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

In the Matter of the Accusation Against: Daniel Quoc Le, M.D. Physician's and Surgeon's Certificate No. G 71070 Respondent.	Case No.: 800-2019-058361

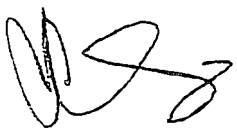
DECISION

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

This Decision shall become effective at 5:00 p.m. on July 26, 2023.

IT IS SO ORDERED: June 26, 2023.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
JASON J. AHN
Deputy Attorney General
State Bar No. 253172
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9433
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **DANIEL QUOC LE, M.D.** **280 S MAIN ST STE 200** **ORANGE CA 92868-3852** **Physician's and Surgeon's Certificate No. G 71070** Respondent.	Case No. 800-2019-058361 OAH No. 2022080867 **STIPULATED SETTLEMENT 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). Then Executive Director William Prasifka previously brought this action solely in his official capacity. Complainant is represented in this matter by Rob Bonta, Attorney General of the State of California, by Jason J. Ahn, Deputy Attorney General.

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2. Respondent Daniel Quoc Le, M.D. (Respondent) is represented in this proceeding by attorney Benjamin J. Fenton, Esq., whose address is: 1990 S. Bundy Drive, Suite 777 Los Angeles, CA 90025.

3. On or about April 8, 1991, the Board issued Physician's and Surgeon's Certificate No. G 71070 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-058361, and will expire on September 30, 2024, unless renewed.

JURISDICTION

4. On July 20, 2022, Accusation No. 800-2019-058361 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on or about July 20, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-058361 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2019-058361. Respondent has also carefully read, fully discussed with his counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

7. 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.

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

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CULPABILITY

Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in First Amended Accusation No. 800-2019-058361, a copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. G 71070 to disciplinary action.

9. Respondent agrees that if an accusation is ever filed against him before the Medical Board of California, all of the charges and allegations contained in First Amended Accusation No. 800-2019-058361 shall be deemed true, correct, and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. G 71070 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

11. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2019-058361 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

ADDITIONAL PROVISIONS

13. This Stipulated Settlement 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.

14. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 71070 issued to Respondent Daniel Quoc Le, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

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

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

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

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

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

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

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

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

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

5. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, legal reviews, and investigation(s), in the amount of $25,000.00 (twenty-five thousand dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

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

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

7. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

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

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

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations.

10. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

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

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

14. FUTURE ADMISSIONS CLAUSE. 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 action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2019-058361 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

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

DATED: 3/22/23 _____

DANIEL QUOC LE, M.D.
Respondent

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

DATED: _____

BENJAMIN J. FENTON, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: April 25, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

JASON J. AHN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A
Accusation No. 800-2019-058361

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
JASON J. AHN
Deputy Attorney General
State Bar No. 253172
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9433
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **DANIEL QUOC LE, M.D.** **280 S MAIN ST, STE 200** **ORANGE, CA 92868-3852** **Physician's and Surgeon's Certificate No. G 71070,** Respondent.	Case No. 800-2019-058361 **ACCUSATION**

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 (Board).

2. On or about April 8, 1991, the Medical Board issued Physician's and Surgeon's Certificate No. G 71070 to Daniel Quoc Le, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2022, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically

appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

6. 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.

7. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming 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.)

COST RECOVERY

8. 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 licensee 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.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. G 71070 to disciplinary action under section 2227 and 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A,[1] as more particularly alleged hereinafter:

10. In or around 2000,[2] Patient A presented to Respondent for chronic low back pain. At that time, Patient A, a female, was approximately nineteen (19) years old.

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[1] The patient herein is identified as Patient A in order to maintain patient confidentiality.

[2] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

11. On or about June 3, 2016, Patient A returned to Respondent. Patient A reported recurrent pain after right L5-S1 epidural[3] and bilateral sacroiliac ligament injections[4] under fluoroscopy[5] in January 2016. Patient A reported 80% relief after the injection. Respondent reviewed MRI[6] from September 2011 and noted to be significant for facet arthropathy[7] at L4-5 and L5-S1, interbody fusion[8] at L5-S1, mild disc protrusion at L4-5, and no central stenosis[9] at either L4-5 or L5-S1. Respondent prescribed Patient A Lyrica[10] 50 mg BID[11], Phenergan[12] 25 mg

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[3] Epidural is a procedure that injects a local anesthetic in to the space around spinal nerves in your lower back.

