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[6] Buprenorphine is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Vivitrol is a brand name for naltrexone, a medication primarily used to manage alcohol or opioid dependence and a dangerous drug pursuant to Business and Professions Code section 4022.

30. On multiple occasions during the course of Respondent's care and treatment of Patient B for heroin dependence or addiction in or around March 2015 to April 2017, Respondent prescribed controlled substances other than methadone to Patient B including, but not limited to, Adderall[8] and multiple benzodiazepines.

31. On multiple occasions in or around March 2015 to January 2016, Respondent concurrently prescribed methadone and citalopram, a non-controlled medication, to Patient B for anxiety or depression.

32. During the course of Respondent's concurrent prescribing of methadone and citalopram to Patient B in or around March 2015 to January 2016, Respondent failed to adequately counsel, or document counseling, Patient B regarding the risks of taking high doses of methadone concurrently with citalopram.

33. In or around March 2015 to April 2017, Respondent prescribed a high dose, approximately 8 mg per day, of benzodiazepines including, but not limited to, clonazepam,[9] lorazepam,[10] or alprazolam, to Patient B for anxiety or depression.

34. During the course of Respondent's prescribing of benzodiazepines to Patient B in or around March 2015 to April 2017, Respondent failed to adequately assess or document Patient B's anxiety symptoms or incidences of panic attacks.

35. During the course of Respondent's prescribing of benzodiazepines to Patient B in or around March 2015 to April 2017, Respondent failed to adequately counsel, or document counseling, Patient B regarding the risks of benzodiazepine medications.

36. During the course of Respondent's prescribing of benzodiazepines to Patient B in or around March 2015 to April 2017, Respondent failed to attempt to reduce Patient B's

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[8] Adderall is a brand name for dextroamphetamine/amphetamine or mixed amphetamine salts, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a stimulant medication commonly used to treat Attention Deficit Disorder.

[9] Clonazepam, also known as Klonopin or Clonopin, 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. It is an anti-anxiety medication in the benzodiazepine family.

[10] Lorazepam, also known as Ativan, 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.

benzodiazepine doses during periods in which he also prescribed other non-benzodiazepine medications to Patient B for anxiety or depression including, but not limited to, citalopram or gabapentin.

37. On or about November 11, 2016, and on multiple occasions thereafter through as late as in or around April 2017, Respondent prescribed Adderall to Patient B for depression. On multiple such occasions, Respondent also concurrently prescribed methadone or a benzodiazepine to Patient B.

38. During the course of Respondent's prescribing of Adderall to Patient B in or around November 2016 to April 2017, Respondent failed to adequately counsel, or document counseling, Patient B regarding the risks of taking high doses of methadone concurrently with Adderall.

39. During the course of Respondent's prescribing of Adderall to Patient B in or around November 2016 to April 2017, Respondent failed to adequately assess Patient B's response to Adderall therapy, or Patient B's symptoms of depression and their severity.

40. During the course of Respondent's prescribing of Adderall to Patient B in or around November 2016 to April 2017, Respondent failed to adequately consider treatment alternatives safer than Adderall for depression including, but not limited to, serotonin norepinephrine reuptake inhibitors ("SNRIs"), selective serotonin reuptake inhibitors ("SSRIs"), bupropion, Cytomel or Abilify.

41. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent only reviewed or documented reviewing one CURES report, on or about July 30, 2016, for controlled substance prescriptions filled by Patient B.

42. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent failed to order and review any toxicology drug screens for Patient B.

43. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent failed to prescribe naloxone to Patient B.

44. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent failed to refer or offer to refer Patient B to a psychiatrist,

Narcotics Anonymous, a narcotic treatment program, or another appropriate mental health or addiction treatment provider.

45. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent failed to order or review any electrocardiograms (ECGs) for Patient B.

46. During the course of Respondent's care and treatment of Patient B in or around March 2015 to April 2017, Respondent failed to adequately counsel, or document counseling, Patient B regarding the risks of chronic opiates or opioids, benzodiazepines, concomitant use of methadone and citalopram or Adderall, concomitant use of methadone with benzodiazepines or alcohol, or use of controlled substances by a patient with a history of drug dependence or addiction.

47. Respondent committed gross negligence in his care and treatment of Patient B including, but not limited to:

(a) Prescribing methadone to Patient B as treatment for heroin dependence or addiction without holding one or more required state or federal registrations.

