

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

In the Matter of the Accusation
Against:

Daniel S. Sewell, M.D.

Physician's and Surgeon's
License No. A 87909

Respondent.

Case No. 800-2016-026947

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 5, 2020.

IT IS SO ORDERED: October 6, 2020.

MEDICAL BOARD OF CALIFORNIA



Kristina D. Lawson, J.D., Chair
Panel B

1 XAVIER BECERRA
Attorney General of California
2 STEVEN D. MUNI
Supervising Deputy Attorney General
3 AARON L. LENT
Deputy Attorney General
4 State Bar No. 256857
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7

8 *Attorneys for Complainant*

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

13 In the Matter of the Accusation Against:
14 **DANIEL S. SEWELL, M.D.**
15 **13555 Bowman Rd., Ste. 100**
Auburn, CA 95603-9560
16 **Physician's and Surgeon's Certificate**
17 **No. A 87909**
18 Respondent.

Case No. 800-2016-026947
OAH No. 2020020429
**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

19
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
24 California (Board). This action was brought by then Complainant Kimberly Kirchmeyer solely in
25 her official capacity.¹ Complainant is represented in this matter by Xavier Becerra, Attorney
26 General of the State of California, by Aaron L. Lent, Deputy Attorney General.

27
28 ¹ Ms. Kirchmeyer became the Director of the Department of Consumer Affairs on October 28, 2019.

1 2. Respondent Daniel S. Sewell, M.D. (Respondent) is represented in this proceeding by
2 attorney Nicholas J. Leonard, whose address is: 2150 River Plaza Drive, Ste. 250, Sacramento,
3 CA 95833.

4 3. On or about January 30, 2004, the Board issued Physician's and Surgeon's Certificate
5 No. A 87909 to Daniel S. Sewell, M.D. (Respondent). The Physician's and Surgeon's Certificate
6 was in full force and effect at all times relevant to the charges brought in Accusation No. 800-
7 2016-026947, and will expire on April 30, 2022, unless renewed.

8 **JURISDICTION**

9 4. Accusation No. 800-2016-026947 was filed before the Board, and is currently
10 pending against Respondent. The Accusation and all other statutorily required documents were
11 properly served on Respondent on October 4, 2019. Respondent timely filed his Notice of
12 Defense contesting the Accusation.

13 5. A copy of Accusation No. 800-2016-026947 is attached as exhibit A and incorporated
14 herein by reference.

15 **ADVISEMENT AND WAIVERS**

16 6. Respondent has carefully read, fully discussed with counsel, and understands the
17 charges and allegations in Accusation No. 800-2016-026947. Respondent has also carefully read,
18 fully discussed with his counsel, and understands the effects of this Stipulated Settlement and
19 Disciplinary Order.

20 7. Respondent is fully aware of his legal rights in this matter, including the right to a
21 hearing on the charges and allegations in the Accusation; the right to confront and cross-examine
22 the witnesses against him; the right to present evidence and to testify on his own behalf; the right
23 to the issuance of subpoenas to compel the attendance of witnesses and the production of
24 documents; the right to reconsideration and court review of an adverse decision; and all other
25 rights accorded by the California Administrative Procedure Act and other applicable laws.

26 8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and
27 every right set forth above.

28 ///

1 **CULPABILITY**

2 9. Respondent understands and agrees that the charges and allegations in Accusation
3 No. 800-2016-026947, if proven at a hearing, constitute cause for imposing discipline upon his
4 Physician's and Surgeon's Certificate.

5 10. Respondent does not contest that, at an administrative hearing, Complainant could
6 establish a *prima facie* case with respect to the charges and allegations contained in Accusation
7 No. 800-2016-026947 and that he has thereby subjected his license to disciplinary action.

8 11. Respondent agrees that if he ever petitions for early termination or modification of
9 probation, or if an accusation and/or petition to revoke probation is filed against him before the
10 Board, all of the charges and allegations contained in Accusation No. 800-2016-026947 shall be
11 deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or
12 any other licensing proceeding involving Respondent in the State of California.

13 12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to
14 discipline and he agrees to be bound by the Board's probationary terms as set forth in the
15 Disciplinary Order below.

16 **RESERVATION**

17 13. The admissions made by Respondent herein are only for the purposes of this
18 proceeding, or any other proceedings in which the Medical Board of California or other
19 professional licensing agency is involved, and shall not be admissible in any other criminal or
20 civil proceeding.

21 **CONTINGENCY**

22 14. This stipulation shall be subject to approval by the Medical Board of California.
23 Respondent understands and agrees that counsel for Complainant and the staff of the Medical
24 Board of California may communicate directly with the Board regarding this stipulation and
25 settlement, without notice to or participation by Respondent or his counsel. By signing the
26 stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek
27 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails
28 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary

1 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal
2 action between the parties, and the Board shall not be disqualified from further action by having
3 considered this matter.

4 15. The parties understand and agree that Portable Document Format (PDF) and facsimile
5 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
6 signatures thereto, shall have the same force and effect as the originals.

7 16. In consideration of the foregoing admissions and stipulations, the parties agree that
8 the Board may, without further notice or opportunity to be heard by the Respondent, issue and
9 enter the following Disciplinary Order:

10 **DISCIPLINARY ORDER**

11 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 87909 issued
12 to Respondent Daniel S. Sewell, M.D. is revoked. However, the revocation is stayed and
13 Respondent is placed on probation for three (3) years on the following terms and conditions:

14 1. STANDARD STAY ORDER. However, revocation stayed and Respondent is placed
15 on probation for three years upon the following terms and conditions.

16 2. EDUCATION COURSE. Within 60 calendar days of the effective date of this
17 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
18 for its prior approval educational program(s) or course(s) which shall not be less than 40 hours
19 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
20 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
21 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
22 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
23 completion of each course, the Board or its designee may administer an examination to test
24 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
25 hours of CME of which 40 hours were in satisfaction of this condition.

26 3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective
27 date of this Decision, Respondent shall enroll in a course in prescribing practices approved in
28 advance by the Board or its designee. Respondent shall provide the approved course provider

1 with any information and documents that the approved course provider may deem pertinent.
2 Respondent shall participate in and successfully complete the classroom component of the course
3 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
4 complete any other component of the course within one (1) year of enrollment. The prescribing
5 practices course shall be at Respondent's expense and shall be in addition to the Continuing
6 Medical Education (CME) requirements for renewal of licensure.

7 A prescribing practices course taken after the acts that gave rise to the charges in the
8 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
9 or its designee, be accepted towards the fulfillment of this condition if the course would have
10 been approved by the Board or its designee had the course been taken after the effective date of
11 this Decision.

12 Respondent shall submit a certification of successful completion to the Board or its
13 designee not later than 15 calendar days after successfully completing the course, or not later than
14 15 calendar days after the effective date of the Decision, whichever is later.

15 4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
16 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
17 advance by the Board or its designee. Respondent shall provide the approved course provider
18 with any information and documents that the approved course provider may deem pertinent.
19 Respondent shall participate in and successfully complete the classroom component of the course
20 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
21 complete any other component of the course within one (1) year of enrollment. The medical
22 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
23 Medical Education (CME) requirements for renewal of licensure.

24 A medical record keeping course taken after the acts that gave rise to the charges in the
25 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
26 or its designee, be accepted towards the fulfillment of this condition if the course would have
27 been approved by the Board or its designee had the course been taken after the effective date of
28 this Decision.

1 Respondent shall submit a certification of successful completion to the Board or its
2 designee not later than 15 calendar days after successfully completing the course, or not later than
3 15 calendar days after the effective date of the Decision, whichever is later.

4 5. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of
5 the effective date of this Decision, Respondent shall enroll in a professionalism program, that
6 meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1.
7 Respondent shall participate in and successfully complete that program. Respondent shall
8 provide any information and documents that the program may deem pertinent. Respondent shall
9 successfully complete the classroom component of the program not later than six (6) months after
10 Respondent's initial enrollment, and the longitudinal component of the program not later than the
11 time specified by the program, but no later than one (1) year after attending the classroom
12 component. The professionalism program shall be at Respondent's expense and shall be in
13 addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

14 A professionalism program taken after the acts that gave rise to the charges in the
15 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
16 or its designee, be accepted towards the fulfillment of this condition if the program would have
17 been approved by the Board or its designee had the program been taken after the effective date of
18 this Decision.

19 Respondent shall submit a certification of successful completion to the Board or its
20 designee not later than 15 calendar days after successfully completing the program or not later
21 than 15 calendar days after the effective date of the Decision, whichever is later.

22 6. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this
23 Decision, Respondent shall submit to the Board or its designee for prior approval as a practice
24 monitor, the name and qualifications of one or more licensed physicians and surgeons whose
25 licenses are valid and in good standing, and who are preferably American Board of Medical
26 Specialties (ABMS) certified. A monitor shall have no prior or current business or personal
27 relationship with Respondent, or other relationship that could reasonably be expected to
28 compromise the ability of the monitor to render fair and unbiased reports to the Board, including

1 but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree
2 to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

3 The Board or its designee shall provide the approved monitor with copies of the Decision(s)
4 and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the
5 Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed
6 statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role
7 of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees
8 with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the
9 signed statement for approval by the Board or its designee.

10 Within 60 calendar days of the effective date of this Decision, and continuing throughout
11 probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall
12 make all records available for immediate inspection and copying on the premises by the monitor
13 at all times during business hours and shall retain the records for the entire term of probation.

14 If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective
15 date of this Decision, Respondent shall receive a notification from the Board or its designee to
16 cease the practice of medicine within three (3) calendar days after being so notified. Respondent
17 shall cease the practice of medicine until a monitor is approved to provide monitoring
18 responsibility.

19 The monitor(s) shall submit a quarterly written report to the Board or its designee which
20 includes an evaluation of Respondent's performance, indicating whether Respondent's practices
21 are within the standards of practice of medicine, and whether Respondent is practicing medicine
22 safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure
23 that the monitor submits the quarterly written reports to the Board or its designee within 10
24 calendar days after the end of the preceding quarter.

25 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
26 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
27 name and qualifications of a replacement monitor who will be assuming that responsibility within
28 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60

1 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
2 notification from the Board or its designee to cease the practice of medicine within three (3)
3 calendar days after being so notified. Respondent shall cease the practice of medicine until a
4 replacement monitor is approved and assumes monitoring responsibility.

5 In lieu of a monitor, Respondent may participate in a professional enhancement program
6 approved in advance by the Board or its designee that includes, at minimum, quarterly chart
7 review, semi-annual practice assessment, and semi-annual review of professional growth and
8 education. Respondent shall participate in the professional enhancement program at Respondent's
9 expense during the term of probation.

10 7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
11 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the
12 Chief Executive Officer at every hospital where privileges or membership are extended to
13 Respondent, at any other facility where Respondent engages in the practice of medicine,
14 including all physician and locum tenens registries or other similar agencies, and to the Chief
15 Executive Officer at every insurance carrier which extends malpractice insurance coverage to
16 Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15
17 calendar days.

18 This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

19 8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE
20 NURSES. During probation, Respondent is prohibited from supervising physician assistants and
21 advanced practice nurses.

22 9. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules
23 governing the practice of medicine in California and remain in full compliance with any court
24 ordered criminal probation, payments, and other orders.

25 10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations
26 under penalty of perjury on forms provided by the Board, stating whether there has been
27 compliance with all the conditions of probation.

28 Respondent shall submit quarterly declarations not later than 10 calendar days after the end

1 of the preceding quarter.

2 11. GENERAL PROBATION REQUIREMENTS.

3 Compliance with Probation Unit

4 Respondent shall comply with the Board's probation unit.

5 Address Changes

6 Respondent shall, at all times, keep the Board informed of Respondent's business and
7 residence addresses, email address (if available), and telephone number. Changes of such
8 addresses shall be immediately communicated in writing to the Board or its designee. Under no
9 circumstances shall a post office box serve as an address of record, except as allowed by Business
10 and Professions Code section 2021, subdivision (b).

11 Place of Practice

12 Respondent shall not engage in the practice of medicine in Respondent's or patient's place
13 of residence, unless the patient resides in a skilled nursing facility or other similar licensed
14 facility.

15 License Renewal

16 Respondent shall maintain a current and renewed California physician's and surgeon's
17 license.

18 Travel or Residence Outside California

19 Respondent shall immediately inform the Board or its designee, in writing, of travel to any
20 areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty
21 (30) calendar days.

22 In the event Respondent should leave the State of California to reside or to practice,
23 Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of
24 departure and return.

25 12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
26 available in person upon request for interviews either at Respondent's place of business or at the
27 probation unit office, with or without prior notice throughout the term of probation.

