

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

In the Matter of the Accusation
Against:

Dwain William Rickertsen, M.D.

Physician's and Surgeon's
Certificate No. A 45073

Respondent.

Case No.: 800-2017-039105

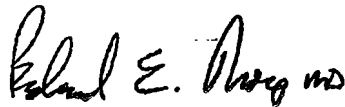
DECISION

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 March 4, 2022.

IT IS SO ORDERED: February 4, 2022.

MEDICAL BOARD OF CALIFORNIA



Richard E. Thorp, M.D., Chair
Panel B

1 ROB BONTA
Attorney General of California
2 STEVEN D. MUNI
Supervising Deputy Attorney General
3 JOHN S. GATSCHET
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**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

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In the Matter of the Accusation Against:

Case No. 800-2017-039105

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DWAIN WILLIAM RICKERTSEN, M.D.
9701 Collier Avenue
Live Oak, CA 95953-9670

OAH No. 2021050157

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**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

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Physician's and Surgeon's Certificate
No. A 45073

18

Respondent.

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

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PARTIES

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1. William Prasifka ("Complainant") is the Executive Director of the Medical Board of California ("Board"). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by John S. Gatschet, Deputy Attorney General.

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1 cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully
2 document in the patient's chart that the patient or the patient's primary caregiver was so
3 informed. Nothing in this condition prohibits Respondent from providing the patient or the
4 patient's primary caregiver information about the possible medical benefits resulting from the use
5 of marijuana.

6 Respondent shall immediately surrender Respondent's current DEA permit to the Drug
7 Enforcement Administration for cancellation and reapply for a new DEA permit limited to those
8 Schedules (IV and V) authorized by this order. Within 15 calendar days after the effective date of
9 this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA
10 permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15
11 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a
12 true copy of the permit to the Board or its designee.

13 2. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO
14 RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled
15 substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any
16 recommendation or approval which enables a patient or patient's primary caregiver to possess or
17 cultivate marijuana for the personal medical purposes of the patient within the meaning of Health
18 and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and
19 address of the patient; 2) the date; 3) the character and quantity of controlled substances involved;
20 and 4) the indications and diagnosis for which the controlled substances were furnished.

21 Respondent shall keep these records in a separate file or ledger, in chronological order. All
22 records and any inventories of controlled substances shall be available for immediate inspection
23 and copying on the premises by the Board or its designee at all times during business hours and
24 shall be retained for the entire term of probation.

25 3. EDUCATION COURSE. Within 60 calendar days of the effective date of this
26 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
27 for its prior approval educational program(s) or course(s) which shall not be less than 40 hours
28 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at

1 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
2 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
3 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
4 completion of each course, the Board or its designee may administer an examination to test
5 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
6 hours of CME of which 40 hours were in satisfaction of this condition.

7 4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective
8 date of this Decision, Respondent shall enroll in a course in prescribing practices approved in
9 advance by the Board or its designee. Respondent shall provide the approved course provider
10 with any information and documents that the approved course provider may deem pertinent.
11 Respondent shall participate in and successfully complete the classroom component of the course
12 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
13 complete any other component of the course within one (1) year of enrollment. The prescribing
14 practices course shall be at Respondent's expense and shall be in addition to the Continuing
15 Medical Education (CME) requirements for renewal of licensure.

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

21 Respondent shall submit a certification of successful completion to the Board or its
22 designee not later than 15 calendar days after successfully completing the course, or not later than
23 15 calendar days after the effective date of the Decision, whichever is later.

24 5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
25 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
26 advance by the Board or its designee. Respondent shall provide the approved course provider
27 with any information and documents that the approved course provider may deem pertinent.
28 Respondent shall participate in and successfully complete the classroom component of the course

1 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
2 complete any other component of the course within one (1) year of enrollment. The medical
3 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
4 Medical Education (CME) requirements for renewal of licensure.

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

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

13 6. MEDICAL EVALUATION AND TREATMENT. Within 30 calendar days of the
14 effective date of this Decision, and on a periodic basis thereafter as may be required by the Board
15 or its designee, Respondent shall undergo a medical evaluation to determine if he has a hearing
16 loss by a Board-appointed physician who shall consider any information provided by the Board or
17 designee and any other information the evaluating physician deems relevant and shall furnish a
18 medical report to the Board or its designee. Respondent shall provide the evaluating physician
19 with any information and documentation that the evaluating physician may deem pertinent.

20 Following the evaluation, Respondent shall comply with all restrictions or conditions
21 recommended by the evaluating physician within 15 calendar days after being notified by the
22 Board or its designee. If Respondent is required by the Board or its designee to undergo medical
23 treatment, Respondent shall within 30 calendar days of the requirement notice, submit to the
24 Board or its designee for prior approval the name and qualifications of a California licensed
25 treating physician of Respondent's choice. Upon approval of the treating physician, Respondent
26 shall within 15 calendar days undertake medical treatment and shall continue such treatment until
27 further notice from the Board or its designee.

28 The treating physician shall consider any information provided by the Board or its designee

1 or any other information the treating physician may deem pertinent prior to commencement of
2 treatment. Respondent shall have the treating physician submit quarterly reports, if needed by the
3 Board, to the Board or its designee indicating whether or not the Respondent is capable of
4 practicing medicine safely. Respondent shall provide the Board or its designee with any and all
5 medical records pertaining to treatment that the Board or its designee deems necessary.

6 If, prior to the completion of probation, Respondent is found to be physically incapable of
7 resuming the practice of medicine without restrictions, the Board shall retain continuing
8 jurisdiction over Respondent's license and the period of probation shall be extended until the
9 Board determines that Respondent is physically capable of resuming the practice of medicine
10 without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

11 A medical evaluation that is performed after the acts that gave rise to the charges in the
12 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
13 or its designee, may be accepted towards the fulfillment of this condition if the medical
14 evaluation determines that Respondent has no hearing loss and does not require on-going
15 evaluation for hearing loss.

16 7. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the
17 solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice
18 where: 1) Respondent merely shares office space with another physician but is not affiliated for
19 purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that
20 location.

21 If Respondent fails to establish a practice with another physician or secure employment in
22 an appropriate practice setting within 60 calendar days of the effective date of this Decision,
23 Respondent shall receive a notification from the Board or its designee to cease the practice of
24 medicine within three (3) calendar days after being so notified. The Respondent shall not resume
25 practice until an appropriate practice setting is established.

26 If, during the course of the probation, the Respondent's practice setting changes and the
27 Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent
28 shall notify the Board or its designee within five (5) calendar days of the practice setting change.

1 If Respondent fails to establish a practice with another physician or secure employment in an
2 appropriate practice setting within 60 calendar days of the practice setting change, Respondent
3 shall receive a notification from the Board or its designee to cease the practice of medicine within
4 three (3) calendar days after being so notified. The Respondent shall not resume practice until an
5 appropriate practice setting is established.

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

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

15 9. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE
16 NURSES. During probation, Respondent is prohibited from supervising physician assistants and
17 advanced practice nurses.

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

21 11. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations
22 under penalty of perjury on forms provided by the Board, stating whether there has been
23 compliance with all the conditions of probation.

24 Respondent shall submit quarterly declarations not later than 10 calendar days after the end
25 of the preceding quarter.

26 12. GENERAL PROBATION REQUIREMENTS.

27 Compliance with Probation Unit

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

1 Address Changes

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

7 Place of Practice

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

11 License Renewal

12 Respondent shall maintain a current and renewed California physician's and surgeon's
13 license.

14 Travel or Residence Outside California

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

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

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

24 14. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
25 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
26 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
27 defined as any period of time Respondent is not practicing medicine as defined in Business and
28 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct

1 patient care, clinical activity or teaching, or other activity as approved by the Board. If
2 Respondent resides in California and is considered to be in non-practice, Respondent shall
3 comply with all terms and conditions of probation. All time spent in an intensive training
4 program which has been approved by the Board or its designee shall not be considered non-
5 practice and does not relieve Respondent from complying with all the terms and conditions of
6 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
7 on probation with the medical licensing authority of that state or jurisdiction shall not be
8 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
9 period of non-practice.

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

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

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

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

22 15. COMPLETION OF PROBATION. Respondent shall comply with all financial
23 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
24 completion of probation. Upon successful completion of probation, Respondent's certificate shall
25 be fully restored.