(b) Improper dosing of methadone for heroin dependence or addiction treatment.

(c) Improper treatment of a patient with heroin dependence or addiction.

(d) Inadequate monitoring of controlled substances in a patient with a history of substance abuse.

***Patient C***

48. On or about March 17, 2014, "Patient C" presented to Respondent for medical care and treatment with a history of symptoms or ailments including, but not limited to, difficulty concentrating at work.

49. In his progress note for the medical appointment with Patient C on or about March 17, 2014, Respondent documented that Patient C reported that he had been taking Adderall that he had been getting from his sister.

50. In his progress note for the medical appointment with Patient C on or about March 17, 2014, Respondent documented a diagnosis of Attention Deficit Disorder (ADD).

51. On or about March 17, 2014, and on multiple occasions thereafter through as late as in or around February 2017, Respondent prescribed approximately 90 mg per day of short-acting Adderall to Patient C for ADD.

52. During the course of Respondent's care and treatment of Patient C for ADD in or around March 2014 to February 2017, Respondent improperly diagnosed Patient C with ADD including, but not limited to, failing to adequately confirm the presence of one or more underlying symptoms of ADD, or consider alternative diagnoses such as hypothyroidism, anemia, or drug-seeking behavior.

53. During the course of Respondent's care and treatment of Patient C for ADD in or around March 2014 to February 2017, Respondent improperly treated Patient C for ADD including, but not limited to, failing to adequately evaluate Patient C's specific symptoms or response to therapy, or consider treatment alternatives to short-acting Adderall with less abuse potential.

54. On or about January 21, 2015, Patient C presented to Respondent for a medical appointment with complaints of, among other things, lower back pain, upper back pain and right ankle pain. Patient C subsequently presented to respondent with similar complaints on multiple occasions through as late as in or around February 2017.

55. In his progress note for the appointment with Patient C on or about January 21, 2015, Respondent documented that Patient C stated that he had been taking up to 120 mg of oxycodone per day prescribed by another healthcare provider after a motor vehicle accident three years prior.

56. On or about January 21, 2015, and on multiple occasions thereafter through as late as in or around February 2017, Respondent prescribed a high dose of oxycodone, approximately 90 mg (135 MME) per day, to Patient C for pain.

57. Prior to prescribing oxycodone to Patient C on or about January 21, 2015, Respondent failed to take adequate steps to confirm Patient C's reported history of prior oxycodone use including, but not limited to, reviewing prior prescription bottles, obtaining and reviewing a patient CURES report, or ordering and reviewing a toxicology screening.

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58. During the course of Respondent's prescribing of oxycodone to Patient C for pain in or around January 2015 to February 2017, Respondent documented normal physical evaluations of Patient C and failed to conduct or document a sufficiently thorough neurological examination.

59. During the course of Respondent's prescribing of oxycodone to Patient C for pain in or around January 2015 to February 2017, Respondent failed to adequately assess or document any affects of Patient C's reported pain on his functioning.

60. During the course of Respondent's prescribing of oxycodone to Patient C for pain in or around January 2015 to February 2017, Respondent failed to order and review any diagnostic testing, such as an x-ray or MRI, or recommend evaluation by a specialist, such as an orthopedic surgeon or physical therapist.

61. During the course of Respondent's prescribing of oxycodone to Patient C for pain in or around January 2015 to February 2017, Respondent failed to offer, or document offering, safer treatment alternatives including, but not limited to, anti-inflammatories.

62. During the course of Respondent's prescribing of oxycodone to Patient C for pain in or around January 2015 to February 2017, Respondent failed to adequately counsel, or document counseling, Patient C regarding the risks of oxycodone.

63. During the course of Respondent's treatment of Patient C in or around March 2014 to February 2017, Respondent failed to order and review any toxicology drug screens for Patient C.

64. During the course of Respondent's care and treatment of Patient C in or around March 2014 to February 2017, Respondent reviewed CURES for controlled substance prescriptions filled by Patient C on only one occasion, on or about March 17, 2014.

65. During the course of Respondent's care and treatment of Patient C in or around March 2014 to February 2017, Respondent failed to prescribe naloxone to Patient C.

66. On multiple occasions during the course of Respondent's care and treatment of Patient C in or around March 2014 to February 2017, Respondent failed to adequately and accurately document details regarding Patient C's back pain, subjective reports of a complaint, or physical examination.

