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

In the Matter of the Accusation Against: Gregg Antony Denicola, M.D. Physician's and Surgeon's Certificate No. G 43562 Respondent.	Case No. 800-2018-051100

DECISION

The attached Stipulated Surrender of License 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 July 1, 2023.

IT IS SO ORDERED April 27, 2023.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Interim Executive Director

ROB BONTA
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **GREGG ANTONY DENICOLA, M.D.** **333 Thalia Street** **Laguna Beach, California 92651** **Physician's and Surgeon's Certificate No. G 43562,** Respondent.	Case No. 800-2018-051100 OAH No. 2022090349 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Interim Executive Director of the Medical Board of California (Board). This action was brought by then Complainant William Prasifka,[1] solely in his official capacity. Complainant is represented in this matter by Rob Bonta, Attorney General of the State of California, and by Joseph F. McKenna III, Deputy Attorney General.

2. Gregg Antony Denicola, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Esq., whose address is: 5440 Trabuco Road, Irvine, CA, 92620.

[1] Mr. Prasifka retired on December 20, 2022.

3. On or about October 14, 1980, the Board issued Physician's and Surgeon's Certificate No. G 43562 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought in Accusation No. 800-2018-051100 and will expire on August 31, 2024, unless renewed.

JURISDICTION

4. On June 2, 2022, Accusation No. 800-2018-051100 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2018-051100 is attached hereto as Exhibit A and hereby incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with his counsel, and understands the charges and allegations contained in Accusation No. 800-2018-051100. Respondent also has carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Surrender of License and Disciplinary Order.

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

7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands and agrees that the charges and allegations contained in Accusation No. 800-2018-051100, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate No. G 43562.

9. Respondent stipulates that, at a hearing, Complainant could establish a *prima facie* case for the charges and allegations contained in the Accusation; that he gives up his right to contest those charges and allegations contained in the Accusation; and that he has thereby subjected his Physician's and Surgeon's Certificate to disciplinary action and hereby surrenders his Physician's and Surgeon's Certificate for the Board's formal acceptance.

CONTINGENCY

10. Business and Professions Code section 2224, subsection (b), provides that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

11. Respondent understands that by signing this stipulation he enables the Interim Executive Director of the Board to issue an Order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate G 43562 without further notice to, or opportunity to be heard by, Respondent.

12. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Interim Executive Director on behalf of the Medical Board. By signing the stipulation, the parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Interim Executive Director for his consideration in the above-entitled matter and, further, that the Interim Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Interim Executive Director, on behalf of the Medical Board, considers and acts upon it.

13. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Interim Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Interim Executive Director and/or the Board may receive oral and written communications from its staff

and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Interim Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Interim Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Interim Executive Director on behalf of the Board, Respondent will assert no claim that the Interim Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

14. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

15. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree the Interim Executive Director of the Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 43562, issued to Respondent Gregg Antony Denicola, M.D., is surrendered and accepted by the Medical Board of California.

1. The effective date of this Decision and Disciplinary Order shall be July 1, 2023.

2. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Medical Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

3. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Medical Board's Decision and Disciplinary Order.

4. Respondent shall cause to be delivered to the Medical Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Board's Decision and Disciplinary Order.

5. If Respondent ever files an application for licensure with the Medical Board of California, the Medical Board shall treat it as a petition for reinstatement of Physician's and Surgeon's Certificate No. G 43562. Respondent must comply with all the laws, regulations and procedures for reinstatement of a surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2018-051100 shall be deemed to be true, correct, and admitted by Respondent when the Medical Board determines whether to grant or deny the petition.

6. Respondent shall pay the Board its costs of investigation and enforcement in the amount of $28,037.50 prior to issuance of a new or reinstated license.

7. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2018-051100 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any application, any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G 43562. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 3-8-23

GREGG ANTONY DENICOLA, M.D.
Respondent

I have read and fully discussed with Respondent Gregg Antony Denicola, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: March 8, 2023

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: March 8, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

JOSEPH F. MCKENNA III
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-051100

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **GREGG ANTONY DENICOLA, M.D.** **333 Thalia Street** **Laguna Beach, California 92651** **Physician's and Surgeon's Certificate No. G 43562,** Respondent.	Case No. 800-2018-051100 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about October 14, 1980, the Medical Board issued Physician's and Surgeon's Certificate No. G 43562 to Gregg Antony Denicola, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on August 31, 2022, unless renewed.

JURISDICTION

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

STATUTORY PROVISIONS

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have such other action taken in relation to discipline as the Board deems proper.

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

> (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board and the Podiatric Medical Board of California shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information internet website, 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.
>
> ...

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

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.

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

...

7. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

8. Section 2266 of the Code states:

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

COST RECOVERY

9. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

PERTINENT DRUG INFORMATION

10. Opioids are Schedule II controlled substances pursuant to Health and Safety Code (HSC) §11055, and are a dangerous drug pursuant to Code section 4022. The Drug Enforcement Administration (DEA) has identified opioids as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at pp. 38-39.)

11. Methadone, a synthetic opioid, is used for the treatment of moderate to severe pain. The DEA has identified methadone as a drug of abuse. (DEA Resource Guide at p. 44.) The Food and Drug Administration (FDA) has issued Black Box Warnings for methadone, which warn about addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The FDA warnings also caution about the risks associated with concurrent use of methadone and benzodiazepines, or other central nervous system (CNS) depressants.