26 16. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
27 of probation is a violation of probation. If Respondent violates probation in any respect, the
28 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and

1 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,
2 or an Interim Suspension Order is filed against Respondent during probation, the Board shall have
3 continuing jurisdiction until the matter is final, and the period of probation shall be extended until
4 the matter is final.

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

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

20 19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
21 a new license or certification, or petition for reinstatement of a license, by any other health care
22 licensing action agency in the State of California, all of the charges and allegations contained in
23 Accusation No. 800-2017-039105 shall be deemed to be true, correct, and admitted by
24 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
25 restrict license.

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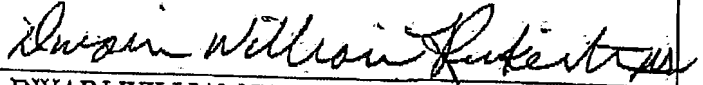
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ACCEPTANCE

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

DATED: 11/9/2021 
DWAIN WILLIAM RICKERTSEN, M.D.
Respondent

I have read and fully discussed with Respondent Dwain William Rickertsen, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

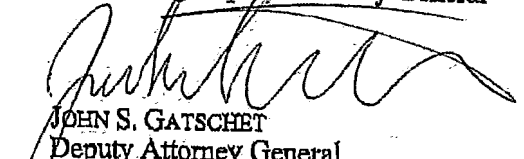
DATED: 11/9/21 
DOMINIQUE A. POLLARA
Attorney for Respondent

ENDORSEMENT

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

DATED: 11-9-2021

Respectfully submitted,
ROB BONTA
Attorney General of California
STEVEN D. MUNE
Supervising Deputy Attorney General


JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

1 XAVIER BECERRA
Attorney General of California
2 STEVEN D. MUNI
Supervising Deputy Attorney General
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8 *Attorneys for Complainant*

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

In the Matter of the Accusation Against:
Dwain William Rickertsen, M.D.
12140 New York Ranch Rd.
Jackson, CA 95642-9407
Physician's and Surgeon's Certificate
No. A 45073,
Respondent.

Case No. 800-2017-039105
ACCUSATION

PARTIES

- 22 1. William Prasifka ("Complainant") brings this Accusation solely in his official
23 capacity as the Executive Director of the Medical Board of California, Department of Consumer
24 Affairs ("Board").
- 25 2. On or about July 25, 1988, the Medical Board issued Physician's and Surgeon's
26 Certificate Number A 45073 to Dwain William Rickertsen, M.D. ("Respondent"). The
27 Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the
28 charges brought herein and will expire on April 30, 2022, unless renewed.

1 JURISDICTION

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

5 4. Section 2227 of the Code provides, in pertinent part, that a licensee who is found
6 guilty under the Medical Practice Act may have his or her license revoked, suspended for a period
7 not to exceed one year, placed on probation and required to pay the costs of probation monitoring,
8 or such other action taken in relation to discipline as the Board deems proper.

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

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

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

14 (b) Gross negligence.

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

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

19 (2) When the standard of care requires a change in the diagnosis, act, or
20 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
21 licensee's conduct departs from the applicable standard of care, each departure
constitutes a separate and distinct breach of the standard of care.

22

23 6. Section 2266 of the Code, states in pertinent part:

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

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1 7. Section 2228.1 of the Code, states in pertinent part:

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

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

14 (A) The commission of any act of sexual abuse, misconduct, or relations with a
15 patient or client as defined in Section 726 or 729.

16 (B) Drug or alcohol abuse directly resulting in harm to patients or the extent that
17 such use impairs the ability of the licensee to practice safely.

18 (C) Criminal conviction directly involving harm to patient health.

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

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

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

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision
(a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and
sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care
surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is
unscheduled, including consultations in inpatient facilities.

1 (3) The licensee who will be treating the patient during the visit is not known to the
2 patient until immediately prior to the start of the visit.

3 (4) The licensee does not have a direct treatment relationship with the patient.

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

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

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

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

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

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

18 (e) Section 2314 shall not apply to this section.

19 PERTINENT DRUG DEFINITIONS

20 8. Oxycodone – Generic name for Roxicodone and Oxecta. Oxycodone has a high risk
21 for addiction and dependence. It can cause respiratory distress and death when taken in high
22 doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting
23 opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting
24 formulation known as Oxycontin-ER. This formulation allows for extended release of the
25 medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal
26 Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California
27 Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant
28 to California Health and Safety Code section 11055 subdivision (b).

9. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and
Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination

1 product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a
2 Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section
3 1308.12.¹ Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business
4 and Professions Code section 4022 and is a Schedule II controlled substance pursuant to
5 California Health and Safety Code section 11055, subdivision (b).

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

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

16 12. Alprazolam – Generic name for Xanax. Alprazolam is a member of the
17 benzodiazepine family and is an anti-anxiety medication used for the short-term management of
18 severe anxiety and panic attacks. Alprazolam is a Schedule IV controlled substance pursuant to
19 Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section
20 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section
21 4022.

22 13. Phenergan Codeine Cough Syrup – Generic name for Codeine with Promethazine.
23 Phenergan Codeine Cough Syrup is a narcotic combination drug used for the short-term treatment
24 of cough, congestion and allergy relief. Phenergan Codeine Cough Syrup is classified as a
25 Schedule I controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.15
26 (c) and a dangerous drug pursuant to Business and Professions Code section 4022.

27
28 ¹ Prior to October 6, 2014, hydrocodone with acetaminophen was a Schedule III
controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).

Date	Prescription	Drug	Quantity	MED ³	Acetaminophen
8/7/2014	30 days	10/325 mg hydrocodone with acetaminophen	300 tablets	150 MED	5,875 mg APAP ⁴
8/27/2014	30 days	10/325 mg hydrocodone with acetaminophen	120 tablets	200 MED	6,500 mg APAP
9/2/2014	30 days	10/325 mg hydrocodone with acetaminophen	240 tablets	171 MED	5571 mg APAP
9/16/2014	30 days	10/325 mg hydrocodone with acetaminophen	240 tablets	--	--

The hydrocodone with acetaminophen prescriptions were filled at two different pharmacies, Safeway and Savesave, were all issued by the Respondent and the prescriptions greatly increased Patient 1's MED. In addition, assuming that Patient 1 took all of the medications that he received, it placed his daily intake of acetaminophen over 4000 mg.

17. According to Respondent's January 14, 2015, charting note, Patient 1's x-rays were negative and indicated that he was normal. The Respondent documented that Patient 1 had initially felt he was paralyzed after the January 2015 accident but that movement had returned to his extremities. The Respondent documented that Patient 1 had returned to work with some back pain, and that Patient 1 reported sinus pressure, congestion, and a productive cough. The Respondent documented that Patient 1 was a smoker. The Respondent failed to document how

³ Morphine Equivalent Dose ("MED"), is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's 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. The State of Washington provides a free MED tool at www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm, which is widely used in the medical community.

⁴ Abbreviation for acetaminophen

1 long Patient 1 had been experiencing symptoms for his sinus pressure, congestion, and his
2 productive cough. The Respondent documented that Patient 1 had "point tenderness L upper
3 back," knee pain, and that his lungs sounded "rhonchi" The Respondent prescribed 300 tablets of
4 10/325 mg hydrocodone with acetaminophen, 120 tablets of 350 mg carisoprodol, and 90 tablets
5 of .5 mg alprazolam. The Respondent also prescribed antibiotics⁵ to deal with a diagnosis of
6 acute bronchitis. As prescribed, Patient 1 had a MED of 100 in combination with a
7 benzodiazepine and a muscle relaxer.

8 18. Between January 2015 and September 2015, the Respondent on a monthly basis,
9 prescribed 240 tablets of 10/325 mg hydrocodone with acetaminophen, 120 tablets of 350 mg
10 carisoprodol, and 60 tablets of .5 mg alprazolam to Patient 1.⁶ On or about September 14, 2015,
11 Respondent's colleague, Doctor A, prescribed 240 tablets of 10/325 mg oxycodone with
12 acetaminophen to Patient 1 after Patient 1 reported that he had suffered a back injury. Patient 1
13 had previously filled Respondent's prescription for 240 tablets of 10/325 mg hydrocodone with
14 acetaminophen on or about September 3, 2015. On or about October 6, 2015, Patient 1 filled a
15 new prescription for 240 tablets of 10/325 mg hydrocodone with acetaminophen, issued by
16 Respondent, after Patient 1 reported to the Respondent that Percocet made him too sleepy and he
17 requested Norco. Patient 1 continued to receive prescriptions for alprazolam and carisoprodol
18 from Respondent during that time. In the Respondent's October 6, 2015, progress note he failed
19 to document whether Patient 1 was instructed to destroy the Percocet and/or document whether he
20 was concerned that the Patient reported as being too sleepy after receiving Percocet. Patient 1
21 also informed Respondent that he had a rash and the Respondent diagnosed it as dermatitis and
22 prescribed an antibiotic⁷, an antifungal and a steroid.