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1 13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
2 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
3 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
4 defined as any period of time Respondent is not practicing medicine as defined in Business and
5 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
6 patient care, clinical activity or teaching, or other activity as approved by the Board. If
7 Respondent resides in California and is considered to be in non-practice, Respondent shall
8 comply with all terms and conditions of probation. All time spent in an intensive training
9 program which has been approved by the Board or its designee shall not be considered non-
10 practice and does not relieve Respondent from complying with all the terms and conditions of
11 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
12 on probation with the medical licensing authority of that state or jurisdiction shall not be
13 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
14 period of non-practice.

15 In the event Respondent's period of non-practice while on probation exceeds 18 calendar
16 months, Respondent shall successfully complete the Federation of State Medical Board's Special
17 Purpose Examination, or, at the Board's discretion, a clinical competence assessment program
18 that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model
19 Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

20 Respondent's period of non-practice while on probation shall not exceed two (2) years.

21 Periods of non-practice will not apply to the reduction of the probationary term.

22 Periods of non-practice for a Respondent residing outside of California will relieve
23 Respondent of the responsibility to comply with the probationary terms and conditions with the
24 exception of this condition and the following terms and conditions of probation: Obey All Laws;
25 General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or
26 Controlled Substances; and Biological Fluid Testing.

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1 14. COMPLETION OF PROBATION. Respondent shall comply with all financial
2 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
3 completion of probation. Upon successful completion of probation, Respondent's certificate shall
4 be fully restored.

5 15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
6 of probation is a violation of probation. If Respondent violates probation in any respect, the
7 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
8 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,
9 or an Interim Suspension Order is filed against Respondent during probation, the Board shall have
10 continuing jurisdiction until the matter is final, and the period of probation shall be extended until
11 the matter is final.

12 16. LICENSE SURRENDER. Following the effective date of this Decision, if
13 Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy
14 the terms and conditions of probation, Respondent may request to surrender his or her license.
15 The Board reserves the right to evaluate Respondent's request and to exercise its discretion in
16 determining whether or not to grant the request, or to take any other action deemed appropriate
17 and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent
18 shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its
19 designee and Respondent shall no longer practice medicine. Respondent will no longer be subject
20 to the terms and conditions of probation. If Respondent re-applies for a medical license, the
21 application shall be treated as a petition for reinstatement of a revoked certificate.

22 17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated
23 with probation monitoring each and every year of probation, as designated by the Board, which
24 may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of
25 California and delivered to the Board or its designee no later than January 31 of each calendar
26 year.

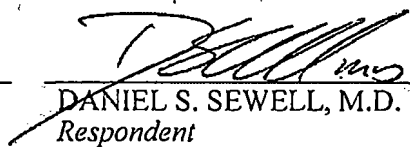
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1 18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
2 a new license or certification, or petition for reinstatement of a license, by any other health care
3 licensing action agency in the State of California, all of the charges and allegations contained in
4 Accusation No. 800-2016-026947 shall be deemed to be true, correct, and admitted by
5 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
6 restrict license.

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1 ACCEPTANCE

2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
3 discussed it with my attorney, Nicholas J. Leonard. I understand the stipulation and the effect it
4 will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and
5 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
6 Decision and Order of the Medical Board of California.

7
8 DATED: 8/7/20 
9 DANIEL S. SEWELL, M.D.
Respondent

10 I have read and fully discussed with Respondent Daniel S. Sewell, M.D. the terms and
11 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
12 I approve its form and content.

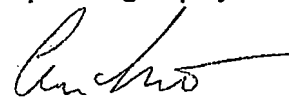
13 DATED: 8/7/20 
14 NICHOLAS J. LEONARD
Attorney for Respondent

15
16 ENDORSEMENT

17 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
18 submitted for consideration by the Medical Board of California.

19
20 DATED: 8/7/2020

Respectfully submitted,
XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

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22
23 
24 AARON L. LENT
25 Deputy Attorney General
26 *Attorneys for Complainant*

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Exhibit A

Accusation No. 800-2016-026947

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8 *Attorneys for Complainant*

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

13
14 In the Matter of the Accusation Against:

Case No. 800-2016-026947

15 **Daniel S. Sewell, M.D.**
13555 Bowman Rd., Ste. 100
16 Auburn, CA 95603-9560

ACCUSATION

17 Physician's and Surgeon's Certificate No. A 87909,
18 Respondent.

19
20 **PARTIES**

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

24 2. On or about June 30, 2004, the Medical Board issued Physician's and Surgeon's
25 Certificate No. A 87909 to Daniel S. Sewell, M.D. (Respondent). That Certificate was in full
26 force and effect at all times relevant to the charges brought herein and will expire on April 30,
27 2020, unless renewed.

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JURISDICTION

10 3. This Accusation is brought before the Board, under the authority of the following
11 laws. All section references are to the Business and Professions Code (Code) unless otherwise
12 indicated.
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14 4. Section 2227 of the Code provides, in pertinent part, that a licensee who is found
15 guilty under the Medical Practice Act may have his or her license revoked, suspended for a period
16 not to exceed one year, placed on probation and required to pay the costs of probation monitoring,
17 or such other action taken in relation to discipline as the Board deems proper.

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STATUTORY PROVISIONS

22 5. Section 2228.1 of the Code states, in pertinent part:

23 (a) On and after July 1, 2019, except as otherwise provided in subdivision (c),
24 the board shall require a licensee to provide a separate disclosure that includes the
25 licensee's probation status, the length of the probation, the probation end date, all
26 practice restrictions placed on the licensee by the board, the board's telephone
27 number, and an explanation of how the patient can find further information on the
28 licensee's probation on the licensee's profile page on the board's online license
information Internet Web site, to a patient or the patient's guardian or health care
surrogate before the patient's first visit following the probationary order while the
licensee is on probation pursuant to a probationary order made on and after July 1,
2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or
admitted findings or prima facie showing in a stipulated settlement establishing any
of the following:

(D) Inappropriate prescribing resulting in harm to patients and a probationary
period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any
of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a
stipulated settlement based upon a nolo contendere or other similar compromise that
does not include any prima facie showing or admission of guilt or fact but does
include an express acknowledgment that the disclosure requirements of this section
would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall
obtain from the patient, or the patient's guardian or health care surrogate, a separate,
signed copy of that disclosure.

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1 (d) On and after July 1, 2019, the board shall provide the following
2 information, with respect to licensees on probation and licensees practicing under
3 probationary licenses, in plain view on the licensee's profile page on the board's
4 online license information Internet Web site.

5 (1) For probation imposed pursuant to a stipulated settlement, the causes
6 alleged in the operative accusation along with a designation identifying those causes
7 by which the licensee has expressly admitted guilt and a statement that acceptance of
8 the settlement is not an admission of guilt.

9 (2) For probation imposed by an adjudicated decision of the board, the causes
10 for probation stated in the final probationary order.

11 (3) For a licensee granted a probationary license, the causes by which the
12 probationary license was imposed.

13 (4) The length of the probation and end date.

14 (5) All practice restrictions placed on the license by the board.

15 ...

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

17 The board shall take action against any licensee who is charged with
18 unprofessional conduct. In addition to other provisions of this article, unprofessional
19 conduct includes, but is not limited to, the following:

20 (a) Violating or attempting to violate, directly or indirectly, assisting in or
21 abetting the violation of, or conspiring to violate any provision of this chapter.

22 (b) Gross negligence.

23 (c) Repeated negligent acts. To be repeated, there must be two or more
24 negligent acts or omissions. An initial negligent act or omission followed by a
25 separate and distinct departure from the applicable standard of care shall constitute
26 repeated negligent acts.

27 (1) An initial negligent diagnosis followed by an act or omission medically
28 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.

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1 7. Section 2266 of the Code states, in pertinent part:

2 The failure of a physician and surgeon to maintain adequate and accurate records
3 relating to the provision of services to their patients constitutes unprofessional conduct.

4 8. Section 3502 of the Code states, in pertinent part:

5 (a) Notwithstanding any other law, a physician assistant may perform those medical
6 services as set forth by the regulations adopted under this chapter when the services are
7 rendered under the supervision of a licensed physician and surgeon who is not subject to a
8 disciplinary condition imposed by the Medical Board of California prohibiting that
supervision or prohibiting the employment of a physician assistant. The medical record,
for each episode of care for a patient, shall identify the physician and surgeon who is
responsible for the supervision of the physician assistant.

9 (b)(1) Notwithstanding any other law, a physician assistant performing medical
10 services under the supervision of a physician and surgeon may assist a doctor of podiatric
11 medicine who is a partner, shareholder, or employee in the same medical group as the
12 supervising physician and surgeon. A physician assistant who assists a doctor of podiatric
13 medicine pursuant to this subdivision shall do so only according to patient-specific orders
14 from the supervising physician and surgeon.

15 (2) The supervising physician and surgeon shall be physically available to the
16 physician assistant for consultation when that assistance is rendered. A physician assistant
17 assisting a doctor of podiatric medicine shall be limited to performing those duties included
18 within the scope of practice of a doctor of podiatric medicine.

19 (c)(1) A physician assistant and his or her supervising physician and surgeon shall
20 establish written guidelines for the adequate supervision of the physician assistant. This
21 requirement may be satisfied by the supervising physician and surgeon adopting protocols
22 for some or all of the tasks performed by the physician assistant. The protocols adopted
23 pursuant to this subdivision shall comply with the following requirements:

24 (A) A protocol governing diagnosis and management shall, at a minimum, include
25 the presence or absence of symptoms, signs, and other data necessary to establish a
26 diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to
27 the patient, and education to be provided to the patient.

28 (B) A protocol governing procedures shall set forth the information to be provided to
the patient, the nature of the consent to be obtained from the patient, the preparation and
technique of the procedure, and the followup care.

(C) Protocols shall be developed by the supervising physician and surgeon or
adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and
the physician assistant.

(2)(A) The supervising physician and surgeon shall use one or more of the following
mechanisms to ensure adequate supervision of the physician assistant functioning under the
protocols:

1 (i) The supervising physician and surgeon shall review, countersign, and date a
2 sample consisting of, at a minimum, 5 percent of the medical records of patients treated by
3 the physician assistant functioning under the protocols within 30 days of the date of
4 treatment by the physician assistant.

5 (ii) The supervising physician and surgeon and physician assistant shall conduct a
6 medical records review meeting at least once a month during at least 10 months of the year.
7 During any month in which a medical records review meeting occurs, the supervising
8 physician and surgeon and physician assistant shall review an aggregate of at least 10
9 medical records of patients treated by the physician assistant functioning under protocols.
10 Documentation of medical records reviewed during the month shall be jointly signed and
11 dated by the supervising physician and surgeon and the physician assistant.

12 (iii) The supervising physician and surgeon shall review a sample of at least 10
13 medical records per month, at least 10 months during the year, using a combination of the
14 countersignature mechanism described in clause (i) and the medical records review meeting
15 mechanism described in clause (ii). During each month for which a sample is reviewed, at
16 least one of the medical records in the sample shall be reviewed using the mechanism
17 described in clause (i) and at least one of the medical records in the sample shall be
18 reviewed using the mechanism described in clause (ii).

19 (B) In complying with subparagraph (A), the supervising physician and surgeon shall
20 select for review those cases that by diagnosis, problem, treatment, or procedure represent,
21 in his or her judgment, the most significant risk to the patient.

22 (3) Notwithstanding any other law, the Medical Board of California or the board may
23 establish other alternative mechanisms for the adequate supervision of the physician
24 assistant.

25 (d) No medical services may be performed under this chapter in any of the following
26 areas:

27 (1) The determination of the refractive states of the human eye, or the fitting or
28 adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection
with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses
to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as
defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the
performance of routine visual screening as defined in Section 3501.

(f) Compliance by a physician assistant and supervising physician and surgeon with this
section shall be deemed compliance with Section 1399.546 of Title 16 of the California
Code of Regulations.

///

1 9. Section 3502.1 of the Code states, in pertinent part:

2 (a) In addition to the services authorized in the regulations adopted by the Medical
3 Board of California, and except as prohibited by Section 3502, while under the supervision
4 of a licensed physician and surgeon or physicians and surgeons authorized by law to
5 supervise a physician assistant, a physician assistant may administer or provide medication
6 to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order
7 to a person who may lawfully furnish the medication or medical device pursuant to
8 subdivisions (c) and (d).

9 (1) A supervising physician and surgeon who delegates authority to issue a drug
10 order to a physician assistant may limit this authority by specifying the manner in which the
11 physician assistant may issue delegated prescriptions.