[4] A sacroiliac joint injection is used to diagnose or treat lower back pain that comes from your sacroiliac joint.

[5] Fluoroscopy is an imaging technique that uses X-rays to obtain real-time moving images of the interior of an object.

[6] Magnetic Resonance Imaging (MRI) is a medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body.

[7] Facet arthropathy (FA) is a painful, arthritic condition of the facet joints.

[8] An interbody fusion is a type of spinal fusion that involves removing the intervertebral disk.

[9] Central stenosis occurs when the central spinal canal is constricted with enlarged ligament and bony overgrowth, causing compression of the spinal cord and cauda equine. Cauda equine is the sack of nerve roots (the nerves that leave the spinal cord between spaces in the bones of the spine to connect to other parts of the body) at the lower end of the spinal cord. These nerve roots provide the ability to move and feel sensation in the legs and the bladder.

[10] Lyrica® (pregabalin) is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, Lyrica® is used for, among other things, the treatment of neuropathic pain associated with spinal cord injury and/or the management of fibromyalgia or seizures. Caution must be exercised when prescribing Lyrica® to patients with a history of depression, suicidal thoughts, drug and/or alcohol addiction.

[11] BID, abbreviation for "bis in die" (Latin), means two times a day.

[12] Phenergan (Promethazine) is an antihistamine and antiemetic, which can be used as a sedative before and after surgery and medical procedures.

PR,[13] Ambien[14] 10- mg at night, Dilaudid[15] 4 mg Q6 hours prn[16], and liquid Tylenol.[17] The physical examination was significant for tenderness to palpation over the SI joints[18] and negative SLR.[19] Patient A underwent trigger point injections, proper biomechanics were reviewed, and Patient A was instructed to follow up in two (2) months. Before initiating opioid therapy with Patient A, Respondent failed to obtain a pain management agreement with Patient A.

12. On or about August 5, 2016, Patient A returned to Respondent. Patient A reported continued low back pain that was more on the right and radiating to the posterior right thigh. Patient A also reported 60% relief with the trigger point injections. Patient A requested repeat L5-S1 epidural steroid injection with sacral trigger point injection. The plan was to proceed with a series of two (2) injections.

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[13] PR means (per rectum), which means by or through the rectum.

[14] Zolpidem Tartrate (Ambien®), a centrally acting hypnotic-sedative, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short-term treatment of insomnia characterized by difficulties with sleep initiation.

[15] Hydromorphone (Dilaudid®), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. The Drug Enforcement Administration (DEA) has identified hydromorphone, such as Dilaudid®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.) The Food and Drug Administration (FDA) has issued black box warnings for Dilaudid® which warn about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warnings also caution about the risks associated with concomitant use of Dilaudid® with benzodiazepines or other central nervous system (CNS) depressants.

[16] PRN stands for "pro re nata," which means that the administration of medication is not scheduled. Instead, the prescription is taken as needed.

[17] Tylenol (acetaminophen) is an analgesic, which can be used to treat minor aches and pains, and reduces fever.

[18] The sacroiliac joint (SI joint) is the joint between the sacrum and the ilium bones of the pelvis, which are connected by strong ligaments.

[19] In a Single Leg Raise (SLR) test, positive results indicate that while performing the straight leg test on the unaffected leg, the symptoms/pain are reproduced on the opposite (affected leg). Negative results mean that no symptoms/pain are felt on the opposite leg.

13. On or about September 29, 2016, Patient A returned to Respondent. Patient A reported no change in symptoms or pain. Patient A underwent L5-S1 sacral trigger point injection, performed on or about September 30, 2016 under intravenous conscious sedation.

14. On or about October 18, 2016, Patient A returned to Respondent. Patient A reported 50% pain relief with the injections. Patient A also reported right buttock pain radiating to the posterior side of the right leg to the right heel and bottom of the right foot, with similar but less severe symptoms on her left side. The plan was to repeat a lumber MRI and proceed with bilateral SI transforaminal epidural steroid injections[20]. On or about October 31, 2016, Patient A underwent the MRI.