23 19. On or about November 12, 2015, the Respondent saw Patient 1 in clinic. The
24 Respondent appeared to electronically cut and paste the general examination portions of Dr. A's
25 September 14, 2015, progress note into his current note. The Respondent also appeared to

26 ⁵ The Respondent prescribed the Z-Pak, Zithromax, a widely used antibiotic for treatment
27 of bronchitis, pneumonia, and infections of the ears and lungs.

28 ⁶ MED of 80, in combination with a benzodiazepine and muscle relaxer.

⁷ The Respondent prescribed Bactram, a combination antibiotic consisting of
sulfamethoxazole and trimethoprim.

1 template the rest of the exam with terms like "tightness of PVM's." The Respondent documented
2 "rhonchi", diagnosed bronchitis and prescribed a Z-Pak. The Respondent failed to diagnose a
3 duration of symptoms related to bronchitis. The Respondent continued to prescribe 240 tablets of
4 10/325 mg hydrocodone with acetaminophen, 120 tablets of 350 mg carisoprodol and 60 tablets
5 of .5 mg alprazolam. On November 23, 2015, Patient 1 contacted the clinic and stated he was
6 still sick and requesting another prescription for a Z-Pak and Phenergan with codeine cough
7 syrup. The Respondent, without doing any additional work-up or seeing the patient, issued
8 another prescription for a Z-Pak and Phenergan with codeine cough syrup.

9 20. On or about December 7, 2015, Patient 1 was seen in clinic by a physician assistant
10 under Respondent's supervision. The physician assistant documented that Patient 1 had a chief
11 complaint of "cold or flu for 3 wks." and noted that the "Z-pak (*sic*) helped a little." The
12 physician assistant documented that Patient 1 was still sick but failed to document any additional
13 symptom details. The physician assistant refilled Patient 1's Phenergan with codeine cough syrup
14 and prescribed antibiotics.⁸ During that period in 2015, Patient 1 called in for early refills twice
15 and on or about October 15, 2015, reported his controlled medications were stolen from his truck.
16 A copy of the October 14, 2015, police record is contained in Patient 1's chart and states that
17 Patient 1 reported a burglary but there is no other information contained in the police record. On
18 or about December 8, 2015, Patient 1 requested more Phenergan with codeine syrup after he
19 stated his bottle shattered and the Respondent wrote him another prescription for Phenergan with
20 codeine cough syrup. Respondent refilled Patient 1's prescriptions for 120 tablets of 350 mg
21 carisoprodol, 240 tablets of 10/325 mg hydrocodone with acetaminophen and 60 tablets of .5 mg
22 alprazolam the next day on December 9, 2015, by phone.

23 21. On or about January 4, 2016, Patient 1 was seen in clinic by Respondent for a back
24 injury caused when Patient 1 tugged at a starter cord on a lawn mower. The Respondent
25 documented that Patient 1 went to worker's compensation, that Patient 1 needed a refill of
26 Percocet and that workmen's compensation would not give Patient 1 anything stronger than
27 Motrin. According to CURES, Patient 1 received 30 tablets of 10/325 mg oxycodone with

28 ⁸ The physician assistant prescribed Levaquin, a fluoroquinolone antibiotic.

1 acetaminophen on or about December 17, 2015, but Respondent makes no mention of this
2 prescription in the records. In addition, Respondent failed to note any of the previous concerns
3 that Patient 1 was made sleepy by Percocet when Respondent's colleague, Doctor A, previously
4 prescribed Percocet. The Respondent documented that he prescribed 40 tablets of 10 mg
5 oxycodone for ten days and continued Patient 1 on carisoprodol. On or about January 5, 2016,
6 Patient 1 called in to the Respondent's clinic and stated that oxycodone caused him a bad
7 migraine and that he wanted hydrocodone with acetaminophen. According to the telephone note,
8 the Respondent requested that Patient 1 bring in his oxycodone prescription and then Respondent
9 would re-issue a Norco prescription. According to the note, Patient 1 "paused for a second" and
10 then stated he had disposed of them in kitty litter. The Respondent refused to issue the
11 hydrocodone with acetaminophen prescription because the patient needed to bring in the
12 oxycodone.

13 22. On or about January 7, 2016, Patient 1 returned to Respondent's clinic. The
14 Respondent documented that Patient 1 was given oxycodone but that he had "threw(sic) them
15 away." The kitty litter story is not mentioned in the progress note. The Respondent documented
16 that Patient 1 wanted Norco, that he was in a previous motor vehicle accident in October 2014,
17 and that he had injured himself at work. The Respondent also documented that Patient 1, "was
18 using meds with increased amount," and being followed at workers compensation clinic. The
19 Respondent documented that Patient 1 had head and neck tenderness, joint pain and back pain.
20 The Respondent documented that Patient 1 consumed alcohol and was a smoker. The
21 Respondent continued Patient 1's prescriptions for 120 tablets of 350 mg carisoprodol, 240
22 tablets of 10/325 mg hydrocodone with acetaminophen and 60 tablets of .5 mg alprazolam.
23 Despite receiving a monthly prescription of medications, Patient 1 received a refill of 120 tablets
24 of 350 mg carisoprodol, 240 tablets of 10/325 mg hydrocodone with acetaminophen and 60
25 tablets of .5 mg alprazolam, 3 days early on February 4, 2016.

26 23. On February 17, 2016, Patient 1 called in to clinic and stated that his current
27 alprazolam prescription was not working well and he requested an increase in dosage. According
28 to the telephonic note, the patient had come to clinic but was turned away because the

1 Respondent's schedule was booked. Despite providing a prescription for 60 tablets of .5 mg
2 alprazolam on February 4, 2016, the Respondent prescribed 90 tablets of 1 mg alprazolam on
3 February 18, 2016. This in effect tripled Patient 1's dosage. The Respondent did not see Patient
4 1 in clinic prior to this rapid increase and continued to prescribe Norco and Soma to Patient 1. In
5 addition, on Patient 1's CURES there is documentation that a different physician provided Patient
6 1 with 20 tablets of 10/325 mg oxycodone with acetaminophen on or about February 15, 2016.
7 On or about March 1, 2016, the Respondent by telephone authorized Patient 1 to refill his 90
8 tablets of 1 mg alprazolam and 120 tablets of 350 mg prescriptions, still without seeing him in
9 clinic.

10 24. In February 2016, Respondent's practice received a letter addressed to Respondent
11 from Express Scripts. The Express Scripts letter noted that Patient 1 was receiving an opioid
12 analgesic in combination with a benzodiazepine and carisoprodol. The letter included a
13 prescription profile that Patient 1 was receiving three short acting opioids in Norco, Percocet⁹ and
14 oxycodone, a narcotic in Codeine cough syrup, alprazolam and carisoprodol at the same time.
15 The letter specifically stated that Patient 1 was receiving a combination of medications known as
16 the "Houston Cocktail" or "Holy Trinity" which the letter noted has a, "strong abuse potential and
17 addictive central nervous system depressant effects may result in an increased risk of serious
18 adverse drug events." The letter went on to note, "(i)n light of the risks of addiction, abuse, and
19 misuse and the greater risks of overdose and death associated with this combination, please
20 consider whether changes in therapy are warranted."

21 25. On March 3, 2016, Respondent saw Patient in clinic for low back pain and a request
22 for a refill of hydrocodone with acetaminophen. The Respondent failed to document any
23 information related to the February 2016 Express Scripts letter regarding the dangerous
24 medication combination or that Patient 1 was receiving drugs from other providers. The review
25 of systems and examination appeared to be electronically cut and pasted from previous notes.
26 The Respondent continued Patient 1 on Norco, Soma, and alprazolam. There is no

27
28 ⁹ This documented that Percocet was being provided from another physician outside of
Respondent's practice.