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67. Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to:

(a) Improperly evaluating and treating Patient C's reported chronic back pain.

(b) Improperly prescribing high-dose opioids or opiates to Patient C.

(c) Inadequately monitoring Patient C's use of controlled substances.

***Patient D***

68. On multiple occasions in or around 2006[11] to April 2017, Respondent rendered medical care or treatment to "Patient D," whose medical history includes, but is not limited to, pain, muscle spasms, anxiety, depression, paroxysmal supraventricular tachycardia, alcoholism, and Suboxone[12] use.

69. On multiple occasions in or around October 2013 to August 2015, Respondent prescribed approximately 20 mg (30 MME) per day of short-acting oxycodone to Patient D for chronic pain.

70. On multiple occasions in or around September 2015 to November 2016, Respondent prescribed approximately 40 mg (60 MME) per day of short-acting oxycodone to Patient D for chronic pain.

71. On multiple occasions in or around January 2017 to September 2017, Respondent prescribed approximately 120 mg (180 MME) per day of short-acting oxycodone to Patient D for chronic pain.

72. On multiple occasions in or around October 2017 to December 2017, Respondent prescribed short-acting oxycodone to Patient D ranging from 150 mg (225 MME) to 180 mg (270 MME) per day for chronic pain.

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[11] Any acts or omissions by Respondent alleged to have occurred more than seven years prior to the date of filing of the instant accusation are not set forth as a basis for discipline against Respondent's license, but rather are set forth for informational purposes only.

[12] Suboxone is a brand name for buprenorphine and naloxone, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

73. On multiple occasions in or around November 2013 to November 2016, Respondent prescribed approximately 80 mg (80 MME) per day of short-acting hydrocodone[13] to Patient D for chronic pain.

74. On multiple occasions in or around January 2017 to September 2017, Respondent prescribed approximately 40 mg (40 MME) per day of short-acting hydrocodone to Patient D for chronic pain.

75. On multiple occasions in or around March 2016 to October 2017, Respondent prescribed approximately 16 mg (64 MME) per day of short-acting hydromorphone[14] to Patient D for chronic pain.

76. In or around March 2016 to December 2017, Respondent concomitantly prescribed to Patient D at least two, and as many as three, different short-acting opioid or opiate medications in doses cumulatively exceeding 200 MME per day.

77. In the period in or around March 2016 to December 2017 during which Respondent prescribed high doses of multiple short-acting opioids or opiates to Patient D, Respondent documented, on or about January 13, 2017, that Patient D was planning to see a pain management specialist. However, Respondent increased his prescribing of opioid or opiate medications on or after this date, and failed to document the outcome of any corresponding pain consultation or any follow-up regarding Patient D's plan to see a pain specialist.

78. In the period in or around March 2016 to December 2017 during which Respondent prescribed high doses of multiple short-acting opioids or opiates to Patient D, Patient D continued to complain of worsening pain. However, Respondent failed to adequately consider treatment alternatives including, but not limited to, physical therapy, transcutaneous electrical nerve stimulation (TENS) treatment, surgical intervention, or safer medications.

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[13] Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[14] Hydromorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

79. In the period in or around March 2016 to December 2017 during which Respondent prescribed high doses of multiple short-acting opioids or opiates to Patient D, Patient D continued to complain of worsening pain. However, Respondent failed to refer Patient D to an orthopedic or spine surgeon.

80. On multiple occasions in or around November 2013 to December 2017, Respondent prescribed approximately 5 mg per day of diazepam,[15] a benzodiazepine, to Patient D for anxiety or insomnia.

81. On multiple occasions in or around July 2014 to December 2017, Respondent prescribed approximately 0.5 mg, or more, per day of alprazolam, a benzodiazepine, to Patient D for anxiety.

82. In the period in or around November 2013 to December 2017 during which Respondent prescribed benzodiazepines to Patient D, Respondent failed to adequately evaluate or document details of Patient D's reported anxiety or insomnia.

83. In the period in or around November 2013 to December 2017 during which Respondent prescribed benzodiazepines to Patient D for anxiety or insomnia, Respondent failed to adequately consider safer treatment alternatives.

84. In the period in or around November 2013 to December 2017 during which Respondent prescribed benzodiazepines to Patient D for anxiety or insomnia, Respondent failed to offer Patient D a referral to a mental health provider.