12. Benzodiazepines are Schedule IV controlled substances pursuant to HSC § 11057, and are a dangerous drug pursuant to Code section 4022. The risk of respiratory depression, drug overdose, and death is increased with the concomitant prescribing of benzodiazepines, opioids, or other CNS depressants. The DEA has identified benzodiazepines as a drug of abuse. (DEA Resource Guide at p. 59.)

13. For a comparison of opioid doses, "morphine milligram equivalents" was developed to equate the many different opioids into one standard value. This standard value is based on morphine and its potency. "Morphine milligram equivalents" is commonly referred to as MEDD

or MME. The Centers for Disease Control and Prevention (CDC) states, "Higher dosages of opioids are associated with higher risk of overdose and death – even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk."

14. The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (HSC § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Scheduled controlled substances as soon as reasonably possible after the prescriptions are filled.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

15. Respondent has subjected his Physician's and Surgeon's Certificate No. G 43562 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patients A, B, C, D, E, F, G, H, and I,[1] as more particularly alleged hereinafter:

16. **Patient A**

(a) Beginning in or around 2014,[2] Respondent began rendering medical care and treatment to Patient A, an adult patient with a documented history of ailments including, but not limited to, chronic low back pain, knee pain, history of migraine, history of insomnia, and prostate enlargement.

(b) For the period in or around July 2015 to October 2019, CURES and Respondent's medical records for Patient A indicate that Respondent regularly prescribed opioids, lorazepam and diazepam (benzodiazepines), and other controlled substances for concurrent use by Patient A.

[1] Patients' true names are not used in the instant Accusation to maintain patient confidentiality. The patients' identities are known to Respondent or will be disclosed to Respondent upon receipt of a duly issued request for discovery in accordance with Government Code section 11507.6.

[2] Any act or omission alleged to have occurred more than 7 years prior to the filing of the instant Accusation is alleged for informational purposes only, and is not alleged as a basis for any disciplinary action in this matter.

(c) For the period in or around July 2015 to October 2019, Respondent's medical records for Patient A document that he has a narcotic addiction.

(d) For the period in or around July 2015 to October 2019, Respondent's medical records for Patient A document that multiple specialty consultations were ordered including, but not limited to, orthopedics, physical therapy, and pain management. Patient A did not comply and/or cancelled these consultations, and Respondent failed to address or document addressing this non-compliance in the records with Patient A.

(e) In or around July 2015 to October 2019, Respondent's non-opiate management of Patient A's chronic pain amounted to a single trial of naproxen, which is a non-steroidal anti-inflammatory drug (NSAID).[3] During this same timeframe, Respondent failed to try other safer non-opioid medication including, but not limited to, more powerful NSAIDs, to address Patient A's pain issues while also reducing his narcotic dependency.

(f) In or around July 2015 to October 2019, Respondent prescribed increasing and excessive opioid dosages to Patient A, which reached 270 mg MEDD by early 2018. Despite these excessive levels of opioids, Respondent failed to prescribe naloxone[4] to Patient A to reduce the risks of accidental overdose.

(g) For the period in or around July 2015 to October 2019, Respondent's medical records for Patient A fail to adequately document relevant physical examination findings which justify the level of narcotic prescriptions that Respondent was prescribing to Patient A. In addition, Respondent also failed to rotate Patient A with different opioids to address his increasing tolerance to oxycodone.

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[3] NSAIDs are members of a therapeutic drug class which reduces pain and decreases inflammation. NSAIDs are the most prescribed medications for treating conditions such as arthritis and other pain.

[4] Naloxone is an opioid antagonist commonly used as an antidote against opiate toxicity or overdose.

(h) For the period in or around July 2015 to October 2019, Respondent's medical records fail to document performing an objective risk stratification and/or address non-compliant behaviors with Patient A. During the same timeframe, the records fail to document consistent and periodic urine toxicology testing to assess for possible aberrant drug-taking behaviors by Patient A.

(i) For the period in or around July 2015 to October 2019, Respondent's medical records for Patient A indicate that Respondent regularly prescribed lorazepam (benzodiazepine); but there is no adequate documentation in the records as to the indication(s) and/or benefits for the long-term therapeutic use of this drug. Respondent also prescribed opioids to Patient A, but he failed to document a proper indication for the concurrent use of this dangerous drug combination.

(j) For the period in or around July 2015 to October 2019, Respondent's medical records for Patient A fail to document that a signed pain care agreement with informed consent was obtained from this patient.

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

(a) Respondent failed to appropriately initiate and monitor Patient A's chronic opiate therapy.

18. **Patient B**

(a) Beginning in or around 2011,[5] Respondent began rendering medical care and treatment to Patient B, an adult patient with a documented history of ailments including, but not limited to, chronic low back pain, shoulder pain, with history of depression, and opioid dependence.

(b) For the period in or around July 2017 to October 2018, CURES and Respondent's medical records for Patient B indicate that Respondent routinely prescribed methadone to this patient. During this same timeframe, Respondent

[5] Any act or omission alleged to have occurred more than 7 years prior to the filing of the instant Accusation is alleged for informational purposes only, and is not alleged as a basis for any disciplinary action in this matter.

increased Patient B's methadone prescription up to an excessive dosage level of 90 mg daily (1080 mg MEDD). Despite these excessive levels of methadone, Respondent failed to prescribe naloxone to Patient B to reduce the risks of accidental overdose.