1 documentation that Patient 1 was dealing with a cough and/or in respiratory distress at the March
2 3, 2016, visit. The Respondent failed to document that he analyzed or assessed why he had
3 tripled Patient 1's alprazolam prescription. On March 4, 2016, Patient 1 called into Respondent's
4 clinic and requested a refill of Phenergan with codeine cough syrup. The Respondent authorized
5 Patient 1 to receive Phenergan with codeine cough syrup despite no clinical rationale present for
6 the medication. On March 17, 2016, the Respondent again authorized a refill of Phenergan with
7 codeine cough syrup despite no clinical rationale present for the medication and also authorized
8 Patient 1's refill of 90 tablets of 1 mg alprazolam. Between March 2016 and May 2017, the
9 Respondent repeatedly prescribed Phenergan with codeine cough syrup to Patient 1.

10 26. On or about May 9, 2016, the Respondent saw Patient 1 in clinic for an infected bite
11 on the back of his ear. The Respondent documented that the ear area was swollen and that there
12 was tenderness present. The Respondent also documented that Patient 1 had a cough and was
13 congested but did not document any information related to the duration of the symptoms. On or
14 about May 10, 2016, the Respondent documented that Patient 1 was present for possible excision
15 and electronically copied and pasted information from the previous note. The Respondent did not
16 document a procedure note for the incision and drainage of the ear lesion. The Respondent
17 prescribed 40 tablets of 10/325 mg oxycodone with acetaminophen despite prescribing a month's
18 prescription of hydrocodone with acetaminophen only 11 days earlier. If Patient 1 took the
19 oxycodone with acetaminophen and hydrocodone with acetaminophen as prescribed his MED
20 was 140 and his acetaminophen intake was 3,900 mg. The Respondent also prescribed
21 antibiotics.¹⁰ On May 20, 2016, the Respondent refilled Patient 1's Bactrim prescription and
22 Phenergan with codeine cough syrup prescription without seeing him in clinic. On or about June
23 1, 2016, Patient 1 called into Respondent's clinic and requested a refill of antibiotics and
24 Percocet. Despite Patient 1 refilling Respondent's prescription for 240 tablets of 10/325 mg
25 hydrocodone with acetaminophen on or about May 27, 2016, the Respondent prescribed 80
26 tablets of 10/325 mg oxycodone with acetaminophen and an additional prescription of Bactrim.
27 The Respondent did not see Patient 1 in clinic prior to issuing those prescriptions. If Patient 1

28 ¹⁰ The Respondent prescribed Rocephin and Bactrim.

1 took the oxycodone with acetaminophen and hydrocodone with acetaminophen as prescribed his
2 MED was 140, his acetaminophen intake was 3,900 mg and he continued to receive Soma and
3 alprazolam.

4 27. On or about June 20, 2016, Patient 1 presented at Respondent's clinic with a chief
5 complaint of chest cold. The Respondent documented that Patient 1 had a cough, congestion for
6 three-to-four days and had missed work for the last two days. The Respondent also documented
7 that Patient 1 had chronic back pain. Despite Patient 1 recently receiving three previous courses
8 of antibiotics, the Respondent again prescribed antibiotics.¹¹ The Respondent refilled Patient 1's
9 monthly prescription of 240 tablets of 10/325 mg hydrocodone with acetaminophen, 120 tablets
10 of 350 mg carisoprodol, and 90 tablets of 1 mg alprazolam. The Respondent did not document
11 any information related to the recent prescriptions for oxycodone with acetaminophen and
12 whether the oxycodone with acetaminophen prescriptions were now part of Patient 1's on-going
13 chronic treatment plan. The Respondent also documented that he prescribed Phenergan with
14 codeine cough syrup to Patient 1. On July 1, 2016, Patient 1 called Respondent's clinic and
15 requested a refill of oxycodone with acetaminophen. Respondent's colleague, Doctor A,
16 provided a prescription of 80 tablets of 10/325 mg oxycodone with acetaminophen without
17 reviewing Patient 1's prior medications. As noted above, Patient 1's MED remained 140.

18 28. On or about July 5, 2016, Patient 1 presented at Respondent's clinic for recurrent
19 cough, body ache, fatigue, headaches and congestion. The Respondent noted that Doctor A
20 refilled Patient 1's Percocet on July 1, 2016. The Respondent prescribed antibiotics and a
21 steroid.¹² The Respondent also provided Patient 1 with more Phenergan with codeine cough
22 syrup. The Respondent documented that Patient 1's Percocet was now being continued for back
23 pain. There is no further analysis into Patient 1's chronic pain treatment plan. On July 14, 2016,
24 Patient 1 called into Respondent's clinic and stated he was almost better but still had a cough.
25 Respondent provided another prescription for Phenergan with codeine cough syrup. On July 19,
26 2016, Patient 1 presented at Respondent's clinic and saw Respondent's physician assistant.

27
28 ¹¹ The Respondent prescribed Levaquin.

¹² The Respondent prescribed Rocephin, Levaquin, and Medrol.

1 Despite previously receiving a monthly refill of hydrocodone with acetaminophen on June 24,
2 2016, Patient 1 requested a refill five days early after stating that on or about July 17, 2016, his
3 buddies had thrown him in a lake and his pills were in his pocket. The physician assistant early
4 refilled Patient 1's hydrocodone with acetaminophen prescription. Seven days after seeing the
5 physician assistant, Patient 1 called into Respondent's clinic and requested a refill of oxycodone
6 with acetaminophen. On July 28, 2016, the Respondent refilled Patient 1's 80 tablet of 10/325
7 mg oxycodone with acetaminophen prescription, continuing Patient 1 on an MED of 140, with
8 two short action opioids, in combination with Soma and alprazolam. The Respondent did not
9 document anything related to the Patient's July 19, 2016, claim that allowed him to have his
10 medication refilled early.

11 29. On August 16, 2016, Patient 1 presented at Respondent's clinic with a complaint of
12 "not feeling well." The Respondent documented that Patient 1 had finished his antibiotics, and
13 was requesting another refill of Phenergan with codeine cough syrup. The Respondent
14 documented that Patient 1 should stop Percocet for back pain and continue with only
15 hydrocodone with acetaminophen. There is no further analysis provided. Patient 1 was to
16 continue with 3 mg of alprazolam and 1400 mg of carisoprodol a day. On or about August 23,
17 2016, Patient 1 contacted Respondent's clinic and asked for a refill of Percocet. The telephonic
18 note documents that Respondent noted that Patient 1 was not to take both hydrocodone with
19 acetaminophen and oxycodone with acetaminophen and that the prescription was switched. On
20 or about September 2, 2016, Patient 1 presented at Respondent's clinic for a work note and
21 prescription refill. Respondent documented that Patient 1 requested a refill of Norco for back
22 pain despite receiving a month prescription of 240 tablets of 10/325 mg hydrocodone with
23 acetaminophen on or about August 16, 2016, just two weeks earlier. The Respondent
24 documented that he would refill Patient 1's Norco prescription, which Patient 1 refilled on or
25 about September 14, 2016, and he documented that Patient 1 should start a monthly prescription
26 of 80 tablets of 10/325 mg oxycodone with acetaminophen. There is no documentation related as
27 to why Respondent was modifying Patient 1's treatment plan to take a daily prescription of two
28

1 short acting narcotics with an MED of 119¹³ in combination with 3 mg of alprazolam and 1400
2 mg of Soma. Nor is there any reference to Respondent's notation from August 23, 2016, that
3 Respondent had stated Patient 1 was not to take both Norco and Percocet at the same time.