85. In the period in or around November 2013 to December 2017 during which Respondent prescribed benzodiazepines to Patient D for anxiety or insomnia, Respondent failed to adequately discuss or document discussing with Patient D the risks of benzodiazepines including, without limitation, the risks of taking benzodiazepines with opiates, Soma[16] or alcohol.

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[15] Diazepam 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.

[16] Soma, a brand name for carisoprodol, is a schedule IV controlled substance pursuant to Health and Safety code section 11057, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code section 4022. It is used as a muscle relaxant.

86. On multiple occasions in or around May 2013 to December 2017, Respondent prescribed Soma to Patient D for pain.

87. In the period in or around May 2013 to December 2017 during which Respondent prescribed Soma to Patient D, Respondent failed to adequately establish or document a medical indication for Soma.

88. In the period in or around May 2013 to December 2017 during which Respondent prescribed Soma to Patient D, Patient D presented with multiple pertinent risk factors including, but not limited to, use of high-dose opiates and benzodiazepines, and a history of alcohol abuse.

89. In the period in or around May 2013 to December 2017 during which Respondent prescribed Soma to Patient D, Respondent failed to adequately counsel Patient D regarding the risks of Soma in conjunction with opiates, benzodiazepines or alcohol.

90. On multiple occasions in or around December 2013 to August 2017, Respondent prescribed phentermine[17] or phendimetrazine,[18] controlled-substance stimulants commonly used to suppress appetite and assist patients with weight loss, to Patient D.

91. Throughout the course of Respondent's prescribing of phentermine or phendimetrazine to Patient D in or about December 2013 to August 2017, Respondent failed to adequately establish or document a medical indication for the prescribing of phentermine or phendimetrazine to Patient D.

92. Throughout the course of Respondent's prescribing of phentermine or phendimetrazine to Patient D in or about December 2013 to August 2017, Respondent failed to adequately consider or discuss with Patient D treatment alternatives including, but not limited to, modifications to her diet, referral to a nutritionist, safer medications, or changes to Patient D's then-existing medication regimen.

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[17] Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a stimulant and an appetite suppressant.

[18] Phendimetrazine is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

93. Throughout the course of Respondent's prescribing of phentermine or phendimetrazine to Patient D in or about December 2013 to August 2017, Patient D had one or more documented contraindications for the use of phentermine or phendimetrazine including, but not limited to, paroxysmal supraventricular tachycardia, anxiety, insomnia, chest pain and risk factors for heart disease, and addiction.

94. On multiple occasions in or around August 2013 to April 2017, Respondent administered, or ordered the administration of, Depo-Provera[19] to Patient D for contraception or hormone replacement therapy.

95. In the period in or around August 2013 to April 2017 during which Respondent administered or ordered the administration of Depo-Provera to Patient D, Respondent failed to adequately counsel, or document counseling, Patient D regarding the risks of Depo-Provera.

96. In the period in or around August 2013 to April 2017 during which Respondent administered or ordered the administration of Depo-Provera to Patient D, Respondent failed to adequately monitor Patient D's bone density, bone turnover markers or other osteoporosis indicators.

97. On one or more occasions in or around May 2014 to December 2017, Respondent generated a progress note for Patient D that contained contradictory information.

98. Respondent failed to adequately monitor Patient D's liver function during the course of his care and treatment of Patient D following 2015.

99. Patient D's medical chart contained a copy of a CURES report dated February 20, 2014. Among other things, the CURES report showed that Patient D had received prescriptions for Suboxone, commonly used to treat opioid dependence, and hydrocodone from other healthcare providers. Respondent failed to address or document addressing these discrepancies with Patient D.

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[19] Depo-provera, a brand name for medroxyprogesterone, is a high-dose synthetic progesterone injection. It is indicated for contraception.

100. Respondent otherwise failed to review or document reviewing the CURES database for controlled substance prescriptions filled by Patient D throughout the course of his care and treatment of Patient D in or around 2014 to December 2017.

101. During the course of Respondent's care and treatment of Patient D in or around May 2013 to December 2017, Respondent only ordered and reviewed a toxicology drug screen for Patient D on, at most, two occasions in or around July or November 2017.

102. During the course of Respondent's care and treatment of Patient D in or around May 2013 to December 2017, Respondent failed to adequately screen Patient D for opiate use disorder.