(c) During this same timeframe, aside from prescribing methadone, Respondent failed to try other safer non-opioid medications including, but not limited to, prescribing NSAIDs and/or non-addictive muscle relaxants, to address Patient B's pain issues while also reducing and tapering his excessive methadone dosage.

(d) For the period in or around July 2017 to October 2018, during the timeframe Respondent managed Patient B's methadone therapy, Respondent's medical records fail to document significant information and data including, but not limited to, electrocardiogram (EKG) monitoring for methadone side-effects[6] on Patient B, obtaining an objective risk stratification, and/or recommending consultation with mental health professionals for cognitive behavioral therapy for depression.

(e) For the period in or around July 2017 to October 2018, Respondent's medical records for Patient B fail to adequately document the monitoring of narcotic therapy including, but not limited to, the majority of progress notes are missing pain intensity scales, adverse side-effects, and functional assessments. During the same timeframe, the records also fail to document consistent and periodic urine toxicology testing to assess for possible aberrant drug-taking behaviors by Patient B.

(f) For the period in or around July 2015 to October 2019, Respondent's medical records for Patient B fail to document that a signed pain care agreement with informed consent was obtained from this patient.

[6] Methadone can result in prolonged QT intervals and place methadone patients at risk for fatal cardiac arrhythmias. Baseline EKG, before therapy and periodic EKG monitoring during therapy, is advised.

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

(a) Respondent failed to appropriately initiate and monitor Patient B's methadone therapy.

20. **Patient C**

(a) Beginning in or around 2015,[7] Respondent began rendering primary medical care and treatment to Patient C, an adult patient with a documented history of ailments including, but not limited to, type 2 diabetes with neuropathy and anxiety disorder.

(b) For the period in or around May 2016 to March 2019, CURES and Respondent's medical records for Patient C indicate that Respondent routinely prescribed a dangerous combination of two (2) short-acting opiates, which exposed Patient C to increased risk of opiate addiction. Respondent prescribed opioids and lorazepam (benzodiazepine) to Patient C, but he failed to document a proper indication for the concurrent use of this dangerous drug combination.

(c) During this same timeframe, Respondent failed to recognize the development of opioid-induced hyperalgesia syndrome[8] with Patient C, as there was no documentation of its consideration in the patient's record.

(d) For the period in or around 2017 to 2019, Respondent's medical records for Patient C indicate that this patient had chronic lung issues, including frequent respiratory symptoms and low oxygen saturation documented during clinical visits. The records show that Patient C was a life-long smoker, who suffered from pulmonary conditions and frequently used an albuterol inhaler. Respondent, notwithstanding Patient C's chronic respiratory symptoms, failed to prescribe

[7] Any act or omission alleged to have occurred more than 7 years prior to the filing of the instant Accusation is alleged for informational purposes only, and is not alleged as a basis for any disciplinary action in this matter.

[8] Opioid-induced hyperalgesia is defined as a state of nociceptive sensitization caused by exposure to opioids. The condition is characterized by a paradoxical response whereby a patient receiving opioids for the treatment of pain could actually become more sensitive to certain painful stimuli.

long-acting inhalers and/or schedule diagnostic pulmonary testing. Respondent, notwithstanding Patient C's chronic respiratory symptoms and concurrent prescriptions for opioids and benzodiazepines, failed to prescribe naloxone to Patient C to reduce the risks of accidental opioid overdose.

(e) For the period in or around 2017 to 2019, Respondent's medical records fail to document performing an objective risk stratification and/or recommending consultation with mental health professionals for cognitive behavioral therapy for anxiety disorder.

(f) For the period in or around 2017 to 2019, Respondent's medical records for Patient C fail to adequately document the monitoring of narcotic therapy including, but not limited to, the majority of progress notes are missing relevant physical examinations and proper functional assessment. During the same timeframe, the records fail to document consistent and periodic urine toxicology testing and CURES queries, to assess for possible aberrant drug-taking behaviors by Patient C.

(g) For the period in or around May 2016 to July 2017, CURES and Respondent's medical records for Patient C indicate that Respondent prescribed lorazepam to manage Patient C's diagnosis of anxiety disorder. During this timeframe, the records fail to document an appropriate and adequate evaluation of Patient C's anxiety condition including, but not limited to, no anxiety screening and/or no functional limitations assessment was performed, and the cause of her anxiety condition was unknown. There is also no documentation of whether Respondent considered the use of other safer medications including, but not limited to, selective serotonin reuptake inhibitors[9] (SSRIs) or antihistamines.

(h) The medical records obtained from Respondent during the Board's investigation of Patient C's case fail to document that Respondent had obtained informed consent and/or a pain care agreement with this patient, despite the

[9] SSRIs are the most commonly prescribed antidepressants. They can ease symptoms of moderate to severe depression, are relatively safe and typically cause fewer side effects than other types of antidepressants.

consistent prescribing of excessively high dosages of opioids between in or around 2016 to 2019.

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

(a) Respondent failed to appropriately initiate and monitor Patient C's chronic opiate therapy.