4 30. On or about September 23, 2016, Respondent's physician assistant refilled Patient 1's
5 prescription for Phenergan with codeine cough syrup. On or about September 27, 2016, Patient 1
6 contacted Respondent's clinic and stated that he had spilled his cough syrup and needed a refill.
7 The Respondent authorized a new refill of Phenergan with codeine cough syrup. On or about
8 September 28, 2016, the pharmacy called Respondent's clinic and noted that Patient 1 had just
9 picked up the cough syrup prescription on September 27, 2016, because they did not have it in
10 stock on September 23, 2016. According to the note, the Respondent determined he was not
11 comfortable with giving the refill based on this new information that the Patient may be misusing
12 medications. In September 2016, Respondent's practice received a letter addressed to
13 Respondent's physician assistant who was misidentified as a physician from Express Scripts. The
14 Express Scripts letter noted that Patient 1 was receiving an opioid analgesic in combination with a
15 benzodiazepine and carisoprodol. The letter included a prescription profile that Patient 1 was
16 receiving two short acting opioids in Norco and Percocet, a narcotic in Codeine cough syrup,
17 alprazolam and carisoprodol. The letter specifically stated that Patient 1 was receiving a
18 combination of medications known as the "Houston Cocktail" or "Holy Trinity" which has a,
19 "strong abuse potential and addictive central nervous system depressant effects may result in an
20 increased risk of serious adverse drug events." The letter went on to note, "(i)n light of the risks
21 of addiction, abuse, and misuse and the greater risks of overdose and death associated with this
22 combination, please consider whether changes in therapy are warranted."¹⁴

23 31. On or about November 2, 2016, Patient 1 called into Respondent's clinic. The note to
24 the Respondent from his staff person read as follows:

25
26 ¹³ The oxycodone with acetaminophen prescription was now documented for thirty days
27 as opposed to the previous prescriptions which had been documented for only twenty days,
causing the 80 tablets of oxycodone with acetaminophen to be more spread out.

28 ¹⁴ A third letter from Express Scripts address to Respondent's physician assistant was
received in March 2017, that made similar statements.

1 "now patient is calling to ask for more refill Percocet for the tooth cracked on sat, this is the
2 third or fourth time in past two weeks he has asked for this refill that you said no more of,
3 that you stopped per your chart notes. What do you want to do? Please note this pt has had
4 refills on Percocet and/or norco on these dates: 07/01, 07/05, 07/14, 07/19, 07/28, 08/02,
5 08/16, 09/02, 09/12, 10/11, and refilled the codeine with Phenergan syrup on: 07/19, 08/02,
6 08/16, 09/23, 09/27, 10/25 per chart."

7 The telephonic note documented that Respondent reviewed the note on November 2, 2016, at
8 approximately 1:44 p.m. On November 3, 2016, the Respondent saw Patient 1 in clinic for
9 complaint of cough, congestion, sore throat and body aches. The Respondent documented that
10 Patient 1 had chronic back pain and tooth pain with a crown procedure scheduled for November
11 22, 2016. The Respondent noted that Patient 1 had Phenergan with codeine refilled on 07/19,
12 08/02, 08/16, 09/23, 09/27, and 10/25. The Respondent documented that he would start Percocet,
13 despite already prescribing it previously, and continue Soma and Norco. The Respondent did not
14 document the September 2016 letter from Express Scripts in the note, nor did he document any
15 analysis on whether or not Patient 1 was misusing controlled substances as implied in the
16 November 2, 2016, telephonic note. The Respondent did not address Patient 1's incessant receipt
17 of codeine cough syrup. The Respondent also prescribed antibiotics.¹⁵ On November 4, 2016,
18 Patient 1 contacted Respondent's clinic and Respondent's physician assistant again refilled his
19 Phenergan with codeine cough syrup prescription.

20 32. On or about November 10, 2016, Patient 1 contacted the clinic regarding a
21 hydrocodone with acetaminophen refill. The telephonic note documented that the Respondent's
22 November 3, 2016, oxycodone with acetaminophen prescription is to be the last prescription for
23 Percocet as the Respondent will not fill it anymore. On or about December 6, 2016, without
24 seeing Patient 1 in clinic, the Respondent continued Patient 1 on monthly prescriptions of 240
25 tablets of 10/325 mg Norco, 120 tablets of 350 mg Soma, and 90 tablets of 1 mg Xanax. On or
26 about December 20, 2016, Patient 1 called the clinic after being late to his appointment. The staff
27 person documented that he would need to reschedule or go to the emergency room. The staff
28 member documented that Patient 1, "was angry and raised his voice, I told him if he gets any
louder I would have to call the police." Respondent next saw Patient 1 on December 23, 2016,

¹⁵ The Respondent prescribed a Z-Pak.

1 for a chief complaint of being sick with cough and congestion. The Respondent prescribed
2 antibiotics, Z-Pak, and Phenergan with codeine cough syrup. The Respondent continued Patient
3 1 on Norco, Soma, and Xanax. Between December 2016, and April 4, 2017, the Respondent
4 prescribed monthly prescriptions of 240 tablets of 10/325 mg Norco, 120 tablets of 350 mg Soma,
5 and 90 tablets of 1 mg Xanax to Patient 1. The Respondent also provided additional prescriptions
6 for Phenergan with codeine cough syrup during that time.

7 33. On April 11, 2017, the Respondent documented that he saw Patient 1 in clinic for
8 congestion and cough. Respondent documented both that, Patient 1 was taking oxycodone with
9 acetaminophen in addition to Norco, Xanax and Soma and that oxycodone with acetaminophen
10 had been discontinued. Despite those counter notations and the November 3, 2016, note in which
11 Respondent stated he would not prescribe Percocet further, Respondent prescribed 80 tablets of
12 10/325 Percocet to Patient 1. Patient 1 also received 80 tablets of 10/325 mg oxycodone with
13 acetaminophen on May 9, 2017, from Respondent's physician assistant. Patient 1 received 80
14 tablets of 10/325 mg oxycodone with acetaminophen from Respondent on June 13, 2017, and
15 July 26, 2017. This was in addition and on top of the Respondent's monthly prescription of 240
16 tablets of 10/325 mg hydrocodone with acetaminophen, 120 tablets of 350 mg carisoprodol, and
17 90 tablets of 1 mg alprazolam. On or about April 11, 2017, the Respondent prescribed an
18 antibiotic, a Z-Pak, and Phenergan with codeine cough syrup for Patient 1's cough and
19 congestion. On or about April 20, 2017, Patient 1 called Respondent's clinic to request a refill of
20 his antibiotics and Phenergan with codeine cough syrup. Respondent, without requiring a visit to
21 clinic, started Patient 1 on a new antibiotic, Levaquin, and refilled Patient 1's codeine cough
22 syrup.

23 34. On or about June 12, 2017, Patient 1 contacted Respondent's office and stated he had
24 lost his Xanax prescription while on vacation. Patient 1 had received a full prescription for 90
25 tablets of 1 mg Xanax on or about May 31, 2017. The next day, June 13, 2017, Patient 1 was
26 seen in clinic for a medication refill. The Respondent documented that he refilled 80 tablets of
27 10/325 mg Percocet, 120 tablets of 350 mg carisoprodol, and 90 tablets of 1 mg Xanax in the
28

1 chart note. The Respondent did not document anything related to Patient 1 losing his Xanax
2 medication and/or how he counseled Patient 1 to be more responsible with his medication.

3 35. According to CURES and in a telephonic note from June 13, 2017, Respondent
4 documented that he had increased Patient 1's prescription to 120 tablets of 10/325 mg oxycodone
5 with acetaminophen. Respondent also continued Patient 1's 240 tablets of 10/325 mg
6 hydrocodone with acetaminophen prescription, which Patient 1 filled on June 28, 2017. In
7 addition on or about July 26, 2017, Patient 1 filled Respondent's prescriptions for 120 tablets of
8 10/325 mg oxycodone with acetaminophen, 240 tablets of 10/325 mg hydrocodone with
9 acetaminophen, a bottle of Codeine with Phenergan cough syrup, and 120 tablets of 350 mg
10 carisprodol. Patient 1 continued to receive 3 mg of alprazolam per day through June and July
11 2017 from Respondent. There is no documentation in Respondent's June or July 2017 progress
12 notes related to why Patient 1's opioid prescriptions were being increased. If taken as prescribed,
13 Patient 1 was again receiving an MED of 140, and consuming 3900 mg of APAP, while in
14 combination with a narcotic in codeine cough syrup, a muscle relaxer, and a benzodiazepine.
15 Following the June and July 2017 appointments, Respondent continued to prescribe alprazolam
16 and carisprodol to Patient 1 through October 2017 in the form of refills.

17 36. On September 30, 2020, the Respondent was interviewed by the Medical Board. The
18 Respondent stated that he failed to perform any additional work-up of Patient 1's report of pain,
19 including advanced medical imaging, between January 2014 and October 2017. The Respondent
20 admitted that he prescribed codeine cough syrup on 14 different occasions to Patient 1 for pain
21 management despite failing to document that the cough syrup was part of Patient 1's chronic pain
22 management treatment plan. The Respondent admitted never having a chest x-ray performed on
23 Patient 1 between January 2014 and October 2017 despite repeatedly prescribing antibiotics for
24 cough and congestion. The Respondent admitted that between January 2014 and October 2017
25 that he never reviewed CURES, nor performed urine toxicology on patient 1 as part of periodic
26 review.