103. During the course of Respondent's care and treatment of Patient D in or around May 2013 to December 2017, Respondent failed to adequately obtain or document informed consent from Patient D for treatment with opioids or opiates, stimulants, benzodiazepines, or Soma, or any combination thereof.

104. On multiple occasions during the course of Respondent's care and treatment of Patient D in or around October 2012 to December 2017, Respondent generated an illegible or difficult to read progress note for Patient D, or documented contradictory information in a progress note for Patient D.

105. Respondent committed gross negligence in his care and treatment of Patient D including, but not limited to:

(a) Improperly prescribing multiple high-dose opioids or opiates to Patient D.

(b) Inadequately monitoring Patient D's use of controlled substances.

(c) Improperly prescribing chronic benzodiazepines to Patient D.

(d) Improperly prescribing phentermine or phendimetrazine to Patient D.

***Patient G***

106. On or about November 4, 2015, "Patient G" presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented diagnoses of a hydrocele and painful scrotum, ordering a urology consultation and a

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testicular and scrotal ultrasound, and that the patient reported being previously treated with approximately 20 mg of oxycodone every five to six hours for pain control.

107. On or about November 4, 2015, Respondent prescribed a high dose of oxycodone, approximately four 20 mg tablets (120 MME) per day, to Patient G for pain.

108. On or about December 11, 2015, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G had not obtained an ultrasound or presented to a urologist since the prior appointment.

109. On or about December 11, 2015, Respondent documented renewing Patient G's prescription for oxycodone.

110. On or about June 1, 2016, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G had not obtained an ultrasound or presented to a urologist since the prior appointment.

111. On or about June 1, 2016, Respondent documented renewing Patient G's prescription for oxycodone.

112. On or about July 6, 2016, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G had not presented to a urologist since the prior appointment.

113. On or about July 6, 2016, Respondent prescribed a higher dose of approximately four 30 mg tablets of oxycodone (180 MME) per day to Patient G.

114. On or about July 15, 2016, Respondent reduced the potency of the tablets prescribed to Patient G, back to the 20 mg tablets, following reports from Patient G that the 30 mg tablets were upsetting his stomach and making him vomit.

115. On or about August 5, 2016, another healthcare provider affiliated with the medical practice at which Respondent regularly treated Patient G reduced Patient G's oxycodone prescription to approximately four 15 mg tablets (90 MME) per day.

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116. On or about September 21, 2016, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G reported fair pain control with the decreased oxycodone prescription, and an order for a pain management consultation.

117. On or about September 21, 2016, Respondent prescribed approximately four 15 mg tablets of oxycodone (90 MME) per day to Patient G.

118. On or about October 7, 2016, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G reported worsening pain, taking up to two 15 mg oxycodone tablets at a time, and that he was starting to run out of oxycodone. Respondent also documented that Patient G and had not presented to a pain management clinic as previously referred.

119. In his progress note for the appointment with Patient G on or about October 7, 2016, Respondent documented that CURES did not show any suspicious activity for Patient G.

120. In fact, the CURES database listed one or more medications containing a controlled substance, including, but not limited to, tramadol, that a healthcare provider unaffiliated with Respondent had prescribed or dispensed to Patient G in or around November 2015 to October 2016. The CURES database further listed that Patient G had obtained controlled substances from at least four different pharmacies or dispensing physicians during that period.

121. On or about October 7, 2016, Respondent prescribed approximately four 30 mg tablets of oxycodone (180 MME) per day to Patient G.

122. On or about November 18, 2016, Respondent renewed the prescription to Patient G for approximately four 30 mg tablets of oxycodone (180 MME) per day.

123. On or about December 9, 2016, Patient G presented to Respondent for medical care and treatment. In his progress note for this medical appointment with Patient G, Respondent documented that Patient G was doing well with his current regimen and that Patient G was requesting an early refill for travel.

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124. In his progress note for the medical appointment with Patient G on or about December 9, 2016, Respondent also documented prescribing a higher dose of approximately five 30 mg tablets of oxycodone (225 MME) per day to Patient G.

125. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to review or document the review of any ultrasound, urology consultation or pain management consultation.

126. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to adequately confirm his hydrocele diagnosis for Patient G or rule out other causes for scrotal swelling or pain.