22. **Patient D**

(a) Beginning in or around 2016, Respondent began rendering primary medical care and treatment to Patient D, an adult patient with a documented history of ailments including, but not limited to, chronic back pain, chronic prescription opiate use, anxiety, insomnia, hypertension, and obesity.

(b) For the period in or around July 2016 to July 2018, CURES and Respondent's medical records for Patient D indicate that Respondent routinely prescribed a dangerous combination of controlled medications including, but not limited to, methadone, alprazolam (benzodiazepine), and Soma.[10] Respondent also failed to document a proper indication for the concurrent use of this dangerous drug combination.

(c) During this same timeframe, Respondent increased Patient D's methadone prescription up to an excessive dosage level of 10 mg daily (600 mg MEDD). Despite these excessive levels of methadone, Respondent failed to prescribe naloxone to Patient D to reduce the risk of accidental overdose.

(d) The medical records obtained from Respondent during the Board's investigation of Patient D's case fail to show that Respondent ever obtained copies of medical records from this patient's prior medical providers to confirm her representations that she was previously diagnosed with Lupus and fibromyalgia.

[10] Soma is a brand name for carisoprodol, a Schedule IV controlled substance pursuant to HSC § 11057, and a dangerous drug pursuant to Code section 4022. It is a centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate, a substance with abuse potential similar to that of a benzodiazepine.

(e) According to CURES and Patient D's medical records, in or around August 2016, Respondent began prescribing methadone to Patient D for treatment of her "chronic pain syndrome" which stemmed from her alleged diagnoses of Lupus and fibromyalgia. Respondent continued prescribing methadone to Patient D until in or around June 2018.

(f) Between in or around August 2016 and June 2018, the records show that Respondent failed to fully and adequately investigate Patient D's chronic pain syndrome and root causes of the alleged diagnoses: no radiologic imaging of hands and knees were performed; no skin rashes or joint effusions to suggest Lupus were found; and Patient D's laboratory serology for Lupus was mostly normal. Significantly, for nearly 2 years, Respondent routinely prescribed excessively high dosages of methadone to Patient D for the treatment of chronic pain syndrome, even though the scientific data and clinical observations found in the record did not support the diagnoses of Lupus and fibromyalgia.

(g) During this same timeframe, Respondent did not discuss or document discussing with Patient D the benefits and/or use of safer non-addictive medications to treat Lupus and fibromyalgia including, but not limited to, NSAIDs.

(h) During this same timeframe, Respondent does not refer Patient D to rheumatology for testing and confirmation of Lupus and fibromyalgia. Respondent also fails to recommend or document recommending a consultation with a pain management specialist or exploring other alternative therapies (e.g., physical therapy, chiropractic manipulation, and/or acupuncture) to address this patient's chronic pain.

(i) Between in or around August 2016 and June 2018, during the timeframe Respondent managed Patient D's methadone therapy, Respondent's medical records fail to document significant information and data including, but not limited to, EKG monitoring for methadone side-effects on Patient D; a review of Patient D's past medical records from prior medical providers; obtaining an objective risk

stratification; and/or recommending consultation with mental health professionals due to Patient D's diagnosis of generalized anxiety disorder.

(j) During the same timeframe, Respondent's medical records for Patient D fail to adequately document the monitoring of narcotic therapy including, but not limited to, the majority of progress notes appear copied from prior visits; the analgesic and functional benefits of methadone therapy are not documented in the record; and the physical examinations are mostly normal and do not justify the need for high dose methadone therapy that was prescribed by Respondent.

(k) For the period in or around 2016 to 2018, only 3 urine toxicology tests were performed on Patient D. Patient D tested "positive" for marijuana on 2 separate occasions. Respondent failed to discuss or document discussing with Patient D about the risks of using marijuana on top of her high dose methadone therapy.

(l) During the same timeframe, the records fail to document consistent and periodic urine toxicology testing to assess for possible aberrant drug-taking behaviors by Patient D; and a CURES query was never documented in this patient's record.

(m) For the period in or around July 2016 to July 2018, CURES and Respondent's medical records for Patient D indicate that Respondent routinely prescribed alprazolam to manage Patient D's diagnosis of anxiety disorder.

(n) During this same timeframe, Respondent failed to document an appropriate and adequate evaluation of Patient D's anxiety condition including, but not limited to, failing to document whether an anxiety screening and/or functional limitations assessment was performed, and whether a referral was made for consultation with a mental health provider. Respondent failed to document the justification for prescribing a benzodiazepine to treat Patient D's anxiety, rather than other safer medications including, but not limited to, SSRIs. Significantly, Respondent failed to document the justification for the long-term prescription of a

benzodiazepine to treat Patient D's anxiety, and whether her anxiety was part of her opiate withdrawal syndrome.

(o) The medical records obtained from Respondent during the Board's investigation of Patient D's case fail to document that Respondent had obtained informed consent and/or a pain care agreement with this patient, despite the consistent prescribing of excessively high dosages of methadone between in or around 2016 to 2018.

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

(a) Respondent failed to adequately evaluate Patient D's "chronic pain syndrome" and properly manage it with non-opiate therapy;

(b) Respondent failed to appropriately initiate and monitor Patient D's methadone therapy; and

(c) Respondent failed to adequately evaluate Patient D's generalized anxiety disorder and properly manage it with safer medications.

