

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

1 ROB BONTA  
Attorney General of California  
2 ALEXANDRA M. ALVAREZ  
Supervising Deputy Attorney General  
3 JOSEPH F. MCKENNA III  
Deputy Attorney General  
4 State Bar No. 231195  
California Department of Justice  
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8 *Attorneys for Complainant*

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

13 In the Matter of the Accusation Against:  
14 **GREGG ANTONY DENICOLA, M.D.**  
333 Thalia Street  
15 **Laguna Beach, California 92651**  
16 **Physician's and Surgeon's Certificate No.**  
**G 43562,**  
17  
18 Respondent.

Case No. 800-2018-051100  
OAH No. 2022090349  
**STIPULATED SURRENDER OF  
LICENSE AND DISCIPLINARY ORDER**

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

21 **PARTIES**

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

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

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<sup>1</sup> Mr. Prasifka retired on December 20, 2022.



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

6                                 CONTINGENCY

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

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

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

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

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

#### 14 **ADDITIONAL PROVISIONS**

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

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

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

#### 24 **DISCIPLINARY ORDER**

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

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

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

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

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

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

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

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


24    ////  
25    ////  
26    ////  
27    ////  
28    ////

**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*

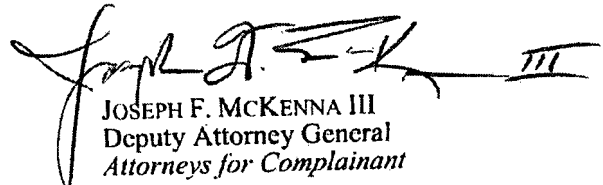
I have read and fully discussed with Respondent Gregg Antony Denicola, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

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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Doc.No.83832507

**Exhibit A**

**Accusation No. 800-2018-051100**



1 ROB BONTA  
Attorney General of California  
2 ALEXANDRA M. ALVAREZ  
Supervising Deputy Attorney General  
3 JOSEPH F. MCKENNA III  
Deputy Attorney General  
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6 San Diego, California 92186-5266  
Telephone: (619) 738-9417  
7 Facsimile: (619) 645-2061  
8 *Attorneys for Complainant*

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

14 In the Matter of the Accusation Against:

Case No. 800-2018-051100

15 **GREGG ANTONY DENICOLA, M.D.**  
16 **333 Thalia Street**  
**Laguna Beach, California 92651**

**A C C U S A T I O N**

17 **Physician's and Surgeon's Certificate No.**  
18 **G 43562,**

Respondent.

19  
20  
21 Complainant alleges:

22 **PARTIES**

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

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

1 **JURISDICTION**

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

5 **STATUTORY PROVISIONS**

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

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

12 (a) On and after July 1, 2019, except as otherwise provided in subdivision (c),  
13 the board and the Podiatric Medical Board of California shall require a licensee to  
14 provide a separate disclosure that includes the licensee's probation status, the length  
15 of the probation, the probation end date, all practice restrictions placed on the licensee  
16 by the board, the board's telephone number, and an explanation of how the patient  
17 can find further information on the licensee's probation on the licensee's profile page  
18 on the board's online license information internet website, to a patient or the patient's  
19 guardian or health care surrogate before the patient's first visit following the  
20 probationary order while the licensee is on probation pursuant to a probationary  
21 order made on and after July 1, 2019, in any of the following circumstances:

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

20 ...

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

22 ...

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

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

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

28 (b) Gross negligence.

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

5 ...  
6 7. Unprofessional conduct under section 2234 of the Code is conduct which breaches  
7 the rules or ethical code of the medical profession, or conduct which is unbecoming to a member  
8 in good standing of the medical profession, and which demonstrates an unfitness to practice  
9 medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

10 8. Section 2266 of the Code states:

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

#### 14 COST RECOVERY

15 9. Section 125.3 of the Code states:

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

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

24 (c) A certified copy of the actual costs, or a good faith estimate of costs where  
25 actual costs are not available, signed by the entity bringing the proceeding or its  
26 designated representative shall be prima facie evidence of reasonable costs of  
27 investigation and prosecution of the case. The costs shall include the amount of  
28 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.

1 (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 (2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally  
3 renew or reinstate for a maximum of one year the license of any licensee who  
4 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.

5 (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  
6 available upon appropriation by the Legislature.

7 (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.

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

#### 10 PERTINENT DRUG INFORMATION

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

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

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

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

1 or MME. The Centers for Disease Control and Prevention (CDC) states, “Higher dosages of  
2 opioids are associated with higher risk of overdose and death – even relatively low dosages (20-  
3 50 morphine milligram equivalents (MME) per day) increase risk.”

4 14. The Controlled Substance Utilization Review and Evaluation System (CURES) is a  
5 program operated by the California Department of Justice (DOJ) to assist health care practitioners  
6 in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and  
7 regulatory agencies in their efforts to control diversion and abuse of controlled substances. (HSC §  
8 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of  
9 Scheduled controlled substances as soon as reasonably possible after the prescriptions are filled.

10 **FIRST CAUSE FOR DISCIPLINE**

11 **(Gross Negligence)**

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

16 16. **Patient A**

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

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

25 <sup>1</sup> Patients’ true names are not used in the instant Accusation to maintain patient  
26 confidentiality. The patients’ identities are known to Respondent or will be disclosed to  
27 Respondent upon receipt of a duly issued request for discovery in accordance with Government  
28 Code section 11507.6.

<sup>2</sup> 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.

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

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

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

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

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

26 <sup>3</sup> NSAIDs are members of a therapeutic drug class which reduces pain and decreases  
27 inflammation. NSAIDs are the most prescribed medications for treating conditions such as  
arthritis and other pain.