27 ///

28 ///

Patient 2

1
2 37. On or about December 3, 2015, Patient 2 presented at Respondent's clinic to begin
3 treatment with the Respondent. The Respondent documented that Patient 2 had been a bad car
4 accident in 2000 with ongoing neck and thoracic pain. The Respondent documented that Patient
5 2 had anxiety, hypothyroidism, hypertriglycerides, and fell into a bonfire in 2003 and suffered
6 burns on her buttocks. The Respondent documented that Patient 2 occasionally consumed
7 alcohol and was a light smoker. The Respondent documented that Patient 2 was taking Norco,
8 Xanax, and Soma. The Respondent's general examination noted that she had tightness of cervical
9 paravertebral muscles under neck and that she had tightness of PVM¹⁶'s, of lumbar under back.
10 The Respondent failed to perform work-up regarding Patient 2's history of anxiety. The
11 Respondent did not document performing any other work-up, including whether he ordered
12 specialized medical imaging, and he did not document reviewing Patient 2's previous medical
13 history. The Respondent began prescribing controlled substances to Patient 2.

14 38. Between December 2015 and July 2017, on a monthly basis the Respondent
15 prescribed 240 tablets of 10/325 mg hydrocodone with acetaminophen, 90 tablets of 1 mg
16 alprazolam and 120 tablets of 350 mg carisoprodol to Patient 2. As prescribed, Patient 2 was
17 receiving an MED of 80 in combination with a muscle relaxer and a benzodiazepine. During the
18 Respondent's care and treatment of Patient 2, it appears that the Respondent often electronically
19 cut and pasted information from previous notes. For example, the history of present illness for
20 January 22, 2016, May 16, 2016, June 23, 2016, and September 6, 2016, are the same. In
21 addition, the general examinations for January 22, 2016, May 16, 2016, June 23, 2016, and
22 September 6, 2016, are the same. Despite seeing Patient 2 on multiple visits over 2016, the
23 Respondent failed to document a justification for Patient 2's continued 3 mg Xanax prescription
24 aside from appears stressed and anxious.

25 39. Between December 2015 and July 2017, Patient 2 used four pharmacies to obtain her
26 medications. Between December 2015 and July 2017, the Respondent failed to review and/or
27 investigate repeated red flags exhibited by Patient 2 during her chronic pain management

28 ¹⁶ An Abbreviation for Paravertebral Muscle.

1 treatment. For example, on November 22, 2016, Patient 2 claimed that she needed an early refill
2 of her medications because her pharmacy was going to be closed over the Thanksgiving holiday.
3 Respondent's staff person verified that the Patient was incorrect and that the pharmacy was open.
4 In addition, between December 2015 and July 2017, the Respondent often refilled Patient 2's
5 medication early. For example, Patient 2 received 240 tablets of 10/325 mg Norco on October
6 27, 2016, November 23, 2016, and December 21, 2016, which indicated early refills.

7 40. On or about May 18, 2017, Patient 2 presented at Respondent's clinic with a boil
8 and/or tender lump near her bikini line. The Respondent documented that the general exam of
9 Patient 2 was non-specific. The Respondent documented that Patient 2 had folliculitis but failed
10 to provide details regarding the duration of her illness and whether the condition was getting
11 worse. The Respondent also failed to document laterality and it is unclear from his note whether
12 she had one area of concern or a more diffuse rash. The respondent prescribed two consecutive
13 days of intramuscular injections of Rocephin and a ten-day course of Bactrim. On or about July
14 6, 2017, Patient 2 presented with left ear pain. The Respondent failed to document details
15 regarding Patient 2's ear pain including the duration of the condition. The Respondent
16 documented on examination that Patient 2's left tympanic membrane was dull but did not
17 document that the membrane was red. The Respondent prescribed an antibiotic, Cefuroxime, and
18 a steroid, Medrol. It is unclear from the records why the Respondent prescribed a steroid.

19 41. Between December 2015 and July 2017, the Respondent failed to document why
20 Patient 2 remained on a morphine equivalent dose of 80. Between December 2015 and July
21 2017, the Respondent failed to document why Patient 2 required repeated monthly prescriptions
22 of 90 tablets of 1 mg alprazolam and/or why her level of anxiety required such a prescription.
23 Between December 2015 and July 2017, the Respondent failed to document why Patient 2
24 required 120 tablets of 350 mg carisprodol and/or the reasons that supported the long-term use of
25 this prescription. Between December 2015 and July 2017, the Respondent did not document
26 whether he provided informed consent to Patient 2 regarding the concomitant use of opioids,
27 benzodiazepines and muscle relaxers.

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1 documentation if the Percocet were to be taken instead of Norco. If the Norco and Percocet was
2 taken as prescribed, Patient 3 received per day an MED of 170, and Patient 3 would have
3 consumed 4550 mg of APAP, while in combination with 3 mg of alprazolam and 1050 mg of
4 carisoprodol. The Respondent next saw Patient 3 on December 19, 2014. The Respondent
5 continued Patient 3 on Norco, Soma, and Xanax.

6 45. On January 16, 2015, the Respondent saw Patient 3 in clinic. The Respondent
7 documented that Patient 3 had two renal stones, had a stent and was scheduled for lithotripsy, (a
8 procedure where ultrasound shock waves are used to disintegrate a kidney or other such stone),
9 with a urologist. The Respondent documented that Patient 3 had spasms along his cervical chain
10 muscles. The Respondent's general examination appeared electronically cut and pasted from the
11 December 19, 2014, note. The Respondent prescribed 240 tablets 10/325 mg hydrocodone with
12 acetaminophen, 90 tablets of 10 mg oxycodone hcl, 90 tablets of 1 mg alprazolam, and 90 tablets
13 of 350 mg carisoprodol. The Respondent failed to document why he was adding oxycodone to
14 Patient 3's chronic pain regimen. If taken as prescribed, Patient 3 was now receiving an MED of
15 125 from two short acting opioids in combination with Xanax and Soma.

16 46. According to CURES, Patient 3, filled a prescription from Respondent for 240 tablets
17 of 10/325 mg hydrocodone with acetaminophen on or about January 19, 2015. Despite this being
18 a prescription scheduled to last 30 days, on or about February 11, 2015, Patient 3 contacted
19 Respondent's clinic requesting an early refill of hydrocodone with acetaminophen. On or about
20 February 16, 2015, Patient 3 received an early refill of 240 tablets of 10/325 mg hydrocodone
21 with acetaminophen. On or about February 17, 2015, Patient 3 requested a refill of 120 tablets of
22 10 mg oxycodone hcl and received that medication on or about February 19, 2015. On or about
23 February 23, 2015, Patient 3 contacted Respondent's clinic and requested that he receive 2 mg
24 Xanax, three times a day, rather 1 mg of Xanax three times a day. On or about February 25,
25 2015, the Respondent documented that Patient 3 was seen in clinic for chief complaint of
26 allergies and Xanax dose. The Respondent documented that Patient 3 had seasonal allergies, was
27 scheduled for a March 18, 2015 lithotripsy, and was using over the counter medication, which
28 was not helping. Under review of symptoms, the Respondent documented that Patient 3 had

1 watery eyes, runny nose, and back pain. The February 25, 2015, general examination portion of
2 the progress note appears to be electronically cut and pasted from the visit on January 16, 2015.
3 The Respondent continued Patient 3's Norco prescription and increased Patient 3's Xanax
4 prescription to 2 mg, three times a day, for "Panic attack." The Respondent failed to document
5 any information related to Patient 3's panic attack, which would justify the doubling Patient 3's
6 alprazolam prescription. In addition, the Respondent failed to document providing Patient 3
7 informed consent regarding the potential dangers of taking two short acting opioids with an MED
8 of 140 in combination with 1050 mg of carisoprodol and 6 mg of Xanax.

9 47. On or about March 18, 2015, Patient 3 received an eight-day prescription for 36
10 tablets of 30/300 mg codeine phosphate with acetaminophen from his urologist who was
11 performing the lithotripsy. Patient 3 received 240 tablets of 10/325 mg hydrocodone with
12 acetaminophen on or about March 13, 2015, and 120 tablets of 10 mg oxycodone hcl on or about
13 March 19, 2015, from Respondent. If taken as prescribed, Patient 3 received a daily MED of 160
14 between March 18, 2015, and March 25, 2015, while in combination with 1050 mg of
15 carisoprodol and 6 mg of Xanax. The Respondent did not see Patient 3 in clinic in March or
16 April 2015, and allowed for refills of multiple controlled substances to occur through telephone
17 encounters with Patient 3.