24. **Patient E**

(a) Beginning in or around 2016, Respondent began rendering primary medical care and treatment to Patient E, an adult patient with a documented history of ailments including, but not limited to, chronic pain syndrome due to a motorcycle accident.

(b) For the period in or around May 2016 to March 2018, CURES and Respondent's medical records for Patient E indicate that Respondent routinely prescribed methadone to this patient. During this same timeframe, Respondent increased Patient E's methadone prescription up to an excessive dosage level of 70 mg daily (840 mg MEDD). Despite these excessive levels of methadone, Respondent failed to prescribe naloxone to Patient E to reduce the risks of accidental overdose.

(c) During this same timeframe, aside from prescribing methadone, Respondent failed to try other safer non-opioid medications including, but not

limited to, prescribing NSAIDs, gabapentin, and/or non-addictive muscle relaxants, to address Patient E's pain issues while also reducing and tapering his excessive methadone dosage. Respondent also failed to recommend or document recommending other alternative therapies (e.g., physical therapy and/or chiropractic manipulation) to address Patient E's chronic pain.

(d) Between in or around May 2016 to March 2018, during the timeframe Respondent managed Patient E's methadone therapy, Respondent's medical records fail to document significant information and data including, but not limited to, EKG monitoring for methadone side-effects on Patient E; obtaining an objective risk stratification; and/or recommending consultation with mental health professionals for cognitive behavioral therapy due to a number of factors, including Patient E's prior alcohol addiction.

(e) During the same timeframe, Respondent's medical records for Patient E fail to adequately document the monitoring of narcotic therapy including, but not limited to, the majority of progress notes appear copied from prior visits; the "5 A's of pain management" (i.e., Analgesia, Activity, Adverse reactions, Aberrant behavior and Affect) are mostly missing in the record; the analgesic and functional benefits of methadone therapy are not documented in the record; and the physical examinations are mostly normal and do not justify the need for high dose methadone therapy that was prescribed by Respondent.

(f) Between in or around May 2016 to March 2018, during the timeframe Respondent managed Patient E's methadone therapy, Respondent failed to taper the excessive dosages of methadone he prescribed to Patient E.

(g) Between in or around May 2016 to March 2018, the records document that Respondent only ran a single CURES query concerning Patient E.

(h) The medical records obtained from Respondent during the Board's investigation of Patient E's case fail to document that Respondent had obtained informed consent and/or a pain care agreement with this patient, despite the

consistent prescribing of excessively high dosages of methadone between in or around 2016 to 2018.

25. Respondent committed gross negligence in his care and treatment of Patient E including, but not limited to, the following:

(a) Respondent failed to appropriately initiate and monitor Patient E's methadone therapy.

26. **Patient F**

(a) In or around 2016, Respondent began rendering primary medical care and treatment to Patient F, an adult patient with a documented history of ailments including, but not limited to, chronic pain syndrome (due to low back pain), opioid dependence, anxiety disorder, and depression.

(b) For the period in or around May 2016 to February 2019, CURES and Respondent's medical records for Patient F indicate that Respondent routinely prescribed a dangerous combination of controlled medications including, but not limited to, methadone, benzodiazepines, Adderall, and Soma. During this same timeframe, Respondent failed to document a proper indication for the concurrent use of this dangerous drug combination.

(c) During this same timeframe, Respondent prescribed excessive dosage levels of methadone to Patient F, including up to 60 mg daily (600 mg MEDD). Despite these excessive levels of methadone, Respondent failed to prescribe naloxone to Patient F to reduce the risks of accidental overdose.

(d) According to CURES and Patient F's medical records, in or around April 2017, Respondent began prescribing methadone to Patient F for treatment of her "chronic pain syndrome" which stemmed from chronic back pain. Respondent continued prescribing methadone to Patient F until in or around February 2019.

(e) Between in or around May 2016 to February 2019, the records show that Respondent prescribed excessive dosages of methadone to Patient F for the treatment of her chronic back pain. During this same timeframe, Patient F's

medical record does not contain any updated imaging, additional diagnostic back pain evaluation, and/or surgical consultation ordered by Respondent that justified the level of methadone he had been prescribing this patient for nearly 3 years.

(f) During this same timeframe, the medical records for Patient F show that Respondent failed to pursue drug therapy treatment options that could have reduced this patient's dependency on high dose methadone. Significantly, Respondent failed to document the justification for routinely prescribing methadone to treat Patient F's chronic back pain, rather than prescribe other safer non-opiate medications including, but not limited to, NSAIDs, and/or gabapentin. Respondent did not discuss or document discussing with Patient F any other alternative therapies (e.g., physical therapy and/or chiropractic manipulation) to address this patient's chronic pain.

(g) Between in or around May 2016 to February 2019, during the timeframe that Respondent managed Patient F's methadone therapy, Respondent's medical records fail to document significant information and data including, but not limited to, EKG monitoring for methadone side-effects on Patient F; obtaining an objective risk stratification and/or recommending consultation with mental health professionals specialized in addiction and cognitive behavioral therapy due to Patient F's history of opioid dependence and non-compliance.