12 (2) Each supervising physician and surgeon who delegates the authority to issue a
13 drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice
14 specific, formulary and protocols that specify all criteria for the use of a particular drug or
15 device, and any contraindications for the selection. Protocols for Schedule II controlled
16 substances shall address the diagnosis of illness, injury, or condition for which the Schedule
17 II controlled substance is being administered, provided, or issued. The drugs listed in the
18 protocols shall constitute the formulary and shall include only drugs that are appropriate for
19 use in the type of practice engaged in by the supervising physician and surgeon. When
20 issuing a drug order, the physician assistant is acting on behalf of and as an agent for a
21 supervising physician and surgeon.

22 (b) "Drug order," for purposes of this section, means an order for medication that is
23 dispensed to or for a patient, issued and signed by a physician assistant acting as an
24 individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of
25 Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued
26 pursuant to this section shall be treated in the same manner as a prescription or order of the
27 supervising physician, (2) all references to "prescription" in this code and the Health and
28 Safety Code shall include drug orders issued by physician assistants pursuant to authority
granted by their supervising physicians and surgeons, and (3) the signature of a physician
assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of
this code and the Health and Safety Code.

(c) A drug order for any patient cared for by the physician assistant that is issued by
the physician assistant shall either be based on the protocols described in subdivision (a) or
shall be approved by the supervising physician and surgeon before it is filled or carried out.

(1) A physician assistant shall not administer or provide a drug or issue a drug order
for a drug other than for a drug listed in the formulary without advance approval from a
supervising physician and surgeon for the particular patient. At the direction and under the
supervision of a physician and surgeon, a physician assistant may hand to a patient of the
supervising physician and surgeon a properly labeled prescription drug prepackaged by a
physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

(2) A physician assistant shall not administer, provide, or issue a drug order to a
patient for Schedule II through Schedule V controlled substances without advance approval
by a supervising physician and surgeon for that particular patient unless the physician
assistant has completed an education course that covers controlled substances and that

1 meets standards, including pharmacological content, approved by the board. The
2 education course shall be provided either by an accredited continuing education provider or
3 by an approved physician assistant training program. If the physician assistant will
4 administer, provide, or issue a drug order for Schedule II controlled substances, the course
5 shall contain a minimum of three hours exclusively on Schedule II controlled substances.
6 Completion of the requirements set forth in this paragraph shall be verified and documented
7 in the manner established by the board prior to the physician assistant's use of a registration
8 number issued by the United States Drug Enforcement Administration to the physician
9 assistant to administer, provide, or issue a drug order to a patient for a controlled substance
10 without advance approval by a supervising physician and surgeon for that particular patient.

11 (3) Any drug order issued by a physician assistant shall be subject to a reasonable
12 quantitative limitation consistent with customary medical practice in the supervising
13 physician and surgeon's practice.

14 (d) A written drug order issued pursuant to subdivision (a), except a written drug
15 order in a patient's medical record in a health facility or medical practice, shall contain the
16 printed name, address, and telephone number of the supervising physician and surgeon, the
17 printed or stamped name and license number of the physician assistant, and the signature of
18 the physician assistant. Further, a written drug order for a controlled substance, except a
19 written drug order in a patient's medical record in a health facility or a medical practice,
20 shall include the federal controlled substances registration number of the physician assistant
21 and shall otherwise comply with Section 11162.1 of the Health and Safety Code. Except
22 as otherwise required for written drug orders for controlled substances under Section
23 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met
24 through stamping or otherwise imprinting on the supervising physician and surgeon's
25 prescription blank to show the name, license number, and if applicable, the federal
26 controlled substances registration number of the physician assistant, and shall be signed by
27 the physician assistant. When using a drug order, the physician assistant is acting on
28 behalf of and as the agent of a supervising physician and surgeon.

(e) The supervising physician and surgeon shall use either of the following
mechanisms to ensure adequate supervision of the administration, provision, or issuance by
a physician assistant of a drug order to a patient for Schedule II controlled substances:

(1) The medical record of any patient cared for by a physician assistant for whom the
physician assistant's Schedule II drug order has been issued or carried out shall be
reviewed, countersigned, and dated by a supervising physician and surgeon within seven
days.

(2) If the physician assistant has documentation evidencing the successful
completion of an education course that covers controlled substances, and that controlled
substance education course (A) meets the standards, including pharmacological content,
established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of
Regulations, and (B) is provided either by an accredited continuing education provider or
by an approved physician assistant training program, the supervising physician and surgeon
shall review, countersign, and date, within seven days, a sample consisting of the medical
records of at least 20 percent of the patients cared for by the physician assistant for whom
the physician assistant's Schedule II drug order has been issued or carried out. Completion
of the requirements set forth in this paragraph shall be verified and documented in the

1 manner established in Section 1399.612 of Title 16 of the California Code of Regulations.
2 Physician assistants who have a certificate of completion of the course described in
3 paragraph (2) of subdivision (c) shall be deemed to have met the education course
4 requirement of this subdivision.

5 (f) All physician assistants who are authorized by their supervising physicians to
6 issue drug orders for controlled substances shall register with the United States Drug
7 Enforcement Administration (DEA).

8 (g) The board shall consult with the Medical Board of California and report during its
9 sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of
10 Part 1 of Division 2 of Title 2 of the Government Code the impacts of exempting Schedule
11 III and Schedule IV drug orders from the requirement for a physician and surgeon to review
12 and countersign the affected medical record of a patient.

13 10. Section 3527¹ of the Code states, in pertinent part:

14 ...

15 (c) The Medical Board of California may order the denial of an application for, or the
16 issuance subject to terms and conditions of, or the suspension or revocation of, or the
17 imposition of probationary conditions upon, an approval to supervise a physician assistant,
18 after a hearing as required in Section 3528, for unprofessional conduct, which includes, but
19 is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a
20 violation of the regulations adopted by the board or the Medical Board of California.

21 ...

22 REGULATORY PROVISIONS

23 11. California Code of Regulations, title 16, section 1399.541, states, in pertinent part:

24 Because physician assistant practice is directed by a supervising physician, and a
25 physician assistant acts as an agent for that physician, the orders given and tasks performed
26 by a physician assistant shall be considered the same as if they had been given and
27 performed by the supervising physician...

28 ...

29 PERTINENT DRUG INFORMATION

30 12. Oxycodone – Generic name for Roxicodone and Oxecta. Oxycodone has a high risk
31 for addiction and dependence. It can cause respiratory distress and death when taken in high
32 doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting

33 ¹ Effective: January 1, 2013. The previous language of section 3527, as set forth between
34 January 1, 2008, to December 31, 2012, underwent stylistic changes but no substantive changes
35 occurred.

1 opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting
2 formulation known as Oxycontin-ER. This formulation allows for extended release of the
3 medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal
4 Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California
5 Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant
6 to California Health and Safety Code section 11055 subdivision (b).

7 13. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet
8 is a short acting semi-synthetic opioid analgesic used to treat moderate to severe pain. Percocet is
9 a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section
10 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code
11 section 4022, and is a Schedule II controlled substance pursuant to Health and Safety Code
12 section 11055 subdivision (b).

13 14. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and
14 Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination
15 product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a
16 Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section
17 1308.12. Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business
18 and Professions Code section 4022 and is a Schedule II controlled substance pursuant to
19 California Health and Safety Code section 11055, subdivision (b)..

20 15. Morphine sulfate – Generic name for the drugs MSIR (“instant release”) and MSER
21 also known as MS Contin (“extended release”). Morphine sulfate is an opioid analgesic drug. It
22 is the main psychoactive chemical in opium. Like other opioids, such as oxycodone,
23 hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to
24 relieve pain. Morphine is a Schedule II controlled substance pursuant to Code of Federal
25 Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to
26 Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and
27 Professions Code section 4022.

28

1 16. Pethidine – Also known as meperidine, generic name for the drug Demerol.
2 Pethidine is a synthetic opioid pain medication of the phenylpiperidine class. Pethidine is a
3 Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section
4 1308.12. Pethidine is a Schedule II controlled substance pursuant to Health and Safety Code
5 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section
6 4022.

7 17. Buprenorphine – Generic name for Butrans. Buprenorphine is an opioid used to treat
8 opioid addiction, moderate acute pain, and moderate chronic pain. When used in combination
9 with naloxone for treating opioid addiction, it is known by the trade name Suboxone. As a
10 transdermal patch, buprenorphine is used to treat chronic pain. Buprenorphine is a Schedule III
11 controlled substance pursuant to Code of Federal Regulations Title 21 Section 1308.13(e).
12 Buprenorphine is a dangerous drug pursuant to Business and Professions Code section 4022.

13 18. Clonazepam – Generic name for Klonopin. Clonazepam is an anti-anxiety
14 medication in the benzodiazepine family used to prevent seizures, panic disorder and akathisia.
15 Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title
16 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety
17 Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions
18 Code section 4022.

19 19. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the
20 benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a
21 Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section
22 1308.14 subdivision (c) and Health and Safety Code section 11057, subdivision (d), and a
23 dangerous drug pursuant to Business and Professions Code section 4022.

24 20. Lorazepam – Generic name for Ativan. Lorazepam is a member of the
25 benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term
26 management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to
27 Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section
28

1 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section
2 4022.

3 21. Alprazolam – Generic name for Xanax. Alprazolam is a member of the
4 benzodiazepine family and is a short-acting medication commonly used for the short-term
5 management of anxiety disorders, specifically panic disorder or generalized anxiety disorder.
6 Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title
7 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a
8 dangerous drug pursuant to Business and Professions Code section 4022.

9 22. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal
10 muscle relaxant. On January 11, 2012, Carisoprodol was classified as a Schedule IV controlled
11 substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c). It is
12 a dangerous drug pursuant to Business and Professions Code section 4022.

13 23. Zolpidem tartrate – Generic name for Ambien. Zolpidem tartrate is a sedative and
14 hypnotic used for short-term treatment of insomnia. Zolpidem tartrate is a Schedule IV controlled
15 substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c). It is
16 a Schedule IV controlled substance pursuant to Health and Safety Code section 11057,
17 subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

18 24. Amphetamine Salts – Generic name for Adderall. Amphetamine salts are used in the
19 treatment of attention deficit hyperactivity disorder (ADHD) and narcolepsy. It is also used
20 recreationally as an aphrodisiac and euphoriant. It works as a central nervous system stimulant.
21 Amphetamine salts are a Schedule II controlled substance pursuant to Code of Federal
22 Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to
23 Health and Safety Code 11055, subdivision (d), and a dangerous drug pursuant to Business and
24 Professions Code section 4022.

25 25. Cyclobenzaprine – Generic name for Flexeril. Cyclobenzaprine is a medication used
26 to treat muscle spasms from musculoskeletal conditions of sudden onset. Cyclobenzaprine may
27 have drug interactions with central nervous system depressants. Cyclobenzaprine is a dangerous
28 drug pursuant to Business and Professions Code section 4022.

1 Respondent listed a thorough ROS⁵ and a complete physical, Respondent failed to document any
2 issues related to anxiety, depression or mental health symptoms in the ROS or in the physical.⁶

3 29. Patient 1 was next seen in clinic by Physician Assistant A on or about November 14,
4 2014. Physician Assistant A documented that Patient 1 was present for a medication consultation
5 and a review of problems which included mixed anxiety and depressive disorder and chronic
6 intractable pain. Physician Assistant A documented that Patient 1 reported "arthralgias/joint pain
7 and back pain" and that the complaints were chronic in nature. Physician Assistant A
8 documented a complete physical that revealed a normal musculoskeletal examination. Physician
9 Assistant A prescribed 90 tablets of 5/325 mg hydrocodone with acetaminophen and 60 tablets of
10 .5 mg alprazolam to Patient 1. Physician Assistant A documented that Patient 1 was advised of
11 Vista Complete Care clinic's controlled drug policies and that he accommodated Patient 1's work
12 schedule for refills of medications. Respondent did not review or sign off on this visit. Physician
13 Assistant A signed off on the November 14, 2014, visit on or about December 9, 2014.

14 30. Physician Assistant A next saw Patient 1 on December 26, 2014. Physician Assistant
15 A increased the dosage of both hydrocodone and alprazolam; prescribing 90 tablets of 10/325 mg
16 Norco and 60 tablets of 1 mg alprazolam. Physician Assistant A documented that Patient 1 felt
17 his medication was "appropriate at the current dosage and regimen," but that Patient 1 was
18 reporting increased tension and claimed a "longer recovery/calm-down" period. Physician
19 Assistant A did not document any other reasons for doubling Patient 1's Norco and alprazolam
20 prescription. Physician Assistant A signed the progress note on January 15, 2015. Respondent
21 did not counter-sign the progress note from December 26, 2014.