18 48. On or about May 4, 2015, the Respondent documented seeing Patient 3 in clinic for
19 allergies, and documented that Patient 3 was present with seasonal allergies, had a headache, was
20 congested, and that he needed a refill of Xanax and Soma. The Respondent documented that
21 Patient 3 had watery eyes, runny nose, back pain and had anxiety. The general examination
22 appeared to be electronically cut and pasted from the February 25, 2015, note. The Respondent
23 diagnosed Patient 3 with sinusitis and prescribed Augmentin, Nasonex, and Medrol. In addition,
24 the Respondent also noted that a Z-Pak should be prescribed. The Respondent failed to document
25 a medical history of Patient 3's sinusitis, including the duration of symptoms and an explanation
26 on why or why not Patient 3's condition required the use of antibiotics.

27 49. On or between May 4, 2015, and August 8, 2015, the Respondent prescribed 240
28 tablets of 10 mg oxycodone hcl, 960 tablets of 10/325 mg hydrocodone with acetaminophen, 360

1 tablets of 360 mg carisoprodol, and 360 tablets of 2 mg alprazolam to Patient 3. On July 10,
2 2015, Patient 3 contacted Respondent's clinic and requested a 30-day supply of 30 mg.
3 temazepam for sleep. Respondent had last seen Patient 3 in clinic on May 4, 2015, and there is
4 no mention in the notes regarding Patient 3's need for sleep medication. On or about July 10,
5 2015, Patient 3 filled the prescription for 30 tablets of 30 mg temazepam after Respondent
6 provided a prescription. At this point, Patient 3 was receiving a daily MED of 140 from two short
7 acting opioids, in combination with two benzodiazepines and a muscle relaxer. There is no
8 documentation from July 10, 2015, that Patient 3 was provided informed consent regarding the
9 dangers of consuming two opioids, two benzodiazepines, and a muscle relaxer in combination.
10 On or about July 29, 2015, the Respondent next saw Patient 3 in clinic. The Respondent
11 documented that Patient 3's chief complaint was refills and that Patient 3 has neck pain and
12 frequent headaches. In addition, the Respondent documented that Patient 3 had degenerative disc
13 disease, that he was scheduled to see a specialist and that he was requesting an MRI of the
14 cervical spine. The Respondent ordered an MRI of the cervical spine, refilled Patient 3's Norco,
15 Soma and Xanax prescriptions and provided a trigger point injection. The Respondent
16 documented that Patient 3 had received temazepam but failed to provide any documentation to
17 justify the prescription or explain why it was being added to Patient 3's treatment regimen.

18 50. On or about August 7, 2015, Patient 3 has a MRI over cervical spine completed. The
19 MRI occurred over nine months after Respondent began prescribing multiple controlled
20 substances to Patient 3. The MRI findings revealed that Patient 3 had degenerative disc disease,
21 pain, and that there was normal alignment of the cervical vertebral bodies. The impression noted
22 that, "(n)ormal MRI of the cervical spine with no disc herniations or acute bony fractures."
23 Between August 7, 2015, and March 14, 2016, the Respondent continued to prescribe monthly
24 prescriptions of 240 tablets of 10/325 mg hydrocodone with acetaminophen, 90 tablets of 2 mg
25 alprazolam, and 90 tablets of carisoprodol. In addition, on or about October 28, 2015, and
26 December 21, 2015, Patient 3 received 30 tablets of temazepam from Respondent's prescriptions.
27 In addition, on or about January 21, 2016, Patient 3 received 120 tablets of 10 mg oxycodone
28 from Respondent. On March 14, 2016, Respondent's office received a telephonic contact from

1 Patient 3 stating that his pharmacy was not refilling his Xanax. Upon further investigation, the
2 note documented that Patient 3 had last received 90 tablets of 2 mg alprazolam on February 15,
3 2016, and had attempted to refill it on March 9, 2016, which was too early. On or about March
4 28, 2016, Patient 3 telephonically contacted Respondent's clinic and reported he was passing a
5 kidney stone and requested a prescription for oxycodone hcl. The Respondent provided a
6 prescription and on or about March 29, 2016, Patient 3 filled that prescription for 120 tablets of
7 10 mg oxycodone hcl. Patient 3 was still receiving Norco, Xanax and Soma. The Respondent
8 did not require that Patient 3 be seen in clinic regarding the early Xanax refill or his request for
9 oxycodone.

10 51. On about April 22, 2016, the Respondent next saw Patient 3 in clinic for flu
11 symptoms. The Respondent documented that Patient 3 was ill with influenza. The Respondent's
12 progress note failed to mention Patient 3's early refill request for Xanax from March 2016 and
13 failed to mention and/or justify Patient 3's telephonic request for oxycodone from March 2016.
14 The Respondent documented that Patient 3 was having difficulty swallowing and under review of
15 symptoms documented a sore throat. However, under general examination the Respondent noted
16 that Patient 3's pharynx was normal. The Respondent did document that Patient 3's oral cavity
17 was red and irritated. The Respondent, despite documenting a normal pharynx, prescribed a Z-
18 Pak for pharyngitis. The Respondent continued Norco, Soma, and Xanax as previously
19 prescribed.

20 52. On or between April 29, 2016, and July 21, 2017, the Respondent and the physician
21 assistant he supervised, continued to provide Patient 3 with monthly prescriptions of 240 tablets
22 of 10/325 mg hydrocodone with acetaminophen, 90 tablets of 350 mg carisoprodol, and 90 tablets
23 of 2 mg Xanax. In addition on or about April 29, 2016, June 28, 2016, August 3, 2016,
24 September 6, 2016, November 7, 2016, December 12, 2016, January 19, 2017, February 21,
25 2017, April 14, 2017, the Respondent prescribed 120 tablets of 10 mg oxycodone hcl to Patient 3.
26 There is no evidence that Respondent provided a tapering dose regimen of oxycodone before
27 discontinuing the oxycodone prescription in April 2017. On or between November 2014 through
28 July 2017, Patient 3 used five different pharmacies to fill prescriptions from the Respondent. On

1 or between November 2014 through July 2017, Patient 3 often attempted to receive and/or
2 received early refills of controlled substances. On or between November 2014 through July 2017,
3 the Respondent often cut and pasted portions of Patient 3's examinations from previous progress
4 notes into future progress notes. During that time, the Respondent failed to document Patient 3's
5 pain levels and/or function on pain medication. During that time, the Respondent failed to
6 document Patient 3's anxiety levels and the Respondent failed to provide any justification for the
7 continued prescribing of high dose Xanax aside from the conclusory statements of "anxiety" and
8 "panic attacks." Finally, on or between November 2014 through July 2017, the Respondent failed
9 to document Patient 3's level of muscle pain and/or muscle spasm in such a way to support a
10 long-term monthly prescription of carisoprodol. The Respondent continued prescribing Soma
11 and Xanax through prescription refills until October 14, 2017.

12 53. On September 30, 2020, the Respondent was interviewed regarding the care and
13 treatment of Patient 3. The Respondent acknowledged that aside from Patient 3's past history of
14 compression fracture and the August 2015 MRI, that he did not perform any other work-up of
15 Patient 3's pain conditions. The Respondent acknowledged that the August 2015 MRI, while
16 showing degenerative disc disease, did not reveal any acute findings. The Respondent stated that
17 he was unaware that Patient 3's MED was 140 between January 2015 and June 2016. The
18 Respondent stated he was unaware that he doubled Patient 3's Xanax prescription in February
19 2015 despite Respondent's medical documentation clearly showing that he increased the
20 medication. At the interview, the Respondent stated that in February 2015, he prescribed Norco,
21 oxycodone, Xanax and Soma to Patient 3 to treat back pain, neck pain, kidney stones and
22 migraines. The Respondent failed to mention "panic attack" which was documented in the
23 February 25, 2015, chart note for the reason that the Respondent was prescribing Xanax.