127. On one or more occasions during the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent prescribed high-dose opioids or opiates to Patient G without adequate medical indication.

128. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to adequately consider or document consideration of treatment alternatives to opioid or opiate therapy for a hydrocele.

129. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to enter into a controlled substance agreement with Patient G, or otherwise discuss and document the risks of chronic opioid or opiate therapy with Patient G including, but not limited to, addiction, dependence, overdose or respiratory depression.

130. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to adequately order or review urine toxicology screenings for Patient G.

131. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to adequately assess Patient G's risk for opioid or opiate addiction or dependence.

132. Throughout the course of Respondent's care and treatment of Patient G in or around November 2015 to December 2016, Respondent failed to adequately review the CURES database

for controlled substance prescriptions filled by Patient G, or address any CURES entries for a controlled substance prescribed or dispensed by a healthcare provider unaffiliated with Respondent and the use of multiple pharmacies or dispensing physicians.

133. Respondent committed gross negligence in his care and treatment of Patient G in that he improperly prescribed high-dose opioids or opiates to Patient G for a hydrocele.

134. Respondent committed gross negligence in his care and treatment of Patient G in that he failed to adequately monitor the prescribing of controlled substances to Patient G.

**SECOND CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

135. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, subdivision (c) of the Code in that he committed repeated negligent acts. The circumstances are as follows:

136. Paragraphs 10 to 134, above, are hereby incorporated by reference as if fully set forth herein.

137. Respondent committed negligence in his care and treatment of Patient A including, but not limited to:

(a) Improper prescribing of high-dose, chronic benzodiazepines in combination with opioids or opiates.

(b) Failing to obtain or document adequate informed consent from Patient A for opioid, opiate or benzodiazepine medications.

(c) Improper treatment of back pain.

138. Respondent committed negligence in his care and treatment of Patient B including, but not limited to:

(a) Improper prescribing of benzodiazepines.

(b) Improper prescribing of methadone and citalopram in combination.

(c) Prescribing Adderall for depression to a patient with a history of drug dependence or addiction.

(d) Failing to obtain or document adequate informed consent from Patient B for chronic opioid, opiate, or benzodiazepine medications, or concomitant use of methadone and citalopram or Adderall.

139. Respondent committed negligence in his care and treatment of Patient C including, but not limited to:

(a) Improperly diagnosing and treating Patient C for ADD.

(b) Failing to obtain or document adequate informed consent from Patient C for oxycodone treatment.

(c) Failing to maintain adequate and accurate documentation for Patient C.

140. Respondent committed negligence in his care and treatment of Patient D including, but not limited to:

(a) Improperly prescribing Soma to Patient D.

(b) Failing to obtain or document adequate informed consent from Patient D for treatment with opioids or opiates, benzodiazepines, or Soma, or any combination thereof.

(c) Improper administration of Depo-provera to Patient D.

(d) Failing to maintain adequate and accurate documentation for Patient D.

***Patient E***

141. On multiple occasions in or around October 2006 to February 2016, Respondent rendered medical care or treatment to "Patient E," whose documented medical history includes, but is not limited to, ADD and hypothyroidism.

142. On or about September 26, 2012, and on multiple occasions thereafter through as late as in or around February 2016, Respondent prescribed to Patient E a high dose of short-acting Adderall, approximately 120 mg per day, for ADD.

143. On at least three occasions, on or about July 30, 2014, April 10, 2015, and October 23, 2015, Respondent concurrently prescribed at least 30 mg per day of extended-release Adderall to Patient E in addition to approximately 120 mg per day of short-acting Adderall.

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144. During the course of Respondent's prescribing of Adderall to Patient E in or around September 2012 to February 2016, Respondent failed to adequately order and review toxicology drug screens of Patient E, or review the CURES database for controlled substance prescriptions filled by Patient E.

145. During the course of Respondent's prescribing of Adderall to Patient E in or around September 2012 to February 2016, Respondent routinely documented normal heart rates and blood pressures for Patient E.

146. During the course of Respondent's prescribing of Adderall to Patient E in or around September 2012 to February 2016, Respondent failed to adequately assess, reevaluate or document Patient E's symptoms of ADD.

147. Respondent committed negligence in his care and treatment of Patient E including, but not limited to, failing to adequately monitor his treatment of Patient E for ADD.