15. On or about December 22, 2016, Patient A returned to Respondent for a review of the MRI taken on December 21, 2016. Respondent noted L4-5 mild disc protrusion, no central stenosis, mild facet arthropathy, L5-S1 interbody fusion with titanium cage, possible epidural fibrosis touching the S1 nerve root, and no central stenosis. The plan was to proceed with bilateral S1 transforaminal epidural steroid injection and add-on bilateral sacroiliac ligament injections.

16. On or about January 27, 2017, Patient A underwent bilateral S1 tf-epidrual steroid injection under intravenous conscious sedation. Patient A followed up on February 20, 2017, reporting 70% relief in her pain. The plan was to continue Dilaudid and refer her to physical therapy.

17. On or about April 17, 2017, Patient A returned to Respondent, reporting continued low back pain. Patient A also reported that she had recently lost her employment and was unable to continue physical therapy since she lost her insurance. The plan was to continue Dilaudid 4 mg QID. Respondent reviewed with Patient A proper posture and body mechanics.

18. On or about June 9, 2017, Patient A returned to Respondent and Respondent continued Dilaudid for pain control.

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[20] Transforaminal injection can help relieve pain in your lower back, legs, and feet caused by sciatica, herniated discs or other back problems.

19. On or about September 8, 2017, Patient A returned to Respondent, reporting worsening low back pain that radiated to the posterior side of the legs. Patient A also reported that she had recently started a new job, which entails sitting down for twelve (12) hours. Respondent noted that most of Patient A's pain was coming from the sacroiliac joints. Patient A underwent trigger point injections. The plan was to refer Patient A to physical therapy and proceed with bilateral S1 injections under fluoroscopy.

20. On or about October 5, 2017, Patient A presented to Respondent, reporting no new complaints. Respondent determined that Patient A was a candidate for the bilateral S1 tranformanial epidural steroid injections and bilateral sacral ligament trigger point injections, which Patient A underwent on October 6, 2017, under intravenous conscious sedation.

21. On or about November 9, 2017, Patient A returned to Respondent, reporting 80% pain relief with injections. Patient A also reported that she fell forward on the floor, leading to increased low back pain, left knee pain, and left foot numbness. The plan was to start topical NSAIDs (Voltaren)[21] for pain, follow-up in clinic in one (1) week for trigger point injections, and to order a new lumbar MRI to evaluate for new disc protrusion given increased back pain and left foot numbness.

22. On or about February 23, 2018, Patient A returned to Respondent, reporting that her low back pain after the fall in November 2017 had subsided. Patient A requested repeat epidural steroid injection and sacroiliac joint injections prior to her wedding. The plan was to repeat the procedure. A urine drug screen was performed that day.

23. On or about April 20, 2018, Patient A returned to Respondent, reporting that her low back pain was a 4 ~ 5 out of a ten point scale, with medication. Patient A also reported compliance with physical therapy and stretching. Patient A was unable to repeat injections due to her busy schedule. The plan was to repeat the injections.

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[21] NASAID (Nonsteroidal anti-inflammatory drugs) are medicines that are widely used to relieve pain, reduce inflammation, and to bring down a high temperature. Voltaren (Diclofenac) is a nonsteroidal anti-inflammatory drug, which can be used to treat pain, migraines, and arthritis in oral form.

24. On or about May 18, 2018, Patient A returned to Respondent, reporting that her pain level is 6 ~ 7 out of a ten point scale, with pain medication. The plan was to repeat the bilateral S1 transformanial epidural and bilateral sacroiliac ligament injections, which were performed under intravenous conscious sedation and fluoroscopy, on or about May 25, 2018.

25. On or about July 13, 2018, Patient A returned to Respondent, reporting 60 ~ 80% relief with the injections she received on or about May 25, 2018. Patient A reported that her pain level was a two out of the ten point scale in the morning, but increases to 6 out of 10 at the end of the day. The plan was to continue Dilaudid, Lyrica, Ambien, and Zofran. Patient A was also instructed to continue physical therapy and core strengthening exercises and educated about proper posture at work.