(h) During the same timeframe, Respondent's medical records for Patient F fail to adequately document the monitoring of narcotic therapy including, but not limited to, the majority of progress notes appear copied from prior visits; the "5 A's of pain management" (i.e., Analgesia, Activity, Adverse reactions, Aberrant behavior and Affect) are mostly missing in the record; the analgesic and functional benefits of methadone therapy are not documented in the record; and the physical examinations are mostly normal and do not justify the need for high dose methadone therapy that was prescribed by Respondent.

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(i) During the same timeframe, the records fail to document consistent and periodic urine toxicology testing to assess for possible aberrant drug-taking behaviors by Patient F; and a single CURES query was documented in this patient's record.

(j) Between in or around December 2017 to February 2019, Respondent prescribed Adderall[11] to Patient F for treatment of attention deficit hyperactivity disorder (ADHD).

(k) Between in or around 2016 to 2019, the records document that Respondent prescribed Adderall to Patient F without first obtaining a screening questionnaire or performing a thorough assessment of this patient for ADHD.

(l) For the period in or around May 2016 to February 2019, CURES and Respondent's medical records for Patient F indicate that Respondent routinely prescribed alprazolam to manage this patient's diagnosis of anxiety disorder.

(m) During this same timeframe, Respondent failed to document an appropriate and adequate evaluation of Patient F's anxiety disorder including, but not limited to, failing to document whether an anxiety screening and/or functional limitations assessment was performed; taking an inadequate history; and whether a referral was made for consultation with a mental health provider in light of this patient's documented history of opioid dependence. Respondent also failed to document the justification for only prescribing a benzodiazepine to treat Patient F's anxiety, rather than other safer medications including, but not limited to, SSRIs.

(n) The medical records obtained from Respondent during the Board's investigation of Patient F's case fail to document that the Respondent had obtained informed consent and/or a pain care agreement with this patient, despite the consistent prescribing of excessively high dosages of controlled substances between in or around 2016 to 2019.

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[11] Adderall is a Schedule II controlled substance pursuant to HSC § 11055, and a dangerous drug pursuant to Code section 4022. Adderall contains 2 drugs (amphetamine and dextroamphetamine) and it belongs to a class of medications called stimulants. When properly prescribed and indicated, Adderall is most commonly used to treat ADHD.

27. Respondent committed gross negligence in his care and treatment of Patient F including, but not limited to, the following:

(a) Respondent failed to adequately evaluate Patient F's chronic pain syndrome and properly manage it with non-opiate therapy;

(b) Respondent failed to appropriately initiate and monitor Patient F's methadone therapy; and

(c) Respondent failed to adequately evaluate Patient F's generalized anxiety disorder and properly manage it with safer means and/or medications.

28. **Patient G**

(a) Beginning in or around 2017, Respondent began rendering primary medical care and treatment to Patient G, an adult patient with a documented history of ailments including, but not limited to, chronic pain syndrome.

(b) Between in or around January 2017 to March 2019, CURES and Respondent's medical records for Patient G indicate that Respondent routinely prescribed methadone to this patient. During this same timeframe, Respondent increased Patient G's methadone prescription up to an excessive dosage level of 80 mg daily (960 mg MEDD). Despite these excessive levels of methadone and Patient G's chronic lung disease, Respondent failed to prescribe naloxone to this patient to reduce the risks of accidental overdose.

(c) Between in or around January 2017 to March 2019, during the timeframe Respondent managed Patient G's methadone therapy, Respondent's medical records fail to document significant information and data including, but not limited to, EKG monitoring for methadone side-effects on Patient G.

(d) During the same timeframe, Respondent's medical records for Patient G fail to adequately document the monitoring of narcotic therapy including, but not limited to, the majority of progress notes appear copied from prior visits; no detailed range of motion examination of the spine was performed; most musculoskeletal examinations were documented as normal; pain intensity scales

and functional benefits of methadone therapy were rarely documented; and the physical examinations are mostly normal and do not justify the need for high dose methadone therapy that was prescribed by Respondent.

(e) Between in or around January 2017 to March 2019, during the timeframe Respondent managed Patient G's methadone therapy, Respondent failed to taper the excessive dosages of methadone prescribed to this patient.

(f) In or around January 2018, Respondent obtained a urine toxicology result for Patient G, which showed inconsistent results for a controlled substance (benzodiazepine) that was not prescribed to this patient by Respondent. Despite this "red flag," Respondent obtained only 1 more additional urine toxicology screen from Patient G between in or around 2018 to 2019.

(g) Between in or around January 2017 to March 2019, during the timeframe Respondent managed Patient G's methadone therapy, Respondent's medical records for Patient G fail to document that he ran a single CURES query concerning Patient G despite this patient's prior inconsistent toxicology results.

(h) The medical records obtained from Respondent during the Board's investigation of Patient G's case fail to document that Respondent had obtained informed consent and/or a pain care agreement with this patient, despite the consistent prescribing of excessively high dosages of methadone between in or around 2017 to 2019.

29. Respondent committed gross negligence in his care and treatment of Patient G including, but not limited to, the following:

(a) Respondent failed to appropriately initiate and monitor Patient G's methadone therapy.

30. **Patient H**

(a) In or around October 2017, Respondent began rendering primary medical care and treatment to Patient H, an adult patient with a documented history of ailments including, but not limited to, chronic pain syndrome and anxiety.