***Patient F***

148. On multiple occasions in or around December 2012 to December 2016, Respondent rendered medical care and treatment to "Patient F," whose medical history includes, but is not limited to, peripheral neuropathy, anxiety, depression, shoulder pain, knee pain, and opioid dependence.

149. On multiple occasions in or around June 2014 to November 2014, Respondent prescribed approximately 3 mg per day of lorazepam, a benzodiazepine, to Patient F for anxiety.

150. On multiple occasions in or around December 2014 to August 2017, Respondent prescribed approximately 1 to 2 mg per day of clonazepam, a benzodiazepine, to Patient F for anxiety.

151. On or about January 23, 2015, and on multiple occasions thereafter through as late as on or about August 23, 2017, Respondent prescribed approximately 30 mg per day of temazepam,[20] a benzodiazepine, to Patient F for insomnia.

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[20] Temazepam 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.

152. In the period in or around June 2014 to August 2017 during which Respondent prescribed one or more benzodiazepines to Patient F, Respondent also concomitantly prescribed multiple opioid or opiate medications to Patient F including, but not limited to, oxycodone, OxyContin (long-acting oxycodone), fentanyl, or Suboxone.

153. In the period in or around June 2014 to August 2017 during which Respondent prescribed one or more benzodiazepines to Patient F, Respondent failed to adequately counsel or document counseling Patient F regarding the risks of benzodiazepines taken in combination with opioid or opiate medications.

154. In the period in or around June 2014 to August 2017 during which Respondent prescribed one or more benzodiazepines to Patient F, Respondent failed to refer or offer to refer Patient F for psychiatric evaluation or treatment.

155. Respondent committed negligence in his care and treatment of Patient F including, but not limited to, improperly prescribing chronic benzodiazepines concomitantly with opioids or opiates to Patient F.

## THIRD CAUSE FOR DISCIPLINE

**(Incompetence)**

156. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, subdivision (d) of the Code in that he exhibited incompetence regarding the care and treatment of a patient with substance abuse disorders as more particularly alleged in paragraphs 23 to 47, and 138, above, which are hereby incorporated by reference as if fully set forth herein.

## FOURTH CAUSE FOR DISCIPLINE

**(Prescribing, Dispensing, or Furnishing of a Dangerous Drug Without an Appropriate Prior Examination and Medical Indication)**

157. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, as defined by section 2242, subdivision (a), of the Code in that he prescribed, dispensed, or furnished a dangerous drug on one or more occasions without an appropriate prior examination

and medical indication as more particularly alleged in paragraphs 10 to 156, above, which are hereby incorporated by reference as if fully set forth herein.

**FIFTH CAUSE FOR DISCIPLINE**

**(Repeated Acts of Clearly Excessive Prescribing)**

158. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, as defined by section 725, subdivision (a), of the Code in that he committed repeated acts of clearly excessive prescribing, furnishing, dispensing or administering of a drug or treatment as more particularly alleged in paragraphs 10 to 157, above, which are hereby incorporated by reference as if fully set forth herein.

**SIXTH CAUSE FOR DISCIPLINE**

**(Violation of Federal or State Statute or Regulation Regulating Dangerous Drugs or Controlled Substances)**

159. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, as defined by section 2238, of the Code in that he violated one or more federal or state statutes or regulations regulating dangerous drugs or controlled substances by prescribing methadone to a patient for heroin dependence or addiction as more particularly alleged in paragraphs 23 to 47, and 138, above, which are hereby incorporated by reference as if fully set forth herein.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Records)**

160. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code in that he failed to maintain adequate and accurate records relating to the provision of services to one or more patients as more particularly alleged in paragraphs 48 to 105, and 139 to 140, above, which are hereby incorporated by reference as if fully set forth herein.

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## EIGHTH CAUSE FOR DISCIPLINE

**(Violating One or More Provisions of the Medical Practice Act)**

161. Respondent Ariel Alexander Cortes, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63637 to disciplinary action under sections 2227 and 2234, subdivision (a) of the Code in that he violated or attempted to violate, directly or indirectly, any provision of the Medical Practice Act as more particularly alleged in paragraphs 10 to 160, above, which are hereby incorporated by reference and realleged 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 Number A 63637, issued to Ariel Alexander Cortes, M.D.;

2. Revoking, suspending or denying approval of Ariel Alexander Cortes, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Ariel Alexander Cortes, 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: December 6, 2019

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*