26. On or about October 1, 2018, Patient A returned to Respondent, reporting that the pain had started to return. Patient A also reported being able to reduce her allotted pain medication, and that Zofran was less effective for nausea than Phenergan. The plan was to continue Dilaudid and Lyrica for pain control, Ambien for insomnia, and start Phenergan for nausea.

27. On or about November 1, 2018, Respondent drafted a memo in the medical records indicating that he spoke with the pharmacist regarding Patient A filling prescriptions for Norco[22] (7.5 mg #20 on or about October 2, 2018, 10 mg #12 on or about October 11, 2018, 10 mg # 12

[22] Hydrocodone APAP (Vicodin®, Lortab® and Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCPs) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the FDA. The FDA black box warning provides that "Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

on or about October 16, 2018, and 10 mg # 12 on or about October 19, 2018) from her dentist. Respondent noted that he would discuss this with Patient A and that Patient A should only receive pain medication from Respondent. Respondent also noted that Patient A should use only one (1) pharmacy per the [purported] pain management contract with him.

28. On or about November 1, 2018, Respondent drafted another memo in the medical records stating that insurance only covered # 84 tablets for 21 days and Patient A was expected to pay for the balance of the prescriptions using cash. Respondent [purportedly] refused to write a new prescription as Patient A had received additional opiate medication from her dentist(s).

29. On or about November 12, 2018, Patient A returned to Respondent, reporting new onset pain after a fall, one month ago. Patient A reported that the pain radiated in the right L4 dermatome[23] to the anterior thigh and anterior lower leg. Respondent recommended MRI and repeat right L4 and bilateral L5-S1 epidural steroid injection. Patient A declined due to financial concerns. Respondent continued prescribing Dilaudid, Lyrica (for pain control), Ambien for insomnia, and Phenergan for nausea. A urine drug screen on Patient A was performed on this day, which showed positive for clonazepam,[24] negative for hydromorphone, and negative for Ambien. The notes on the specimen indicate possible sample dilution with recommendation to recollect specimen with direct observation.

30. On or about December 3, 2018, Patient A returned to Respondent. There were no changes in her symptoms and no changes in the medical plan. On or about December 4, 2018, Patient A underwent a right L4 and bilateral L5-S1 transoframinal epidural steroid injections under intravenous conscious sedation.

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[23] The L4 dermatome is an area of skin that receives sensations through the L4 spinal nerve and includes parts of the thigh, knee, leg, and foot.

[24] Klonopin® (clonazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. Concomitant use of Klonopin® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Klonipin®, as drugs of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

31. On or about December 11, 2018, Patient A returned to Respondent, reporting 50% pain relief along the right L4 dermatome and 60% relief of low back pain. The plan was to repeat the procedure.

32. On or about December 26, 2018, Patient A returned to Respondent, reporting no changes in her symptoms. On or about December 28, 2018, Patient A underwent a second right L4 and bilateral L5-S1 transforaminal epidural steroid injections (with sacroiliac ligament injections) under intravenous conscious sedation.

33. On or about January 25, 2019, Patient A returned to Respondent, reporting 70% relief with the injection. The plan was to continue the Dilaudid medication, as needed.

34. On or about February 21, 2019, Patient A returned to Respondent. The history section of the medical records noted frequent vomiting from taking hormone injections for infertility. The plan was to continue Dilaudid as needed for pain control and follow up in one (1) month.

35. On or about March 21, 2019, Patient A returned to Respondent. Patient A was recently diagnosed with diabetes insipidus[25] and was undergoing fertility treatment. Patient A's low back and leg pain were unchanged. The plan was to continue Dilaudid, as needed, for pain control.

36. On or about April 18, 2019, Patient A returned to Respondent, reporting increased stress after euthanizing her cat. Patient A also reported increased low back and leg pain. The plan was to continue Dilaudid, Soma,[26] and Lyrica.

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[25] Diabetes insipidus is a disorder of salt and water metabolism marked by intense thirst and heavy urination.