(b) For the period in or around June 2016 to March 2019, CURES and Respondent's medical records for Patient H indicate that Respondent routinely prescribed a dangerous combination of controlled medications including, but not limited to, methadone and benzodiazepines. Respondent also failed to document a proper indication for the concurrent use of this dangerous drug combination.

(c) During this same timeframe, Respondent prescribed excessive dosage levels of methadone to Patient H, including up to 120 mg daily (1440 mg MEDD). Despite these excessive levels of methadone, Respondent failed to prescribe naloxone to Patient H to reduce the risks of accidental overdose.

(d) According to CURES and Patient H's medical records, in or around June 2016, Respondent began prescribing methadone to Patient H for treatment of her chronic pain syndrome (chronic back pain). Respondent continued prescribing methadone to Patient H until in or around March 2019.

(e) For the period in or around June 2016 to March 2019, the medical records for Patient H show that Respondent failed to pursue drug therapy treatment options that could have reduced this patient's dependency on high dose methadone. Significantly, Respondent, after Patient H complained of chronic abdominal pains, failed to recognize and diagnose this patient with functional narcotic bowel syndrome and initiate a tapering of the methadone prescription. Respondent also failed to document the justification for routinely prescribing methadone to treat Patient H's chronic back pain, rather than prescribe other safer non-opiate medications including, but not limited to, NSAIDs, non-addictive muscle relaxants, and/or gabapentin. Finally, Respondent did not discuss or document discussing with Patient H any other alternative therapies (e.g., physical therapy and/or acupuncture) to address this patient's chronic pain.

(f) Respondent's medical records for Patient H show that he failed to perform an objective stratification of this patient's opioid addiction risks prior to initially refilling her methadone in or around June 2016.

(g) Between in or around June 2016 to March 2019, during the timeframe that Respondent managed Patient H's methadone therapy, the records show that Respondent failed to recognize the adverse side-effects that methadone therapy was having on this patient after she complained of abdominal pain and constipation. Significantly, notwithstanding Patient H's complaints, Respondent failed to initiate a tapering of the methadone prescription, which likely caused harm to this patient.

(h) During the same timeframe, Respondent's medical records for Patient H fail to adequately document the monitoring of narcotic therapy including, but not limited to, the majority of progress notes appear copied from prior visits; functional assessment and/or pain intensity data are missing; relevant spine examinations are mostly documented as normal and do not justify the need for high dose methadone therapy; and Respondent did not discuss or document discussing with Patient H the need to taper her methadone therapy.

(i) During this same timeframe, the only EKG monitoring obtained for Patient H was done as part of her preoperative evaluation for gallbladder surgery in late 2018.

(j) Not until in or around early 2019 did Respondent order a urine toxicology screen and run a query of CURES for Patient H, which was more than 2 years after Respondent had begun prescribing methadone to this patient.

(k) For the period in or around June 2016 to March 2019, CURES and Respondent's medical records for Patient H indicate that Respondent routinely prescribed alprazolam and diazepam to manage this patient's anxiety.

(l) During this same timeframe, Respondent failed to document an appropriate and adequate evaluation of Patient H's anxiety disorder including, but not limited to, failing to document whether an anxiety screening and/or functional limitations assessment were performed, and there was no detailed history of this patient's anxiety documented in the record. Respondent also failed to document the justification for only prescribing a benzodiazepine to treat Patient H's anxiety, rather than other safer medications including, but not limited to, SSRIs.

Significantly, Respondent's prescribing of chronic benzodiazepine monotherapy for Patient H's anxiety caused harm to this patient by worsening her benzodiazepine dependency and addiction.

(m) The medical records obtained from Respondent during the Board's investigation of Patient H's case fail to document that the Respondent had obtained informed consent and/or a pain care agreement with this patient, despite the consistent prescribing of excessively high dosages of controlled substances between in or around 2016 to 2019.

31. Respondent committed gross negligence in his care and treatment of Patient H including, but not limited to, the following:

(a) Respondent failed to adequately evaluate Patient H's chronic pain syndrome and properly manage it with non-opiate therapy;

(b) Respondent failed to appropriately initiate and monitor Patient H's methadone therapy; and

(c) Respondent failed to adequately evaluate Patient H's generalized anxiety disorder and properly manage it with safer means and/or medications.

32. **Patient I**

(a) In or around 2014,[12] Respondent began rendering primary medical care and treatment to Patient I, an adult patient with a documented history of ailments including, but not limited to, chronic low back pain, anxiety disorder, schizophrenia, and opioid dependence/alcohol dependence with a history of drug and alcohol abuse.

(b) For the period in or around March 2016 to August 2017, CURES and Respondent's medical records for Patient I indicate that Respondent routinely prescribed a dangerous combination of controlled medications including, but not limited to, methadone, benzodiazepines, and Ambien.[13]

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[12] Any act or omission alleged to have occurred more than 7 years prior to the filing of the instant Accusation is alleged for informational purposes only, and is not alleged as a basis for any disciplinary action in this matter.

[13] Ambien is a brand name for zolpidem tartrate, a Schedule IV controlled substance ...

(c) During this same timeframe, Respondent failed to adequately document in the records the indication(s) for concurrently prescribing high dosages of lorazepam (benzodiazepine) with high dosages of methadone to Patient I, who had a history of chronic liver failure.