24 54. At the September 30, 2020, interview the Respondent acknowledged that he did not
25 check CURES while prescribing controlled substances to Patient 3. The Respondent
26 acknowledged that he did not perform urine toxicology screening while prescribing controlled
27 substances to Patient 3. The Respondent acknowledged that he failed to calculate morphine-
28 equivalent doses for Patient 3 while prescribing Norco and oxycodone. The Respondent

1 acknowledged that he did not send Patient 3 to physical therapy. The Respondent acknowledged
2 that he did not send Patient 3 for a psychiatric evaluation and that he did not attempt any non-
3 opiate pain therapies aside from ibuprofen. The Respondent stated he sent Patient 3 for a pain
4 management referral one time in July 2015 as documented in his July 29, 2015, progress note.
5 Following the July 29, 2015, visit, the Respondent did not see Patient 3 in his clinic until January
6 8, 2016. The Respondent failed to document anything related to the pain management visit in his
7 January 8, 2016, chart note.

8 **FIRST CAUSE FOR DISCIPLINE**

9 **(Gross Negligence)**

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

13 56. Complainant realleges paragraphs 17 to 54, and those paragraphs are incorporated by
14 references as if fully set forth herein.

15 57. Respondent's license is subject to disciplinary action because he committed gross
16 negligence during the care and treatments of Patients 1, 2, and 3, in the following distinct and
17 separate ways:

18 a. By repeatedly prescribing high dose opioids in combination with sedatives and
19 muscle relaxers between January 2014 and October 2017, to Patient 1 despite multiple indications
20 that the prescriptions were dangerous as prescribed;

21 b. By repeatedly failing to adequately justify the long term use of multiple
22 controlled substances, including but not limited to justifying the prescription of multiple short
23 acting opioids at the same time, justifying the monthly prescription of carisoprodol, and/or the
24 justifying the monthly prescription of alprazolam, which also included the tripling of the dosage
25 in February 2016, between January 2014 and October 2017, to Patient 1;

26 c. By failing to monitor and adjust Patient 1's chronic pain management treatment
27 plan between January 2014 and October 2017, despite multiple incidents of Patient 1 requiring
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1 early refills and/or exhibiting signs that he was misusing medication and/or using multiple
2 pharmacies and/or receiving prescriptions from other medical providers;

3 d. By failing to properly document a history and physical, treatment plan and/or
4 perform periodic review of Patient 1's chronic pain management regiment and/or Patient 1's
5 anxiety medication between January 2014 and October 2017;

6 e. By failing to perform proper documentation of Patient 1's treatment between
7 January 2014 and October 2017, because Respondent electronically cut and pasted previous
8 notes, and/or failing to document a procedure note for an incision and drainage;

9 f. By repeatedly prescribing antibiotics to Patient 1 between January 2014 and
10 October 2017 without detailing sufficient information to support the continued prescribing of
11 antibiotics and/or ordering chest imaging when confronted with Patient 1's constant recurring
12 respiratory infections.

13 g. By repeatedly failing between January 2014 and October 2017, to provide
14 Patient 1 with adequate informed consent regarding the dangers of using concomitant controlled
15 substances;

16 h. By repeatedly failing to refer Patient 1 for specialized pain management
17 treatment with a pain management expert and/or document why a referral was not possible;

18 i. By repeatedly prescribing high dose opioids in combination with sedatives and
19 muscle relaxers between December 2015 and July 2017, to Patient 2 despite multiple indications
20 that the prescriptions were dangerous as prescribed;

21 j. By repeatedly failing to adequately justify the long-term use of controlled
22 substances, including justifying the monthly prescription of Norco, justifying the monthly
23 prescription of carisoprodol, and/or justifying the monthly prescription of alprazolam between
24 December 2015 and July 2017, to Patient 2;

25 k. By failing to monitor and adjust Patient 2's chronic pain management treatment
26 plan between December 2015 and July 2017, despite Patient 2 receiving early refills of
27 medications and receiving controlled substances from multiple pharmacies;

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1 l. By failing to properly document a history and physical, treatment plan and/or
2 perform periodic review of Patient 2's chronic pain management regiment and/or Patient 2's
3 anxiety medication between December 2015 and July 2017;

4 m. By failing to perform proper documentation of Patient 2's treatment between
5 December 2015 and July 2017, because Respondent electronically cut and pasted previous notes,
6 and/or failing to document the location of folliculitis;

7 n. By repeatedly prescribing antibiotics to Patient 2 between December 2015 and
8 July 2017, without detailing sufficient justification and by way of example, prescribing a 10-day
9 course of oral antibiotics plus two days of IM Rocephin for folliculitis and cefuroxime for an ear
10 infection instead of amoxicillin;

11 o. By repeatedly failing between December 2015 and July 2017, to provide
12 Patient 2 with adequate informed consent regarding the dangers of using concomitant controlled
13 substances;

14 p. By repeatedly failing to refer Patient 2 for specialized pain management
15 treatment with a pain management expert and/or document why a referral was not possible;

16 q. By repeatedly prescribing high dose opioids in combination with sedatives and
17 muscle relaxers between November 2014 and October 2017, to Patient 3 despite multiple
18 indications that the prescriptions were dangerous as prescribed;

19 r. By repeatedly failing to adequately justify the long term use of multiple
20 controlled substances, including but not limited to failing to justify the prescription of multiple
21 short acting opioids at the same time, failing to justify the monthly prescription of carisoprodol,
22 failing to justify the monthly prescription of alprazolam, which also included doubling of the
23 dosage in February 2015, and/or failing to justify the prescriptions for temazepam, between
24 November 2014 and October 2017, to Patient 3;

25 s. By failing to monitor and adjust Patient 3's chronic pain management treatment
26 plan between November 2014 and October 2017, despite multiple incidents of Patient 3 requiring
27 early refills and/or exhibiting signs that he was misusing medication and/or using multiple
28 pharmacies and/or receiving prescriptions from other medical providers;

1 t. By failing to properly document a history and physical, treatment plan and/or
2 perform periodic review of Patient 3's chronic pain management regimen and/or Patient 3's
3 anxiety medication between November 2014 and October 2017;

4 u. By failing to perform proper documentation of Patient 3's pain management
5 treatment between November 2014 and October 2017, because the Respondent electronically cut
6 and pasted previous notes;

7 v. By repeatedly prescribing antibiotics to Patient 3 between January 2014 and
8 October 2017, without detailing sufficient information to support the prescribing of antibiotics;

9 w. By repeatedly failing between November 2014 and October 2017, to provide
10 Patient 3 with adequate informed consent regarding the dangers of using concomitant controlled
11 substances; and,

12 x. By repeatedly failing to refer Patient 3 for specialized psychiatric treatment
13 with a psychiatric expert and/or document why a referral was not possible.

14 **SECOND CAUSE FOR DISCIPLINE**

15 **(Repeated Negligent Acts)**

16 58. Respondent's license is subject to disciplinary action under section 2234, subdivision
17 (c), in that the Respondent committed repeated negligent acts during the care and treatment of
18 Patients 1, 2, and 3. The circumstances are as follows:

19 59. Complainant realleges paragraphs 17 to 57, and those paragraphs are incorporated by
20 reference as if fully set forth herein. Each of the instances of gross negligence are also considered
21 separate and distinct negligent acts and are incorporated by reference as if fully set forth herein.

22 **THIRD CAUSE FOR DISCIPLINE**

23 **(Inadequate and Inaccurate Medical Record Keeping)**

24 60. Respondent's license is subject to disciplinary action under section 2266 of the Code
25 in that he failed to keep adequate and accurate medical records during his care and treatment of
26 Patients 1, 2, and 3. The circumstances are as follows:

27 61. Complainant realleges paragraphs 17 to 59, and those paragraphs are incorporated by
28 references as if fully set forth herein.

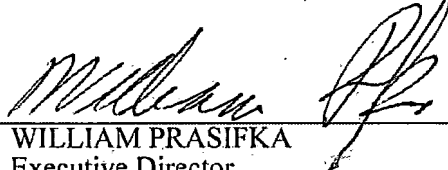
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PRAYER

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 Number A 45073, issued to Dwain William Rickertsen, M.D.;
2. Revoking, suspending or denying approval of Dwain William Rickertsen, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Dwain William Rickertsen, M.D., if placed on probation, to pay the Board the costs of probation monitoring;
4. Ordering Dwain William Rickertsen, M.D., if placed on probation for five years or more, to notify his patients pursuant to Business and Professions Code § 2228.1; and
5. Taking such other and further action as deemed necessary and proper.

DATED: DEC 02 2020



WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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