[26] Soma® (carisoprodol) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short-term treatment of acute and painful musculoskeletal conditions. Soma® is commonly used by those who abuse opioids to potentiate the euphoric effect of opioids, to create a better "high." According to the DEA, Office of Diversion Control, "[c]arisoprodol abuse has escalated in the last decade in the United States. According to Diversion Drug Trends, published by the DEA on the trends in diversion of controlled and noncontrolled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma® ranged from

37. On or about May 16, 2019, Patient A returned to Respondent, reporting mild increased low back and leg pain. The medical records noted, among other things, that Patient A wanted to repeat lumber epidural steroid injection[27] in June [2019] and possibly stem cell injections in August [2019]. Patient A reported 2~3 out of a 10 point pain scale for her leg and 7 out of 10 for her low back pain. The plan was to continue Dilaudid, Soma, and Lyrica and proceed with the requested injections.

38. On or about June 13, 2019, Patient A returned to Respondent, reporting low back pain radiating to both legs with new onset radiating right anterior thigh and right lower leg pain along the L4 dermatome. The plan was to proceed with right L4 and L5-S1 epidural steroid injections. Patient A underwent a Urine Drug Screen on this day.

39. On or about June 21, 2019, Patient A returned to Respondent. There were no changes in Patient A's symptoms and no changes in the medical plan. Patient A underwent right L4 and L5-S1 epidural steroid injections (with sacroiliac ligament injections).

40. On or about July 1, 2019, Patient A returned to Respondent, reporting 60% pain relief and overtaking Dilaudid and Soma, secondary to abdominal pain and vomiting. Patient A also reported pelvic pain, was diagnosed with sever uterine prolapse,[28] and planned to have hysterectomy[29] in two (2) to four (4) weeks. Respondent counseled Patient A and the medication was refilled early.

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$1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

[27] Lumber epidural steroid injection (LESI) is an injection of corticosteroids into the space just outside the covering (dura) of the spinal cord in your lower back.

[28] Uterine prolapse occurs when the muscles and tissue in your pelvis weaken.

[29] Hysterectomy is the surgical removal of the uterus.

41. On or about July 31, 2019, Patient A returned to Respondent, reporting an episode of trouble with speaking four (4) weeks prior. Patient A [purportedly] went to a hospital where a stroke was ruled out with a brain MRI. Since the episode of dysarthria,[30] Patient A reported a drop right wrist.[31] The plan was to continue medication and request a repeat right L4 and L5-S1 epidural steroid injections. Respondent refilled Dilaudid and Soma. On or about August 9, 2019, Patient A underwent right L4-5 and L5-S1 epidural steroid injection.

42. On or about August 29, 2019, Patient A returned to Respondent, reporting that she recently fell and fractured her left foot (minimally displaced left 5th metatarsal fracture). The facture was managed without an operation by an orthopedic surgeon with a boot. Patient A reported 70% pain relief with the August 9, 2019 epidural steroid injection. The plan was to reduce Dilaudid to 2 mg QID and hold the repeat epidural steroid injection, given the recent foot fracture.

43. On or about September 4, 2019, Patient A returned to Respondent, reporting no changes in symptoms. Patient A's hysterectomy was delayed until November 2019.

44. On or about October 3, 2019, Patient A returned to Respondent. Patient A was evaluated for a repeat epidural steroid injection and was found to be a good candidate.

45. On or about October 15, 2019, Patient A underwent a bilateral L5-S1 transforaminal epidural steroid injections.

46. On or about October 21, 2019, Respondent had a discussion with Patient A's psychiatrist, Dr. S.G., regarding Patient A's slurred speech and missed appointment. Respondent was [purportedly] concerned about Patient A's medication overuse and planned to discontinue Ambien and Soma. Dr. S.G. planned to discontinue amitriptyline,[32] reduce Cymbalta,[33] and keep

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[30] Dysarthria refers to the weakness in the muscles used for speech, which often causes slowed or slurred speech.

[31] A wrist drop refers to the inability to actively extend the hand at the wrist.

[32] Amitriptyline is an antidepressant and nerve pain medication.

[33] Cymbalta (Duloxetine) is an antidepressant and nerve pain medication.

clonazepam and Wellbutrin.[34]

47. On or about October 31, 2019, Patient A returned to Respondent, reporting 40% relief with injections received on or about October 15, 2019. Patient A's left foot was healing well with minimal pain. The plan was to decrease Dilaudid 4 mg tablets from QID to TID,[35] reduce Soma to 2 pills a day [rest of the current month] and 1 pill a day, thereafter, and gradually discontinuing Ambien 10 mg over the next two (2) months.