(d) During this same timeframe, Respondent prescribed excessive dosage levels of methadone to Patient I, including up to 60 mg daily (600 mg MEDD). Despite these excessive levels of methadone, Respondent failed to prescribe naloxone to Patient I to reduce the risks of accidental overdose.

(e) According to CURES and Patient I's medical records, in or around March 2016, Respondent began prescribing methadone to Patient I for treatment of his chronic back pain. Respondent continued prescribing methadone to Patient I until in or around August 2017.

(f) For the period in or around March 2016 to August 2017, the medical records for Patient I show that Respondent failed to document the justification for routinely prescribing methadone to treat his chronic back pain, rather than prescribe other safer non-opiate medications including, but not limited to, non-addictive muscle relaxants and/or gabapentin. Respondent did not discuss or document discussing with Patient I any other alternative therapies (e.g., physical therapy and/or acupuncture) to address his chronic pain and reduce his methadone dosages.

(g) Respondent's medical records for Patient I show that he failed to perform an objective stratification of this patient's elevated opioid addiction risks prior to initially refilling his methadone in or around March 2016. Respondent failed to discuss or document discussing with Patient I a multi-disciplinary approach to managing his back pain. Respondent also failed to document his justification for prescribing methadone to a cirrhotic patient.

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pursuant to HSC § 11057, and a dangerous drug pursuant to Code section 4022. Ambien is a brand name for zolpidem tartrate. Ambien has CNS depressant effects and its use can potentially worsen symptoms of depression and suicidal thoughts in patients suffering from depression.

(h) During the same timeframe, Respondent's medical records for Patient I fail to adequately document the monitoring of narcotic therapy including, but not limited to, the majority of progress notes appear copied from prior visits; intensity pain scales, adverse side-effects, and functional assessments are missing; and no relevant examinations were documented in the record that justified the need for high dose methadone therapy.

(i) For the period in or around March 2016 to August 2017, the medical records for Patient I show that Respondent failed to obtain an EKG, despite the concurrent use of methadone and anti-psychotic medications.

(j) During the same timeframe, Respondent, despite having full knowledge of Patient I's elevated risks for aberrant drug-taking behaviors, only ordered 1 urine toxicology screen for this patient. In addition, Respondent failed to document running a CURES query in Patient I's records during this same timeframe.

(k) For the period in or around March 2016 to August 2017, CURES and Respondent's medical records for Patient I indicate that Respondent routinely prescribed lorazepam to manage this patient's anxiety.

(l) During this same timeframe, Respondent failed to document an appropriate and adequate evaluation of Patient I's anxiety disorder including, but not limited to, failing to document whether an anxiety screening and/or functional limitations assessment were performed, and there was no detailed history of this patient's anxiety documented in the record. Respondent also failed to document the justification for only prescribing a benzodiazepine to treat Patient I's anxiety, rather than other safer medications including, but not limited to, SSRIs. Respondent also failed to document any justification for prescribing Patient I chronic benzodiazepine monotherapy to treat this patient's anxiety.

(m) The medical records obtained from Respondent during the Board's investigation of Patient I's case fail to document that the Respondent had obtained informed consent and/or a pain care agreement with this patient, despite the

consistent prescribing of excessively high dosages of controlled substances between in or around 2016 to 2019.

33. Respondent committed gross negligence in his care and treatment of Patient I including, but not limited to, the following:

(a) Respondent failed to appropriately initiate and monitor Patient I's methadone therapy;

(b) Respondent failed to adequately evaluate Patient I's generalized anxiety disorder and properly manage it with safer means and/or medications; and

(c) Respondent issued concurrent prescriptions of high dose methadone and high dose lorazepam, which drug combination posed serious risks to Patient I's health due to his history of chronic liver failure.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

34. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 43562 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patients A, B, C, D, E, F, G, H, and I, as more particularly alleged hereinafter:

35. **Patient A**

(a) Paragraphs 15, 16, and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

36. **Patient B**

(a) Paragraphs 15, 18, and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

37. **Patient C**

(a) Paragraphs 15, 20, and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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38. **Patient D**

(a) Paragraphs 15, 22, and 23, above, are hereby incorporated by reference and realleged as if fully set forth herein.

39. **Patient E**

(a) Paragraphs 15, 24, and 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

40. **Patient F**

(a) Paragraphs 15, 26, and 27, above, are hereby incorporated by reference and realleged as if fully set forth herein.

41. **Patient G**

(a) Paragraphs 15, 28, and 29, above, are hereby incorporated by reference and realleged as if fully set forth herein.

42. **Patient H**

(a) Paragraphs 15, 30, and 31, above, are hereby incorporated by reference and realleged as if fully set forth herein.

43. **Patient I**

(a) Paragraphs 15, 32, and 33, above, are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

44. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 43562 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patients A, B, C, D, E, F, G, H, and I, as more particularly alleged in paragraphs 15 through 43, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

45. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 43562 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 15 through 44, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 43562, issued to Respondent Gregg Antony Denicola, M.D.;

2. Revoking, suspending or denying approval of Respondent Gregg Antony Denicola, M.D.'s authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Gregg Antony Denicola, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent Gregg Antony Denicola, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: JUN 0 2 2022

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

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