22 31. On or about May 4, 2015, Patient 1 was seen in clinic by Respondent. Between
23 December 27, 2014, and May 4, 2015, Patient 1 had filled multiple prescriptions from Physician
24 Assistant A that totaled 180 tablets of 1 mg alprazolam, 180 tablets of 10/325 mg Norco, 120
25 tablets of 5 mg oxycodone, 60 tablets of 10 mg oxycodone, and 30 tablets of 1 mg lorazepam. A

26 ⁵ Review of Systems

27 ⁶ The Problems list included "problems not review (last reviewed August 18, 2014)" and
28 bullet pointed "Anxiety state." Under Constitutional: "Level of Distress," Respondent
documented NAD for No Acute Distress. Under Psychiatric, Respondent documented, "normal
mood and affect and active and alert."

1 review of the medical records showed no documentation from Physician Assistant A regarding
2 the oxycodone or lorazepam prescriptions that Patient 1 had received. Respondent documented
3 the chief complaint for the May 4, 2015, as "trouble sleeping, depressed." Respondent did not
4 document or mention any of the prior medication switches and refills by Physician Assistant A in
5 his progress note. Respondent documented that Patient 1 had a significant change in his weight,⁷
6 was alcohol-free, and had anxiety/depression/insomnia due to a job change. Respondent
7 documented a ROS and physical examination that were very similar to prior examinations.
8 Respondent ordered labs but no x-rays. Respondent started the patient on 10 mg of Paxil⁸ and 50
9 mg of trazodone. Respondent did not prescribe controlled substances at the May 4, 2015, visit.
10 Pharmacy records show that Patient 1 filled controlled substance prescriptions from other
11 providers on or about June 5, 2015, and December 11, 2015.

12 32. On or about November 14, 2015, Physician Assistant B saw Patient 1 in clinic.
13 Respondent did not counter-sign the progress note. Patient 1's weight was documented as 172
14 pounds. The ROS and physical were documented as normal with "no significant weight loss"
15 entered. Under the physical exam portions titled "Psychiatric," Physician Assistant B
16 documented that Patient 1 had "normal mood and affect and active and alert," and under the
17 portion titled "Constitutional" that Patient 1 had "NAD" (No Apparent Distress). The normal
18 documented examination was in contrast to the past problem list of major depressive episodes,
19 anxiety, and mixed anxiety and depressive disorder. Physician Assistant B doubled Patient 1's
20 Paxil prescription without medical justification.

21 33. On or about December 19, 2015, Patient 1 was seen by Nurse Practitioner C in the
22 clinic. Respondent countersigned the December 19, 2015, progress note. Patient 1's chief
23 complaint was documented as having "heart palpitations, anxious, sweaty palms, and shaky
24 hands." Patient 1's weight was documented as 167 pounds. Nurse Practitioner C did document
25 in ROS and in the Physical Examination portions of the note that Patient 1 reported having a
26

27 ⁷ 228.8 pounds on 8-16-2014, to 183.2 pounds on May 4, 2015.

28 ⁸ Paxil (paroxetine) is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Paroxetine affects chemicals in the brain that may be unbalanced in people with depression, anxiety, or other disorders.

1 "racing heart," "restless sleep" and that he was "anxious: very talkative/rapid speech." Nurse
2 Practitioner C restarted Patient 1 on a benzodiazepine and prescribed 90 tablets of .5 mg
3 alprazolam.

4 34. On or about January 16, 2016, Patient 1 was seen by Physician Assistant D in the
5 clinic. Patient 1 signed a pain contract. The chief complaint is listed as anxiety meds. Under
6 HPI,⁹ it lists that Patient 1 had been taking lorazepam for anxiety as well as Paxil. Under ROS,
7 Physician Assistant D documented that Patient 1 had anxiety, but that Patient 1 was not suffering
8 from any physical pain and did not suffer from fatigue. Physician Assistant D documented under
9 the physical examination portion titled "Psychiatric" that Patient 1 had, "normal mood and affect
10 and active and alert." Physician Assistant D prescribed a month's supply of 90 tablets of .5 mg
11 alprazolam to be submitted on January 24, 2016, and provided two refills. Physician Assistant D
12 did not document that he clarified with Patient 1 why Patient 1 made the statement that he was
13 taking lorazepam when he had been previously prescribed alprazolam. Physician Assistant D
14 documented in the notes that Patient 1 must do a "drug screen in 3 month follow up."
15 Respondent did not counter-sign the progress note.

16 35. On or about March 21, 2016, Respondent saw Patient 1 in clinic for a chief complaint
17 of "med refills." Respondent documented in the HPI that Patient 1 had "low back pain from long
18 haul trucking up and down I5." Respondent also documented that Patient 1 had "increased back
19 pain after lifting a heavy load." Yet, Respondent documented "no muscle aches, no muscle
20 weakness, no arthralgias/joint pain, no back pain..." in the ROS. Respondent documented that
21 Patient 1 was NAD (No Acute Distress) and documented a normal musculoskeletal examination.
22 Respondent documented that Patient 1 had "pain with full flexion and right worse than left."
23 Respondent continued Patient 1's Paxil prescription, doubled Patient 1's prescription of
24 alprazolam by prescribing 90 tablets of 1 mg alprazolam per month and prescribed 30 tablets of
25 5/325 mg oxycodone with acetaminophen for fifteen days. Respondent did not document a drug
26 screen, nor did he document why a drug screen was not being completed despite Physician
27 Assistant D's progress note on January 16, 2016.

28 ⁹ History of Present Illness

1 36. On or about May 14, 2016, Physician Assistant E saw Patient 1 in clinic for a chief
2 complaint of "none recorded." Under HPI, Physician Assistant E documented that Patient 1
3 reported musculoskeletal pain but that the back pain was stable on medications, and severity was
4 improving. Patient 1 requested three months of medications due to his job as a truck driver and
5 difficulty scheduling appointments. Physician Assistant E documented an extensive physical
6 examination and noted the presence of "pain with full flexion and extension and right worse than
7 left." Physician Assistant E also documented back tenderness and chronic back pain. Physician
8 Assistant E prescribed a monthly prescription of 90 tablets of 10 mg oxycodone and provided
9 three separate hard copy prescriptions that were postdated for Patient 1 to fill on May 14, 2016,
10 June 14, 2016, and July 13, 2016. Physician Assistant E also continued the monthly prescription
11 of 90 tablets of 1 mg alprazolam, and started Patient 1 on a monthly prescription of 90 tablets of
12 10 mg of diazepam. Physician Assistant E provided two refills each for the benzodiazepines.
13 Physician Assistant E also continued Patient 1's 20 mg Paxil prescription and provided refills for
14 a years' supply. Physician Assistant E failed to document why he was tripling Patient 1's opiate
15 prescription from 10 mg to 30 mg of oxycodone per day and why he was prescribing an
16 additional benzodiazepine to Patient 1's treatment regimen. Respondent did not counter-sign this
17 progress note.

18 37. On or about May 26, 2016, Physician Assistant D saw Patient 1 for a chief complaint
19 of "medication consult." Respondent counter-signed the May 14, 2016, progress note on May 30,
20 2016. The medications prescribed on May 14, 2016, are listed in Physician Assistant D's
21 progress note. In the HPI, Physician Assistant D documented the following: (grammatical errors
22 appear as they do in the progress note)

23 28 year old male pmh of chronic pain, anxiety and insomnia here for a medication
24 change. He says that oxycodone is not working but is not taking it as much as has
25 been prescribed. When asked why pt has both alprazolam and valium he said
26 "Valium made me feel weird and I threw it out." When asked why he is not taking the
27 full amount of oxycodone he was prescribed he said "I was wondering if you could
28 prescribe me some dilaudid." Using alprazolam for sleep. Complains of low back
pain 7/10. He says he has been told in the past that he has Hep C and Hep B.

1 Physician Assistant D performed a physical examination and documented the presence of back
2 pain. Physician Assistant D also documented that, "told pt he has enough pain medication for
3 current conditions. He is not using NSAIDs. He is asking for more pain meds and more
4 benzodiazepines with seeking type behavior and questions." Physician Assistant D ordered
5 Patient 1 to get laboratory testing done but did not order a drug screen, and ordered that Patient 1
6 start taking naproxen.¹⁰ Despite telling Physician Assistant D that he had thrown the prescription
7 for Valium out, Patient 1 continued to refill both the diazepam and alprazolam prescriptions in
8 June and July.

9 38. On or about July 22, 2016, Physician Assistant E saw Patient 1 for a chief complaint
10 of "med refill." Respondent did not counter-sign the progress note from July 22, 2016. Patient 1
11 signed a pain contract. Under HPI, Physician Assistant E noted that Patient 1 reported his
12 symptoms were well-controlled and that he denied intolerable side effects of medications.
13 Physician Assistant E also documented that Patient 1 was "feeling well." Physician Assistant E's
14 ROS was normal and the complete physical was similar in documentation to previous physicals,
15 noting that Patient 1 had pain and tenderness. Physician Assistant E prescribed a monthly
16 prescription of 90 tablets of 30 mg oxycodone and provided three separate hard copy
17 prescriptions for Patient 1 that were postdated to be filled on August 12, 2016, September 12,
18 2016, and October 12, 2016. Physician Assistant E prescribed a monthly prescription of 90
19 tablets of 2 mg alprazolam and provided two refills and continued Patient 1's 90 tablet of 10 mg
20 diazepam prescription with two refills. Physician Assistant E failed to document why he was
21 again tripling Patient 1's oxycodone prescription from 30 mg a day to 90 mg a day and failed to
22 explain why he was doubling Patient 1's alprazolam prescription from 3 mg a day to 6 mg a day.
23 Physician Assistant E also did not document why Patient 1 needed to be prescribed two
24 benzodiazepines while also being prescribed an opiate.

25 39. According to the medical records, Patient 1 was assaulted in Las Vegas on or about
26 August 7, 2016, and suffered a broken jaw and had to have his jaw surgically wired shut. On or
27 about August 16, 2016, Patient 1 was seen in clinic by Physician Assistant D. This progress note

28 ¹⁰ Naproxen is an over-the-counter nonsteroidal anti-inflammatory drug (NSAID).

1 was not counter-signed by Respondent. According to Patient 1, his pain was managed by the
2 oxycodone and he was able to take his pain medication through a gap in his missing teeth.
3 Physician Assistant D recommended that Patient 1 take NSAIDS and viscous lidocaine for pain
4 and continue his opiate and benzodiazepine regime. On or about August 24, 2016, Patient 1's
5 mother went to the clinic and explained that Patient 1 was abusing his medications, drank heavily
6 and showed photos of Patient 1 passed out on the floor to office staff. On or about August 25,
7 2016, Patient 1's mother faxed a letter to the staff at the clinic that her son was an alcoholic,
8 misusing his medications, and potentially at risk of killing himself and others in his job as a long
9 haul truck driver. On or about September 3, 2016, Patient 1's step-father went to the clinic and
10 stated that Patient 1 was mixing medications in pill bottles and currently in the hospital. Patient
11 1's step-father requested a call back from office staff.

12 40. On or about September 13, 2016, Respondent saw Patient 1 in clinic for a chief
13 complaint of "medication consult." Respondent documented that Patient 1's pain level was 3 out
14 of ten, and that Patient 1 wished to taper his pain medications and discontinue Valium.
15 Respondent documented that Patient 1 had not had a "drink in over a month" and continued to list
16 that Patient 1 was a social drinker under social history despite new evidence that Patient 1 was
17 abusing alcohol. Under the assessment and plan, Respondent document that Patient 1 had low
18 back pain, a jaw fracture, spasms of his back muscles, anxiety, alcoholism, and constipation.
19 Respondent documented that Patient 1 had filled a prescription for 90 tablets of 30 mg oxycodone
20 on September 12, 2016. Respondent instructed Patient 1 to perform exercises, take NSAIDs,
21 taper his oxycodone to 15 mg or half a tablet every 8 hours, discontinue Valium, continue 6 mg
22 alprazolam daily, and abstain from alcohol. Respondent documented that Patient 1 would be
23 rechecked in a month for a tapering dose, that they would consider "10 mg tid" (oxycodone) at
24 the next visit and that Patient 1 was to bring in any hard copies of medications next month and all
25 remaining medications. Respondent documented that there was a discussion regarding patient's
26 chronic and new diagnoses. Respondent also documented that a CURES¹¹ report was reviewed

27 ¹¹ Controlled Substance Utilization Review and Evaluation System (CURES) is a database
28 maintained by the California Department of Justice which tracks all controlled drug prescriptions
that are dispensed in the State of California.