48. On or about November 22, 2019, Patient A returned to Respondent. Patient A was evaluated for increased right side low back pain after a fall in the shower approximately three (3) weeks prior. Patient A [purportedly] weaned off of Soma. Dilaudid was decreased to 4 mg BID, Ambien was gradually reduced, and a lumbar flex/ex films[36] were ordered to assess her fall.

49. On or about December 20, 2019, Patient A returned to Respondent, who evaluated her for low back pain radiating into the legs mostly along the L5 dermatome. Patient A's pain was worse with prolonged sitting. Patient A had stopped taking Elavil,[37] Soma, and Ambien. Patient A had been continuing HEP (home exercise program) and physical therapy. Respondent noted drug seeking behavior by Patient A and had a peer-to-peer consultation with Patient A's psychiatrist, Dr. G., with a plan to discontinue Soma, Ambien, and reduce Dilaudid. Patient A was prescribed Dilaudid 2 mg TID and Lyrica 50 mg BID. The medical records noted, among other things, that Patient A underwent x-ray examination(s), but the results were not noted.

50. On or about February 5, 2020, Patient A returned to Respondent, reporting continued low back pain following a L5-S1 fusion. Respondent noted that Patient A had a past psychiatric history of depression, which was managed by her psychiatrist. The history section of the medical records noted that Patient A continued to see her psychiatrist and that Patient A was off of Elavil and Ambien. The physical examination section of the medical records noted bilateral sacroiliac

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[34] Wellbutrin (Bupropion) is an antidepressant and smoking cessation aid.

[35] Ter in die (TID) means three times a day.

[36] A lumber spine flexion and extension views images of the lumbar spine, which consists of five vertebrae.

[37] Elavil (Amitriptyline) is an antidepressant and nerve pain medication.

joint tenderness, low back pain with extension, decreased ROM (range of motion), decreased sensation in the right S1 dermatome, and negative straight leg raise.

51. During the time period that Respondent prescribed controlled substances to Patient A, in or around June 3, 2016 through February 5, 2020, Respondent failed to adequately utilize a pain management agreement with Patient A.

52. Respondent committed gross negligence in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Respondent failed to properly monitor Patient A while prescribing controlled substances to her by failing to properly and/or adequately utilize CURES[38] and/or urine drug screens.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

53. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 71070 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patient A, Patient B, and Patient C, as more particularly alleged herein.

Patient A

54. Respondent committed repeated negligent acts in his care and treatment of Patient A, including, but not limited to:

55. Paragraphs 9 through 52, above, are hereby incorporated by reference and realleged as if fully set forth herein.

(a) Respondent failed to properly monitor Patient A while prescribing controlled substances to her by failing to properly and/or adequately utilize CURES and/or urine drug screens;

(b) Respondent concurrently prescribed opiate(s) and benzodiazepines to Patient A without adequate medical justification, and

[38] CURES is the Controlled Substances Utilization Review and Evaluation System (CURES), a database of schedule II, III, and IV controlled substance prescriptions dispensed in California, serving the public health, regulatory oversight agencies, and law-enforcement.

(c) Respondent failed to obtain a pain management agreement prior to initiating opioid therapy on Patient A and/or failed to adequately utilize a pain management agreement while prescribing controlled substances to Patient A.

Patient B

56. On or about April 4, 2016, Patient B, a fifty-six (56) year-old woman who suffered from chronic neck pain and chronic low back pain, both secondary to degenerative disc disease and radiculitis,[39] presented to Respondent. Patient B had contracted HIV[40] from a transfusion. Respondent prescribed Xarelto[41] and Robaxin[42] to Patient B.

57. On or about May 2, 2016, Patient B returned to Respondent. Respondent prescribed Oxycodone for Patient B's breakthrough pain. Before initiating opioid therapy with Patient B, Respondent failed to obtain a pain management agreement with Patient B.

58. On or about May 26, 2016, Patient B returned to Respondent and her medications were continued with no changes, including, but not limited to, OxyContin 40 mg and Oxycodone 10 mg.