28 <sup>4</sup> Naloxone is an opioid antagonist commonly used as an antidote against opiate toxicity or  
overdose.

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

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

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

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

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

19 18. **Patient B**

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

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

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

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

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

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

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

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

27 <sup>6</sup> Methadone can result in prolonged QT intervals and place methadone patients at risk for  
28 fatal cardiac arrhythmias. Baseline EKG, before therapy and periodic EKG monitoring during  
therapy, is advised.



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

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

5           20. **Patient C**

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

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

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

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

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

27                 <sup>8</sup> Opioid-induced hyperalgesia is defined as a state of nociceptive sensitization caused by  
28                 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.

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

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

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

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

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

27 <sup>9</sup> SSRIs are the most commonly prescribed antidepressants. They can ease symptoms of  
28 moderate to severe depression, are relatively safe and typically cause fewer side effects than other  
types of antidepressants.

1 consistent prescribing of excessively high dosages of opioids between in or around  
2 2016 to 2019.

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

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

7 22. **Patient D**

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

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

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

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

26  
27 <sup>10</sup> Soma is a brand name for carisoprodol, a Schedule IV controlled substance pursuant to  
28 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 10 (a) Respondent failed to adequately evaluate Patient D's "chronic pain  
11 syndrome" and properly manage it with non-opiate therapy;  
12 (b) Respondent failed to appropriately initiate and monitor Patient D's  
13 methadone therapy; and  
14 (c) Respondent failed to adequately evaluate Patient D's generalized  
15 anxiety disorder and properly manage it with safer medications.

16 24. **Patient E**

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

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

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

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

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

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

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

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

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

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

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

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

7 26. **Patient F**

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

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

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

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

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



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

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

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

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

28 ////

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

4 (j) Between in or around December 2017 to February 2019, Respondent  
5 prescribed Adderall<sup>11</sup> to Patient F for treatment of attention deficit hyperactivity  
6 disorder (ADHD).

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

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

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

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

26  
27 <sup>11</sup> Adderall is a Schedule II controlled substance pursuant to HSC § 11055, and a  
28 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.

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

- 3           (a) Respondent failed to adequately evaluate Patient F's chronic pain  
4                 syndrome and properly manage it with non-opiate therapy;
- 5           (b) Respondent failed to appropriately initiate and monitor Patient F's  
6                 methadone therapy; and
- 7           (c) Respondent failed to adequately evaluate Patient F's generalized anxiety  
8                 disorder and properly manage it with safer means and/or medications.

9           28. **Patient G**

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

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

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

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

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

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

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

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

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

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

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

25 30. **Patient H**

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

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

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

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

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

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

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

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

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

16 (j) Not until in or around early 2019 did Respondent order a urine  
17 toxicology screen and run a query of CURES for Patient H, which was more than  
18 2 years after Respondent had begun prescribing methadone to this patient.

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

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

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

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

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

- 11 (a) Respondent failed to adequately evaluate Patient H's chronic pain  
12 syndrome and properly manage it with non-opiate therapy;  
13 (b) Respondent failed to appropriately initiate and monitor Patient H's  
14 methadone therapy; and  
15 (c) Respondent failed to adequately evaluate Patient H's generalized anxiety  
16 disorder and properly manage it with safer means and/or medications.

17 32. **Patient I**

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

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

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

28 <sup>13</sup> Ambien is a brand name for zolpidem tartrate, a Schedule IV controlled substance ...

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

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

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

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

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

26 ////

27 \_\_\_\_\_  
28 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.



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

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

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

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

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

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

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

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

- 5 (a) Respondent failed to appropriately initiate and monitor Patient I's  
6 methadone therapy;
- 7 (b) Respondent failed to adequately evaluate Patient I's generalized anxiety  
8 disorder and properly manage it with safer means and/or medications;  
9 and
- 10 (c) Respondent issued concurrent prescriptions of high dose methadone and  
11 high dose lorazepam, which drug combination posed serious risks to  
12 Patient I's health due to his history of chronic liver failure.

13 **SECOND CAUSE FOR DISCIPLINE**

14 **(Repeated Negligent Acts)**

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

19 35. **Patient A**

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

22 36. **Patient B**

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

25 37. **Patient C**

26 (a) Paragraphs 15, 20, and 21, above, are hereby incorporated by reference  
27 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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1 **FOURTH CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct)**

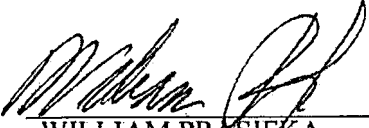
3 45. Respondent has further subjected his Physician's and Surgeon's Certificate No.  
4 G 43562 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has  
5 engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct  
6 which is unbecoming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

9 **PRAYER**

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

- 12 1. Revoking or suspending Physician's and Surgeon's Certificate No. G 43562, issued  
13 to Respondent Gregg Antony Denicola, M.D.;
- 14 2. Revoking, suspending or denying approval of Respondent Gregg Antony Denicola,  
15 M.D.'s authority to supervise physician assistants pursuant to section 3527 of the Code, and  
16 advanced practice nurses;
- 17 3. Ordering Respondent Gregg Antony Denicola, M.D., to pay the Board the costs of the  
18 investigation and enforcement of this case, and if placed on probation, the costs of probation  
19 monitoring;
- 20 4. Ordering Respondent Gregg Antony Denicola, M.D., if placed on probation, to  
21 provide patient notification in accordance with Business and Professions Code section 2228.1;  
22 and
- 23 5. Taking such other and further action as deemed necessary and proper.

24  
25 DATED: JUN 02 2022

26   
27 WILLIAM PRASIEKA  
28 Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

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