1 and appropriate. Respondent documented that there are "no discrepancies" despite Patient 1
2 exhibiting drug seeking behavior and the complaints of his parents regarding misuse. Respondent
3 documented urine testing was randomly tested, despite the fact there were no urine drug and/or
4 alcohol screening results in the chart between August 16, 2014, and September 13, 2016.
5 Respondent documented that a follow-up appointment for Patient 1 was scheduled for October
6 12, 2016.

7 41. On or about October 5, 2016, Respondent saw Patient 1 in clinic. Respondent
8 documented that Patient 1 reported that his chronic pain level was 2 out of 10, that he was not
9 abusing his medications, that he was not drinking alcohol, and that he was tapering his
10 medications. According to Respondent's documented progress note, Patient 1 wanted to get off
11 some of his pain medications and that he was ready to drop to 10 mg tablets. Respondent
12 prescribed 90 tablets of 10 mg oxycodone to be filled on October 12, 2016, and prescribed 45
13 tablets of 10 mg oxycodone to be filled on November 4, 2016, to continue Patient 1's taper
14 program. Respondent also prescribed 90 tablets of 2 mg alprazolam to be filled on October 5,
15 2016, and November 21, 2016. Respondent documented that urine drug testing was being
16 randomly tested but there are no documented results in Patient 1's chart from on or about the
17 October 5, 2016, visit.

18 42. According to the medical records, Patient 1 visited an emergency room on or about
19 October 22, 2016, suffering from acute psychosis and hallucinations and he was admitted to
20 inpatient psychiatry. On or about November 4, 2016, Patient 1 was again treated for
21 hallucinations and he was sent to an inpatient psychiatric facility under Welfare and Institutions
22 Code section 5150. Following an 18-day stay in an inpatient psychiatric facility, Patient 1 was
23 released and appeared to have immediately filled the controlled drug prescriptions he had
24 received from Respondent during his October 5, 2016, visit on or about November 21, 2016,
25 according to pharmacy records. On or about November 22, 2016, Patient 1 returned to the
26 emergency room due to an overdose.

27 43. On or about November 23, 2016, Physician Assistant B saw Patient 1 in clinic.
28 Under HPI, Physician Assistant B noted a "long history of abuse of medications," that Patient 1

1 reported he was in the emergency room the night before, and that he was out of Xanax and having
2 severe anxiety. Physician Assistant B also noted that the emergency room report specifically
3 stated there was a concern that Patient 1 had been taking illicit drugs and was possibly
4 withdrawing from his Xanax and oxycodone. Patient 1 also reported that he had lost his
5 medications. Patient 1 stated that his anxiety was only controlled with Xanax 2 mg three times a
6 day. Physician Assistant B documented that Patient 1 was a long haul truck driver. Physician
7 Assistant B documented that he discussed the patient with Respondent and that no more
8 benzodiazepines or pain medication would be prescribed to Patient 1. Physician Assistant B
9 documented that Patient 1 became angry, kicked a chair, and stormed out of the office. Physician
10 Assistant B documented that there was a concern that the patient would become violent so Patient
11 1 was allowed to leave. On or about November 28, 2016, Respondent signed a letter that was
12 addressed to Patient 1 notifying him that the clinic was withdrawing from providing him further
13 and cited a breach of Patient 1's pain contract as the basis.

14 44. Between August 16, 2014, and November 23, 2016, as noted above, Respondent
15 failed to provide adequate supervision over the mid-level medical providers that were providing
16 care to Patient 1, in particular Physician Assistant A and Physician Assistant E. As noted above,
17 on July 22, 2016, Physician Assistant E began prescribing 90 mg of oxycodone a day to Patient 1
18 which resulted in a morphine equivalent dose (MED¹²) of 135 and he provided multiple post-
19 dated hard copy prescriptions which allowed for repeated medication filling without close
20 monitoring and follow-up. Furthermore, between July 22, 2016, and October 12, 2016, Physician
21 Assistant E prescribed 6 mg of alprazolam and 30 mg of diazepam on a daily basis in
22 combination with Patient 1's 90 mg oxycodone prescription. Between August 16, 2014, and
23 November 22, 2016, there is no documentation that Respondent or the mid-level providers
24 working under him performed a detailed alcohol use assessment on Patient 1 despite evidence
25 that Patient 1 may have been misusing alcohol. Between August 16, 2014, and November 22,

26 ¹² Morphine Equivalent Dose ("MED"), An MED is a numerical standard against which
27 most opioids can be compared, yielding an apples-to-apples comparison of each medication's
28 potency. The California Medical Board Guidelines issued in November 2014 stated that any
physicians should proceed cautiously (yellow flag warning) once an MED reaches 80 mg per day.
http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf at page 17.

1 2016, there was repeated mention that urine drug screening was being performed in the progress
2 notes, but there is no documentation of any urine drug screening-test results in Patient 1's medical
3 records to support those assertions. Finally, between August 16, 2014, and November 22, 2016,
4 the medical records kept by Respondent and the mid-level providers working under him fail to
5 document why pain medications were being prescribed to Patient 1 and fail to show clear,
6 objective proof of the nature of the pain being treated. The clinic records kept for Patient 1
7 between August 16, 2014, and November 22, 2016, are lacking in x-rays, specialist's notes,
8 documentation of careful and detailed functional examinations of the musculoskeletal system,
9 documentation of careful reasoning on why certain medications were being prescribed, and
10 documentation of detailed discussions of trying to utilize other non-pharmacologic modalities
11 which would have supported the continued prescribing of controlled substances.

12 Patient 2

13 45. Respondent began caring for Patient 2 in July 2012. On or about February 20, 2015,
14 Respondent saw Patient 2 for a follow-up labs and three-month follow-up. Respondent
15 documented that Patient 2 suffered from chronic pain, was obese, had hypertension, had heart
16 disease, had hyperlipidemia, suffered from migraines, had hypogonadism, suffered from
17 depression, had anxiety, suffered from insomnia, had diabetes, had fibromyalgia, and had a past
18 history of stroke with partial left hemiparesis. Under social history, Respondent documented that
19 Patient 2 was self-employed, married, a former smoker, that Patient 2 denied alcohol, tobacco,
20 and illicit drug use. Under alcohol intake, Respondent documented "none." Respondent did not
21 document a pain score but did document a complete review of systems and physical examination,
22 noting a wide based gait. Respondent documented that Patient 2's medications were refilled
23 which included 60 tablets of 1 mg alprazolam BID with two refills, 8 patches of 20 mcg/hr.
24 Butrans Transdermal Patches to be taken one patch weekly with three refills, 180 tablets of
25 10/325 mg Norco Q4H, testosterone, atorvastatin, beta-blockers, Cialis, sumatriptan nasally,
26 lisinopril, metformin, Flexeril, 100 mg of trazodone nightly, and 10 mg of zolpidem to be taken
27 nightly. At that time, Respondent was prescribing opioids in combination with a benzodiazepine
28 and a hypnotic.

1 46. On or about April 15, 2015, Respondent saw Patient 2 in clinic for a complaint of six-
2 week follow-up. Respondent increased Patient 2's Butrans Transdermal Patch prescription to one
3 patch every 72 hours with no refills and prescribed 8 patches. Respondent did not document why
4 he was increasing the Butrans Transdermal Patch prescription. All other prescriptions remained
5 the same. On or about July 15, 2015, Respondent saw Patient 2 in clinic for a chief complaint of
6 three-month follow-up. Respondent increased Patient 2's alprazolam prescription to 3 mg per
7 day and increased Patient 2's Butrans Transdermal Patch to two patches every 72 hours with 3
8 refills.¹³¹⁴ Respondent did not document why he was increasing the alprazolam and the Butrans
9 Transdermal Patch prescriptions. Respondent also continued Patient 2 on 180 tablets of 10/325
10 mg hydrocodone with acetaminophen per month. Respondent also provided the patient with
11 hard-copy prescriptions of the opioids with post-dating to be filled at later dates which allowed
12 the patient to fill prescriptions without additional oversight. At the July 15, 2015 visit,
13 Respondent documented and incorporated a pain contract signed by Patient 2 into the medical
14 records. The Respondent did not document what Patient 2 was required to do with the wastage
15 from the Butrans patches as the patches were seven day patches and he was ordering that Patient
16 2 apply two patches every 72 hours rather than for one week as recommended by the
17 manufacturer.

18 47. On or about October 11, 2015, Respondent documented that he saw Patient 2 in clinic
19 and entered a pain score of 7 out of ten. Respondent ordered a urine drug screen that showed
20 consistent results. On or about December 4, 2015, Respondent documented that he saw Patient 2
21 in clinic. Patient 2 was still being prescribed a daily dose of 3 mg of alprazolam, 40 mcg/hr.
22 Butrans transdermal patch, 60 mg of hydrocodone, 10 mg of zolpidem, 100 mg of trazodone, and
23

24 ¹³ The MED of two 20 mcg./hr. patches (40 mcg./hr.) multiplied times 24 hours is 960
25 mcg/day and when converted to milligrams with one mg of buprenorphine equal to a 75 mg
26 morphine equivalent dose. As such, Patient 2 was receiving an MED of 135 each day (the Butrans
27 and the Norco as they were prescribed on July 15, 2015.)
<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-Aug-2017.pdf>

28 ¹⁴ There is risk of prolonged QTc interval when a patient is dosed over a level of 20
mcg/hour. <https://www.drugs.com/dosage/butrans-patch.html>

1 30 mg of cyclobenzaprine. Respondent documented that Patient 2 reported he had continued
2 pain, that he was having TIA's¹⁵ on a daily basis, got stupors of thought, and had trouble
3 concentrating. Respondent ordered labs (which were generally normal), had Patient 2 sign
4 another pain contract, and referred Patient 2 for a neurological consult.

5 48. A neurologist saw Patient 2 in office on or about February 1, 2016. The neurologist
6 noted a past history of illicit drug and alcohol use, and determined based on his exam and all the
7 CT and MRI studies that Patient 1's symptoms did not have organic causes and the neurologist
8 suggested a possible somatization or conversion disorder. The neurologist also thought a
9 dissociative disorder may be present. The neurologist's report became part of Respondent's
10 medical records for Patient 2 on or about February 15, 2016. A psychologist saw Patient 2 on or
11 about February 26, 2016. The psychologist noted that Patient 2 reported that he used cocaine in
12 high school and college. The psychologist also noted that Patient 2 drank excessive amounts of
13 alcohol 4-5 times a week prior to suffering a stroke in 2009-2010. The psychologist made
14 recommendations regarding work abilities and deferred treatment of depression, anxiety,
15 confusion, and memory issues to Respondent. The psychologist's report was scanned into
16 Respondent's medical records for Patient 2 on or about March 21, 2016.

17 49. On or about March 3, 2016, Respondent saw Patient 2 for a chief complaint of lab
18 review and prescription refill. Respondent noted that Patient 2 reported he had fallen off a ladder,
19 hit his thumb with a hammer and hit a guard rail while driving his vehicle. A medication review
20 was performed and Respondent documented that Patient 2's pain was a seven out of ten.
21 Respondent refilled Patient 2's medications, including providing multiple hard copy prescriptions
22 that were postdated to be filled on later dates which limited additional patient oversight in the
23 form of monthly office visits. Respondent failed to incorporate the neurologist's findings, that
24 Patient 2 had a prior history of illicit drug use and alcohol use, into Patient 2's treatment plan for
25 chronic pain management.

26
27
28 ¹⁵ While not defined in Respondent's records, he may be referring to transient ischemic
attack with the abbreviation of "TIA".

1 50. On or about August 31, 2016, Respondent saw Patient 2 in clinic for a chief
2 complaint of follow-up on labs and annual physical examination. Respondent documented that
3 he modified the order for the Butrans Transdermal Patch to two 20 mcg/hr. patches per week as
4 opposed to two 20 mcg/hr. patches every three days and prescribed eight boxes of four patches
5 with three refills. Respondent also continued to prescribe opioids to Patient 2 by filling out
6 multiple hard copy prescriptions that were post-dated for future dates to be filled. Respondent did
7 not incorporate the psychologist's report from February 26, 2016, that Patient 2 had a history of
8 cocaine use and excessive alcohol use, into Patient 2's substance abuse history. On or about
9 November 9, 2016, Respondent saw Patient 2 in clinic and document that Patient 2 reported that
10 he fell down some stairs. Respondent documented Patient 2's chronic pain as 4 out of 10 on
11 Norco and Butrans. On or about January 25, 2017, Respondent saw Patient 2 in clinic and
12 ordered a urine drug screen. Respondent documented that Patient 2 reported he had two episodes
13 of dizziness and fell down. Patient 2's January 25, 2017, urine drug screen was generally
14 consistent with Respondent's prescriptions, but the urine drug screen also showed an inconsistent
15 result for butalbital, a Schedule III controlled barbiturate. Respondent next saw Patient 2 in clinic
16 on or about April 26, 2017. Respondent documented that Patient 2 reported having many falls
17 since his January 25, 2017, visit and that he had nerve pain and numbness which was causing him
18 to drop things. Respondent did not document whether he discussed the January 25, 2017,
19 inconsistent drug screen result with Patient 2, but Respondent continued Patient 2 on two 20
20 mcg/hour Butrans transdermal patches, 10 mg of zolpidem, 3 mg of alprazolam and 60 mg of
21 Norco per day despite the potential presence of butalbital which can increase risk of sedation and
22 respiratory depression when combined with the medications Respondent was prescribing.

23 51. On or about May 20, 2017, Patient 2 suffered a chain saw accident to his leg. On or
24 about May 23, 2017, Patient 2 was seen in clinic by Physician Assistant E for a check of his leg
25 wound. Respondent did not counter-sign the May 23, 2017, progress note. Physician Assistant
26 E documented that Patient 2 was reporting that he was suffering from musculoskeletal pain,
27 documented a complete ROS and a complete physical examination. Physician Assistant E did not
28 document any further details regarding how or why Patient 2 suffered a chain saw accident to his

1 leg in the progress note. Physician Assistant E next saw Patient 2 on May 30, 2017, for suture
2 removal. Patient 2 remained on 2 patches of 20 mcg/hr Butrans transdermal patch, 60 mg of
3 Norco, 10 mg of zolpidem, and 3 mg of alprazolam as previously prescribed. Patient 2 also
4 continued to take cyclobenzaprine and trazodone.

5 52. On or about July 24, 2017, Respondent saw Patient 2 in clinic for a three-month
6 follow-up. Under social history Respondent continued to document that Patient 2 had no alcohol
7 intake despite a prior documented history of alcohol abuse and documented that Patient 2 denied
8 illicit drug use despite a documented history of illicit drug use. Respondent documented that
9 Patient 2 was suffering from frequent falls, averaging 1.5 falls in the last three months and
10 documented that the chainsaw injury was healing well. Respondent documented that Patient 2's
11 pain level was 4 out of 10 and that Patient 2 had "(n)o negative side effects." Respondent
12 documented in the progress note that he discussed Patient 2's memory loss problems due to
13 benzodiazepines and zolpidem despite documenting "no negative side effect." Respondent
14 documented that Patient 2 was not interested in stopping either medications. Respondent
15 continued Patient 2 on 2 patches of 20 mcg/hr Butrans transdermal patch, 60 mg of Norco, and 10
16 mg of zolpidem per day. Respondent prescribed 90 tablets of 1 mg clonazepam to be taken TID
17 to Patient 2 with three refills. Respondent did not document whether he was having Patient 2 stop
18 taking alprazolam or why he was starting a prescription for clonazepam. A urine drug screen
19 performed on July 24, 2017, was consistent.

20 53. Respondent next saw Patient 2 on or about October 23, 2017 in clinic. Respondent
21 documented that Patient 2 reported he was now falling 2 to 3 times a week. Respondent
22 documented that Patient 2 reported he was using ankle supports due to the multiple falls.
23 Respondent documented that Patient 2 reported clonazepam was helping with headache related
24 pain and he documented that Patient 2 reported alprazolam was helping with anxiety. It is not
25 clear from the record if Patient 2 was now taking both clonazepam and alprazolam and whether or
26 not that was Respondent's intended treatment plan. Respondent noted that Patient 2 was having
27 trouble using the Butrans patches but continued to prescribe a daily dosage of 40 mcg/hr. Butrans,
28 60 mg Norco, 10 mg of zolpidem, and 3 mg of clonazepam. Respondent also continued to

1 provide hard copy prescriptions for the opiates that were postdated to be filled by Patient 2 at later
2 dates.

3 54. On or about January 25, 2018, Respondent saw Patient 2 in clinic for an unknown
4 chief complaint. Respondent documented that Patient 2 continued to fall, but noted that falls
5 were not related to opiate use. Respondent did not explain how he concluded that falls were not
6 caused by Patient 2's medications. Respondent continued to document an alcohol intake of
7 "none" and that Patient 2 denied both alcohol use, and illicit drug use, despite a documented past
8 history of both illicit drug and alcohol abuse. Respondent noted in the records that Patient 2
9 should not self-medicate. Respondent lowered Patient 2's Norco prescription to 50 mg a day, but
10 continued prescriptions of Butrans, clonazepam, and zolpidem at previous levels.

11 55. On or about April 23, 2018, Respondent saw Patient 2 in clinic for med refills and
12 "DISCUSS CCM ENROLLMENT." Respondent was prescribing 2 20 mcg/hr patches of
13 Butrans, 50 mg of hydrocodone, 3 mg of alprazolam, and 10 mg of zolpidem per day.
14 Respondent had Patient 2 provide a urine drug screen. On or about April 25, 2018, the urine drug
15 screen result was consistent for opioids and benzodiazepines but also showed the presence of
16 alcohol metabolites. The alcohol metabolites¹⁶ were greater than 100000 ng/ml for ETG and
17 97500 ng/ml for ETS. The cut off range for this particular urine drug screen was 500 ng/ml for
18 ETG and 100 ng/ml for ETS. On or about June 2, 2018, Doctor F saw Patient 2 in clinic. Doctor
19 F did not modify Patient 2's social history in the medical record and did not document whether
20 the April 25, 2018, urine drug screen that showed the presence of alcohol impacted Patient 2's
21 treatment plan. On or about June 14, 2018, Respondent saw Patient 2 in clinic. Respondent did
22 not modify Patient 2's social history, continued to document that Patient 2 denied alcohol use and
23 did not document whether or not the April 25, 2018, urine drug screen that was positive for
24 alcohol metabolites had any impact on Respondent's continued treatment plan for chronic pain
25 care for Patient 2. Respondent continued Patient 2 on 3 mg of clonazepam, 2 20 mcg/hr Butrans
26

27 ¹⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3711108/> As noted in this 2010
28 article, ETG and ETS are minor metabolites of ethanol. Peak levels of 100,000 ng/ml may
indicate heavy drinking as noted in the article.

1 Transdermal patches, 50 mg of hydrocodone, and 10 mg of Ambien per day. On or about
2 February 26, 2019, during an interview with the Board, Respondent stated the following that,

3 We meet on a monthly basis to – uh – review our protocols and what we’re doing and the
4 last concern actually is when --- these alcohol metabolites are positive and to understand
5 them better as far as their numbers and – and what that means, does that mean they had one
6 drink, you know, two hours ago or last night, I – I don’t know that answer.

6 Respondent went on to say at the interview that if Patient 2 was telling him that he was
7 alcohol free and had a positive urine drug result that Respondent would discuss that result at the
8 next visit despite the fact that Respondent failed to discuss the positive alcohol result on June 14,
9 2018, with Patient 2.

10 56. Between February 20, 2015, and June 14, 2018, Respondent, and the mid-level
11 providers under his supervision, failed to properly monitor and treat Patient 2 as a high risk
12 patient and failed to modify his chronic pain management treatment accordingly. Patient 2 was
13 on high dose opiates, combined with multiple sedatives, and had a prior history of illicit drug and
14 alcohol use that was ignored by Respondent. In addition, Patient 2 had multiple psychiatric
15 diagnoses. Between February 20, 2015, and June 14, 2018, Respondent ignored multiple warning
16 signs that Patient 2 may be experiencing medication related side effects including Patient 2
17 reporting multiple falls, Patient 2 having memory issues, Patient 2 driving his vehicle into a
18 guardrail, and Patient 2 suffering a chain saw accident. Respondent ignored the findings of the
19 neurology report from February 2016, which did not find an organic basis for Patient 2’s
20 symptoms based on a normal MRI and the suggestion of the neurologist that indicated that Patient
21 2’s issues may be caused by psychiatric causes. Respondent did not take into account Patient 2’s
22 abnormal urine drug screen from January 25, 2017, which showed the presence of a barbiturate.
23 On or about July 24, 2017, Respondent allowed Patient 2 the choice of continuing to take a
24 benzodiazepine and hypnotic despite his own documented concerns regarding Patient 2’s
25 continued memory loss. Finally, Respondent ignored the urine drug screen from April 25, 2018,
26 which showed a markedly high metabolite for alcohol use and continued prescribing Patient 2
27 controlled substances.

1 57. Between February 20, 2015, and June 14, 2018, Respondent, and the mid-level
2 providers under his supervision, kept Patient 2 on a chronic pain management regimen where the
3 MED was above 125. At his subject interview on February 26, 2019, Respondent incorrectly
4 stated that Patient 2, "started out at about 120 morphine equivalent doses and is now down to 50
5 with the Butrans and I don't know - I don't remember the conversion of Butrans right now."

6 Between February 20, 2015, and June 14, 2018, Respondent failed to closely follow the patient,
7 as evidenced by missing multiple red flags as noted in paragraph 53 of the Accusation, failed to
8 refer patient to a pain management specialist for a chronic pain management consultation, failed
9 to document any side effects from medications, failed to adequately taper the patient's
10 medications, prescribed twice the recommended dosage of Butrans, and failed to make
11 modifications to Patient 2's chronic pain treatment plan as issues arose during treatment.

12 58. Between February 20, 2015, and June 14, 2018, Respondent, and the mid-level
13 providers under his supervision, prescribed multiple drugs that in combination can lead to severe
14 respiratory depression and death. These dangerous combinations included, but are not limited to,
15 prescribing trazodone with Flexeril, hydrocodone with Butrans, hydrocodone with Flexeril,
16 opioids with benzodiazepines, and opioids with hypnotics. Respondent continued to mix and
17 combine medications throughout Patient 2's treatment history despite multiple red flags as listed
18 in paragraphs 53 and 54 of the Accusation.

19 Patient 3

20 59. The Medical Board of California reviewed medical records for Patient 3 from on or
21 about January 15, 2015, and through on or about May 22, 2018. Patient 3 was a complex patient
22 with a number of medical issues. For example, on or about January 26, 2015, Patient 3 was seen
23 in clinic by Physician Assistant E for a chief complaint of medication refill, headaches, and for a
24 urine drug screen. Patient 3's various medical conditions and problems included, depression,
25 ADHD, chronic pain from her shoulder, knee, lower back, and muscle spasms, migraines,
26 hypertension, insomnia, fibromyalgia, and hypothyroidism. As of January 25, 2016, Patient 3
27 was taking a 20 mg tablet of Adderall BID,¹⁷ a 350 mg tablet of Soma QID, a tablet of 10 mg of

28 ¹⁷ BID means twice a day, TID means three times a day, QID means four times a day.

1 diazepam BID, a tablet of 10/325 mg of Norco QID, a tablet of 15 mg immediate release
2 morphine sulfate QID, a tablet of 60 mg extended release morphine sulfate (TID). Patient 3 was
3 also prescribed Remeron, venlafaxine, insulin, and thyroid medication. Her daily morphine
4 equivalent dose was 280 MED while she was also receiving a sedative and muscle relaxer.
5 Physician Assistant E administered a 100 mg Demerol injection and a 50 mg Phenergan injection
6 during the office visit which added an additional 10 MED. According to Respondent, during his
7 February 26, 2019, subject interview with the Medical Board, the clinic knew that Patient 3 used
8 marijuana, but that was not documented in her medical records as part of her treatment plan or
9 social history. Patient 3's social history as documented in the medical records showed that she
10 denied alcohol and illicit drug use, she was a pack a day cigarette smoker for the last 40 years,
11 and she was in a wheelchair due to severe knee arthritis and pain. Patient 3 was documented with
12 a BMI of 29.5, had a moderately elevated blood pressure of 161/86, and an oxygen saturation of
13 95% on room air which indicated she was mildly hypoxic. Physician Assistant E did not
14 document a pain score but did document that Patient 3 reported she had no significant side effects
15 from her medication and that the current regimen of medications was effective for the
16 management of her chronic pain. Physician Assistant E documented a thorough ROS and
17 physical examination. Physician Assistant E had Patient 3 provide a urine drug screen and
18 Patient 3 signed a pain contract.

19 60. Between January 15, 2015, and through May 22, 2018, Patient 3 was seen in clinic by
20 Respondent, Doctor F, and a combination of mid-level practitioners who were supervised by
21 Respondent and Doctor F. Patient 3 was seen in clinic every one to three months on average.
22 Patient 3's surgical history between January 15, 2015, and through May 22, 2018, included
23 having a left rotator cuff surgery on March 3, 2015, a total right knee replacement surgery in
24 November 2015, and a total left knee replacement surgery on May 28, 2017. Between January
25 15, 2015, and through May 22, 2018, Patient 3 had a number of oxygen saturation results which
26 indicated mild hypoxia which included the following examples: On April 5, 2015, with Physician
27 Assistant D, Patient 3 had a 91% oxygen saturation; On July 9, 2015, with Respondent, Patient 3
28 had a 94% oxygen saturation; On July 12, 2016, with Physician Assistant D, Patient 3 had a 94%

1 oxygen saturation; On April 5, 2017, with Physician Assistant C, Patient 3 had a 94% oxygen
2 saturation; On August 17, 2017, with Physician Assistant E, Patient 3 had a 94% oxygen
3 saturation; and On May 22, 2018, with Respondent, Patient 3 had a 93% oxygen saturation.
4 Between January 15, 2015, and through May 22, 2018, Patient 3 had a number of blood pressure
5 results which indicated possible hypertension which included the following examples: On May
6 12, 2016, with Physician Assistant G, Patient 3 had a blood pressure of 181/111; On July 5, 2016,
7 with Respondent, Patient 3 had a blood pressure of 183/115; On July 12, 2016, with Physician
8 Assistant D, Patient 3 had a blood pressure of 164/114; and On December 1, 2017, with
9 Respondent, Patient 3 had a blood pressure of 193/95.

10 61. Between January 15, 2015, and through May 22, 2018, a review of the medical
11 records showed the following events: On or about October 22, 2015, Vistaril 50 mg QID was
12 added for nausea, Patient 3 provided a consistent urine screen, and Patient 3 was prescribed
13 temazepam for sleep. On or about February 4, 2016, Respondent was noted as personally seeing
14 Patient 3 and he documented a pain score of 7 out of 10 and reviewed Patient 3's pain contract
15 with her. On or about May 12, 2016, during a pre-operative EKG,¹⁸ the test showed the presence
16 of a new inferior-lateral myocardial infarction of an unknown date and Patient 3 was referred to a
17 cardiologist for pre-operative clearance. On or about July 9, 2016, a nuclear study showed that
18 there was evidence of an old, fixed infarction but no ongoing ischemia and Patient 3 was cleared
19 for surgery. It is noteworthy that Patient 3 had evidence of transient atrial fibrillation after her
20 right knee replacement in November 2015. The May 12, 2016, visit with Physician Assistant G,
21 which also revealed Patient 3's blood pressure to be 181/111, was co-signed by Respondent. This
22 was the only mid-level provider note that was co-signed by Respondent for Patient 3 between
23 January 15, 2015, through May 22, 2018.

24 62. On or about May 16, 2016, Respondent saw Patient 3 in clinic and lowered her
25 prescription of a 60 mg tablet of morphine sulfate extended release TID prescription to a
26 prescription of 60 mg tablet of morphine sulfate extended release BID. Respondent added a
27

28 ¹⁸ Electrocardiography is the process of producing an electrocardiogram (EKG), a recording of the electrical activity of the heart using electrodes placed on the skin.

1 prescription for 2 mg tablet alprazolam TID to be taken concurrently with a prescription for 10
2 mg diazepam BID. Patient 3 remained on carisoprodol, amphetamine salts, and morphine sulfate
3 immediate release. Patient 3 returned to a 60 mg tablet of morphine sulfate TID prescription on
4 July 5, 2016. Patient 3 continued to fill alprazolam through August 9, 2016. In addition,
5 morphine sulfate immediate release was stopped on July 5, 2016, and restarted on April 15, 2017.
6 Also, Norco was stopped on or around April 11, 2016, and restarted on September 27, 2016. On
7 September 27, 2016, a urine drug screen was performed which was consistent with her
8 prescriptions and Patient 3 signed a new pain contract with the clinic.

9 63. On or about April 5, 2017, Patient 3 was seen by Nurse Practitioner C for a
10 medication refill. At that time, Patient 3 was receiving a daily dose of 6 mg of alprazolam, 40 mg
11 of amphetamine salts, 1400 mg of carisoprodol, 20 mg of diazepam, 40 mg of hydrocodone, 45
12 mg of morphine sulfate immediate release, and 180 mg of morphine sulfate extended release.
13 The morphine equivalent dosage was 265 MED in combination with two benzodiazepines, one
14 muscle relaxer, and one stimulant. Patient 3's September 27, 2016, pain contract specifically
15 stated that she specifically agreed to not get pain medication from any other doctor, dentist, or
16 healthcare provider. Nurse Practitioner C documented Patient 3's pain level as 0 at the April 5,
17 2017, visit. On or about May 1, 2017, Patient 3, filled a 15-day prescription for 160 tablets of 10
18 mg oxycodone for post-operative pain from a Physician Assistant affiliated with the orthopedist
19 who would be performing her knee surgery scheduled for May 28, 2017. Assuming Patient 3
20 took the oxycodone as prescribed, her morphine equivalent dose when combined with her
21 existing opioid prescriptions in June 2017 would have been 445 MED while still being prescribed
22 a combination of two benzodiazepines, one muscle relaxer, and one stimulant.

23 64. On or about July 7, 2017, Physician Assistant D saw Patient 3 in clinic for a
24 medication refill and ordering labs. Physician Assistant D documented that Patient 3 was
25 requesting Norco. Physician Assistant D documented that Patient 3 was told that due to the high
26 amount of opiate medication she was taking, that she would need to see a physician on the next
27 visit. At the next visit to the clinic, on or about August 17, 2017, Physician Assistant E saw
28 Patient 3 for a chief complaint of migraine. Respondent did not see Patient 3 on August 17, 2017,

1 and did not counter-sign the note despite Physician Assistant D's notation on July 7, 2017, that
2 Patient 3 see a physician on her next visit. Physician Assistant E gave Patient 3, a 100 mg/ml.
3 shot of Demerol for Patient 3's migraine despite the fact that in 2017 Demerol had a black box
4 warning that the medication could cause cardiac toxicity. On August 17, 2017, Patient 3 filled a
5 prescription for 90 tablets of 15 mg morphine sulfate immediate release, and on August 18, 2017,
6 Patient 3 filled a prescription for 90 tablets of 60 mg morphine sulfate extended release, 120
7 tablets of 10/325 mg hydrocodone with acetaminophen, and, 60 tablets of 20 mg amphetamine
8 salts. Patient 3 was still filling prescriptions for carisoprodol and diazepam at that time.

9 65. On or about September 12, 2017, Respondent saw Patient 3 in clinic for a medication
10 refill and consultation. Respondent documented that Patient 3 was prepared to begin tapering her
11 medications. Respondent ordered that Patient 3 taper from 60 mg of morphine sulfate extended
12 release TID to 50 mg of morphine sulfate extended release TID. Respondent also ordered that
13 Patient 3 take one less 10/325 mg Norco per day. Respondent documented a "(g)goal of getting
14 off morphine but 1st goal is down to 120 MED's". Respondent continued to prescribe morphine
15 sulfate immediate release, carisoprodol, alprazolam and diazepam to Patient 3. Respondent did
16 not refer Patient 3 to a pain management specialist.

17 66. On or about September 29, 2017, Patient 3's medical insurance company sent
18 Respondent a letter that Patient 3's MED was above 120 and also that Respondent's medical
19 practice was prescribing opiates in combination with benzodiazepines and carisoprodol to Patient
20 3. The insurance company cited to existing medical research and CDC guidelines that opiate
21 prescriptions were recommended to be below 120 MED, that medical research recommended use
22 of non-controlled substance therapies and the document specifically stated that medical
23 prescribers should not co-prescribe opiates with benzodiazepines, sedatives-hypnotics, muscle
24 relaxants, or barbiturates. This letter was incorporated into Patient 3's medical record on or about
25 October 26, 2017.

26 67. On or about May 22, 2018, Respondent saw Patient 3 in clinic for a medication refill.
27 Respondent documented that Patient 3 was prescribed a daily dose of 60 mg tablet of morphine
28 sulfate extended release BID, a 15 mg tablet of morphine sulfate immediate release BID, a 10/325

1 mg hydrocodone with acetaminophen TID, a 10 mg tablet of diazepam BID, a 350 mg tablet of
2 carisoprodol QID, and 40 mg of amphetamine salts.¹⁹ A drug screen performed on May 22, 2018,
3 was consistent with these prescriptions, but also showed the presence of marijuana and the
4 presence of oxycodone. According to pharmacy records, oxycodone was last prescribed on May
5 1, 2017, which could potentially show that the patient was hoarding medication or receiving
6 medication from a different source. Test results obtained on or around May 22, 2018, revealed in
7 two eye exams, that Patient 3 had hypertensive retinopathy. Also, test results obtained on or
8 around May 22, 2018, revealed that Patient 3's labs showed an A1C of 8.3% and a high
9 hemoglobin of 19.4.

10 68. Between January 15, 2015, and through May 22, 2018, Respondent repeatedly failed
11 to properly monitor Patient 3 as he prescribed controlled medications, in particular high-dose
12 opioids, to Patient 3. Patient 3's morphine equivalent dosing was often above 200 and sometimes
13 was much higher. Respondent failed to detail the presence of specific side effects, failed to
14 perform more frequent urine drug testing, and failed to refer Patient 3 to a pain specialist for
15 chronic pain management. In addition, Patient 3 received a high amount of oxycodone from a
16 different medical provider in violation of her pain contract without any documented analysis in
17 the clinic's medical records on whether that impacted Patient 3's chronic pain treatment plan.
18 Respondent's mid-level provider also gave Patient 3 Demerol on two occasions, including on one
19 occasion in 2017 which was after Demerol contained a black box warning in regards to cardiac
20 toxicity. Finally, Patient 3 repeatedly presented at visits with potential evidence of hypoxia and
21 Respondent failed to monitor whether that hypoxia was related to the controlled substances that
22 he or the mid-level providers under his supervision were prescribing.

23 69. Between January 15, 2015, and through May 22, 2018, Respondent, and the mid-level
24 providers under his supervision, prescribed multiple drugs that in combination could lead to
25 severe respiratory depression and death. For example, Patient 3 was prescribed two short-acting
26 opioids at the same time in the form of hydrocodone with acetaminophen and morphine sulfate

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28 ¹⁹ Patient 3 was still receiving a MED of 180 in combination with a benzodiazepine and a
muscle relaxant.

1 immediate release, prescribed hydrocodone in combination with Demerol, prescribed opioids in
2 combination with benzodiazepines, and prescribed opioids in combination with carisoprodol. Of
3 particular concern, in or around May 2017, Patient 3 was taking four different opiate/opioid
4 medications, in combination with a benzodiazepine and a muscle relaxer which greatly increased
5 her risk of respiratory depression and death. Between January 15, 2015, and through May 22,
6 2018, Respondent, and the mid-level providers under his supervision, prescribed other dangerous
7 combinations of drugs including but not limited to venlafaxine in combination with Demerol, and,
8 venlafaxine in combination with Phenergan.

9 70. Between January 15, 2015, and through May 22, 2018, Respondent, and the mid-level
10 providers under his supervision, failed to properly manage Patient 3's multiple and serious
11 medical problems that were in addition to her chronic pain. By way of example, Respondent and
12 the mid-level providers under his supervision, failed to address Patient 3's blood pressure
13 readings that evidenced hypertension despite Patient 3 being a diabetic. Also, by way of
14 example, Respondent and the mid-level providers under his supervision ignored hypertensive
15 retinopathy results on two eye exams. Respondent and the mid-level providers under his
16 supervision failed to treat Patient 3's hyperlipidemia, despite Patient 3 being diabetic, nor did
17 they offer her the prescription of an ace-inhibitor to protect her kidneys. Respondent and the mid-
18 level providers under his supervision failed to address Patient 3's cardiac issues despite evidence
19 that Patient 3 had suffered a myocardial infarction between November 2015 and May 2016 and
20 which was confirmed by a nuclear study in July 2016. Furthermore, Respondent and the mid-
21 level providers under his supervision never referred Patient 3 to a diabetologist for management
22 of her diabetes, never referred her for a sleep study despite repeated evidence of hypoxia and
23 obesity, and never performed an in depth analysis of her elevated hemoglobin of 19.4 to
24 determine its cause.

25 Patient 4

26 71. On or between February 3, 2015, and through June 19, 2018, Respondent, Doctor F,
27 Physician Assistants B, D, and E, saw Patient 4 in clinic. A review of the progress notes showed
28 a very thorough review of systems and physical examinations, even when visits were for

1 relatively minor complaints like a pre-operation EKG or a wound-care follow-up. A review of
2 the progress notes showed that the notes were very similar, that the pain score was usually
3 documented as a seven out of ten, that Patient 4 chewed tobacco and that Patient 4 consumed
4 three alcoholic beverages on a weekly basis.

5 72. A review of the records between February 3, 2015, and through June 19, 2018,
6 revealed that Patient 4 had chronic pain arising from a work injury to his back that occurred in
7 2005. Patient 4 also had a previous surgical history that included neck surgery in 2000, and back
8 surgery in 2007. Patient 4's chronic neck and back pain required chronic pain management
9 treatment. Patient 4 was also followed for severe knee arthritis which eventually led to a knee
10 replacement in 2017, suffered from hypertension, hepatitis C, depression, insomnia, muscle
11 spasms, neuropathy, and gastroesophageal reflux. A review of the records between February 3,
12 2015, and through June 19, 2018, Respondent rarely counter-signed the progress notes of the mid-
13 level providers working under his supervision.

14 73. By way of example, on or about February 13, 2015, Physician Assistant E saw Patient
15 4 in clinic for a 3-month follow-up. At the time, Patient E was receiving monthly prescriptions of
16 90 pills of 10/325 mg hydrocodone with acetaminophen, 60 tablets of carisoprodol, and 30 pills
17 of 12.5 mg Ambien. In essence, Patient 4 was receiving a MED of 30 in combination with a
18 hypnotic and muscle relaxant. It is noteworthy that on this occasion, and on other occasions
19 between February 3, 2015, and June 19, 2018, Patient 4 received two hard copy prescriptions for
20 opiates that were post-dated to be filled at later dates in addition to his prescription that was to be
21 filled on the day of the treatment visit.²⁰ Respondent did not counter-sign the progress note on
22 February 13, 2015. A urine screen was performed on or about March 10, 2015. The urine drug
23 screen result was completely negative despite the fact that Patient 4 was being prescribed
24 hydrocodone, carisoprodol, and Ambien.

25 74. On or about April 7, 2015, Physician Assistant E saw Patient 4 in clinic for a
26 workmen's compensation follow-up. Physician Assistant E started Patient 4 on a daily

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28 ²⁰ For example, it appears post-dated scripts were also issued on August 31, 2015, for
hydrocodone and morphine sulfate.

1 prescription of 30 mg tablet of morphine sulfate extended release, 2 tablets of 10/325 mg
2 hydrocodone, 3 tablets of 350 mg carisoprodol, and 1 tablet of 2 mg lorazepam. Physician
3 Assistant E discontinued Ambien and replaced it with lorazepam. In essence, Physician Assistant
4 E increased Patient 4's MED to 50 in combination with a muscle relaxer and a benzodiazepine.
5 Physician Assistant E failed to document in the progress note that Patient 4 had provided a
6 negative urine drug screen, nor did he incorporate that negative urine drug screen into Patient 4's
7 chronic pain treatment plan. Respondent did not counter-sign the April 7, 2015, progress note.

8 75. On or about November 30, 2015, Patient 4 signed a pain contract. The pain contract
9 did not state whether or not Patient 4 could take illicit drugs, marijuana, or consume alcohol while
10 on chronic pain management. On or about January 22, 2016, Patient 4 provided a urine drug
11 screen which showed the presence of marijuana, opiates, and benzodiazepines. At the subject
12 interview with the Medical Board on February 26, 2019, Respondent stated that he was aware that
13 Patient 4 was consuming marijuana. However, on or about March 29, 2016, at his next visit to
14 the clinic, Patient 4 saw Respondent in clinic for a chief complaint of "w/c" and Respondent
15 failed to document that Patient 4 was consuming marijuana in addition to receiving chronic pain
16 therapy. By March 29, 2016, Respondent was prescribing Patient 4 a daily chronic pain regimen
17 of 90 mg of morphine sulfate extended release, 30 mg of hydrocodone with acetaminophen, 4 mg
18 of lorazepam, and 1050 mg of carisoprodol. In essence, Respondent had Patient 4 on a MED of
19 120 in combination with a muscle relaxant and a benzodiazepine and evidence of on-going
20 marijuana use. A review of the medical records between March 29, 2016, and June 19, 2018,
21 reveal no other urine drug screens despite Patient 4's November 30, 2015, pain contract clearly
22 stating that urine drug screens would be performed every three months.

23 76. On or about January 12, 2018, Respondent saw Patient 4 in clinic for a chief
24 complaint of follow-up. At the time, Respondent was prescribing a daily prescription of 90 mg of
25 morphine sulfate extended release, 30 mg of Norco, 1050 mg of Soma, and 6 mg of lorazepam.
26 In essence, Respondent was continuing to prescribe Patient 4 a MED of 120 in combination with
27 a muscle relaxant and a benzodiazepine and evidence of on-going marijuana use. The January 12,
28

1 2018, prescriptions represented a significant increase in medication over the prescriptions that
2 Patient 4 had received in February 2015.

3 77. Between February 3, 2015, and through June 19, 2018, Respondent and the mid-level
4 providers he was supervising, failed to properly monitor Patient 4, as he was prescribed
5 controlled substances, in particular, high dose opiates and opioids. For example, the medical
6 records only revealed the documented results of two urine drug screens, one of which was
7 negative for drugs despite on-going prescriptions and the other drug screen showed the presence
8 of marijuana which was not incorporated into Patient 4's documented on-going chronic treatment
9 plan. Respondent and the mid-level providers he was supervising failed to document whether
10 they referred Patient 4 to pain management specialists, psychiatrists, or neurosurgeons.
11 Respondent and the mid-level providers he was supervising failed to perform formal evaluations
12 such as a CAGE questionnaire or Beck Depression Inventory on Patient 4. In addition,
13 Respondent failed to more regularly review and counter-sign the progress notes of the mid-level
14 providers that he was supervising as they provided medical care to Patient 4, despite his complex
15 issues with chronic pain. Respondent, at the subject interview with the Medical Board, stated that
16 he enlisted the help of Patient 4's wife to tell Respondent if Patient 4 was having problems with
17 his chronic pain treatment without using more objective means to test Patient 4's compliance on
18 chronic pain therapy. Finally, Respondent repeatedly received letters in 2016 and 2017 as part of
19 Patient 4's worker's compensation case that indicated independent expert medical reviewers had
20 raised concerns with Patient 4's on-going high dose opiate and opioid prescriptions, Patient 4's
21 on-going benzodiazepine prescriptions, and Patient 4's on-going carisoprodol prescriptions,
22 without modifying Patient 4's chronic pain treatment plan.

23 78. Between February 3, 2015, and through June 19, 2018, Respondent, and the mid-level
24 medical providers that he was supervising, continued to prescribe multiple combinations of
25 medications to Patient 4 that placed him at greater risk of respiratory depression and death. For
26 example, Respondent prescribed opiates in combination with benzodiazepines and carisoprodol
27 on multiple occasions. Opiates and benzodiazepines in combination are known to cause severe
28 sedation. Opiates and carisoprodol in combination are known to cause severe sedation. In

1 addition, Respondent and the mid-levels providers he was supervising, prescribed Naprosyn and
2 benazepril in combination, which can cause serious renal compromise, and he prescribed Lyrica
3 and benazepril in combination which can cause respiratory compromise. Respondent also failed
4 to adequately examine and/or document whether Patient 4's marijuana use and alcohol use in
5 combination with opiates, benzodiazepines, and carisoprodol could also lead to additional risk of
6 sedation and/or death. Finally, Respondent, and the mid-level providers he was supervising failed
7 to show any significant efforts at tapering the multiple combinations of drugs that Patient 4 was
8 taking between February 3, 2015, and June 19, 2018.

9 **FIRST CAUSE FOR DISCIPLINE**

10 **(Gross Negligence)**

11 79. Respondent's license is subject to disciplinary action under section 2234, subdivision
12 (b), of the Code, and Title 16, California Code of Regulations section 1399.541, in that he
13 committed gross negligence during the care and treatment of Patients 1, 2, and 3. The
14 circumstances are as follows:

15 80. Complainant realleges paragraphs 24 through 70, and those paragraphs are
16 incorporated by reference as if fully set forth herein.

17 81. Respondent's license is subject to disciplinary action because he, and the mid-level
18 providers he was supervising, committed gross negligence during the care and treatment of
19 Patients 1, 2, and 3 in the following distinct and separate ways:

- 20 a. By failing to properly provide supervision and oversight to mid-level practitioners
21 who prescribed high quantities of controlled substances to Patient 1 in such a way to place
22 Patient 1 at risk of overdose and death;
- 23 b. By failing to properly evaluate and manage Patient 2 while Patient 2 received
24 controlled substances as a high risk patient who was at risk of suffering from serious side
25 effects due to a past history of illicit drug use and alcohol use; and
- 26 c. By failing to manage Patient 3's complex, multiple, and serious medical problems
27 that were in addition to her chronic pain issues.

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1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 82. Respondent's license is subject to disciplinary action under section 2234, subdivision
4 (c), of the Code, and Title 16, California Code of Regulations section 1399.541 in that he, and the
5 mid-level providers he was supervising, committed repeated negligent acts during the care and
6 treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

7 83. Complainant realleges paragraphs 24 through 78, and those paragraphs are
8 incorporated by reference as if fully set forth herein.

9 84. Respondent committed the following negligent acts during the care and treatment of
10 Patients 1, 2, 3, and 4:

- 11 a) By failing to properly provide supervision and oversight to mid-level practitioners
12 who prescribed high quantities of controlled substances to Patient 1 in such a way to place
13 Patient 1 at risk of overdose and death;
- 14 b) By failing to closely monitor the dangerous amounts of controlled substances,
15 specifically multiple prescriptions of 90 mg of oxycodone per day, that were prescribed to
16 Patient 1 in the form of multiple hard copy prescriptions which allowed for refills without
17 office visits;
- 18 c) By prescribing opiate medications in combination with sedatives, specifically a daily
19 dosing of 90 mg of oxycodone with 6 mg of alprazolam and 30 mg of diazepam, to Patient
20 1 which may increase the risk of respiratory depression and death;
- 21 d) By failing to evaluate and manage Patient 1 as a high-risk chronic pain patient to
22 ensure that Patient 1 was not at risk of improperly using controlled medications, specifically
23 failing to do an assessment of Patient 1's alcohol use and failing to perform drug screening;
- 24 e) By failing to properly document accurate and complete medical records during the
25 treatment of Patient 1;
- 26 f) By failing to properly evaluate and manage Patient 2 while Patient 2 received
27 controlled substances as a high risk patient who was at risk of suffering from serious side
28 effects due to a past history of illicit drug use and alcohol use;

- 1 g) By prescribing dangerous levels of opiates to Patient 2 without properly managing
2 Patient 2's plan of treatment;
- 3 h) By prescribing multiple combinations of medications, including but not limited to
4 multiple opioids with multiple sedatives, to Patient 2 which may have increased the risk of
5 respiratory depression and death;
- 6 i) By failing to manage Patient 3's complex, multiple, and serious medical problems
7 that were in addition to her chronic pain issues;
- 8 j) By failing to properly monitor dangerous amounts of controlled substances,
9 specifically opiates, to Patient 3 in such a way to place Patient 3 at risk of addiction and
10 serious side effects;
- 11 k) By prescribing opiate medications in combination with sedatives to Patient 3 which
12 may increase the risk of respiratory depression and death;
- 13 l) By failing to properly monitor dangerous amounts of controlled substances,
14 specifically opiates, to Patient 4 in such a way to place Patient 4 at risk of addiction and
15 serious side effects; and
- 16 m) By prescribing opiate medications in combination with sedatives to Patient 4 which
17 may increase the risk of respiratory depression and death.

18 **THIRD CAUSE FOR DISCIPLINE**

19 **(Inaccurate and Inadequate Medical Records)**

20 85. Respondent's license is subject to disciplinary action under section 2266 of Code, and
21 Title 16, California Code of Regulations section 1399.541, in that he, and the mid-level providers
22 he was supervising, kept inaccurate and incomplete medical records. The circumstances are as
23 follows:

24 86. Complainant realleges paragraphs 24 through 78, and those paragraphs are
25 incorporated by reference as if fully set forth herein.

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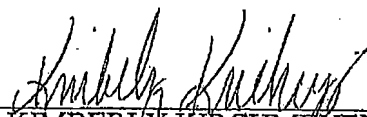
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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 87909, issued to Daniel S. Sewell, M.D.;
2. Revoking, suspending or denying approval of Daniel S. Sewell, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Daniel S. Sewell, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and
4. Ordering Daniel S. Sewell, M.D., if placed on probation, to disclose the disciplinary order to patients pursuant to section 2228.1 of the Code; and
5. Taking such other and further action as deemed necessary and proper.

DATED: October 4, 2019


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

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