59. On or about June 24, 2016, Patient B returned to Respondent, reporting unchanged moderate neck pain radiating to the right arm and low back pain radiating to the leg. Patient B also reported right shoulder and hip pain. MRI of Patient B was significant for labral tears.[43]

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[39] Radiculitis refers to pain that radiates along the nerve caused by inflammation at the root of its connection to the spinal column.

[40] Human Immunodeficiency Virus (HIV) is a virus that attacks the body's immune system.

[41] Xarelto (Rivaroxaban) is a blood thinner, which can treat and prevent blood clots.

[42] Robaxin (Methocarbamol) is a muscle relaxant, which can be used to treat muscle spasms and pain.

[43] A labral tear is an injury to the tissue that holds the ball and socket parts of the hip together.

60. On or about July 22, 2016, Patient B returned to Respondent. Patient B was following up with her neurologist about a new nerve conduction study to evaluate new onset right arm radiculopathy.[44]

61. On or about August 22, 2016, Patient B returned to Respondent. The plan was to review new cervical MRI and EMG, once available. The subjective portion of the medical record notes that Patient B was prescribed Norco, but Oxycodone was prescribed in the plan section of the medical plan.

62. On or about September 19, 2016, Patient B returned to Respondent and there were no changes, including, but not limited to, Respondent prescribing OxyCodone 10mg and Oxycontin 40 mg to Patient B.

63. On or about October 17, 2016, Patient B returned to Respondent. Patient B had undergone a right ulnar nerve block[45] and her medications were continued, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

64. On or about November 14, 2016, Patient B returned to Respondent, reporting almost complete relief of her elbow pain radiating to the ulnar aspect of her right hand and fingertips, after an ulnar nerve block. Patient B's medications were refilled with no changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

65. On or about December 12, 2016, Patient B returned to Respondent, reporting worsening neck pain and headache over the past two (2) weeks. Patient B reported radicular pain down to the right forearm and hand. The plan was to proceed with CESI[46] and refill Patient B's medications without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

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[44] Radiculopathy is a disease of the root of a nerve, such as from pinched nerve or tumor.

[45] Ulnar nerve block anesthetizes both the volar and dorsal surfaces of the hypothenar half of the hand. Hypothenar refers to the group of muscles that control the movement of the little finger.

[46] A cervical epidural steroid injection (CESI) is an injection of corticosteroids (similar to cortisone) into the space just outside the covering (the dura) of the spinal cord in your lower back.

66. On or about December 21, 2016, Patient B's urine drug screen results showed, among other things, a positive for Oxycodone and Barbiturates/Butalbital.

67. On or about January 9, 2017, Patient B returned to Respondent, after undergoing a C4-5 CESI, reporting 80% relief in her neck and arm pain. Her medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg. Respondent failed to discuss and/or failed to document having discussed Patient B's urine drug screen results from her December 21, 2016 urine drug screen.

68. On or about February 6, 2017, Patient B returned to Respondent, reporting that her sinus surgery had improved her headache pain. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

69. On or about March 7, 2017, Patient B returned to Respondent, reporting unchanged chronic neck and low back pain. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

70. On or about April 3, 2017, Patient B underwent a urine drug screen. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

71. On or about April 5, 2017, the results from Patient B's April 3, 2017 urine drug screen showed positive for Oxycodone and negative for Soma.

72. On or about May 1, 2017, Patient B returned to Respondent, requesting a repeat ulnar nerve block at the elbow. Patient B had previously undergone a nerve conduction study at University of California at Irvine showing right ulnar neuropathy at the elbow. Respondent noted that nortriptyline and gabapentin were being given by another physician. Respondent failed to discuss and/or failed to document having discussed the April 3, 2017 urine drug screen results with Patient B. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

73. On or about June 26, 2017, Patient B returned to Respondent, reporting worsening neck and back pain secondary to positioning requirements following retina detachment surgery. Soma was added as a muscle relaxant. Oxycodone and Oxycontin were continued without change.

74. On or about August 21, 2017, Patient B returned to Respondent, reporting no changes to her neck and back pain.

75. On or about September 18, 2017, Patient B returned to Respondent, reporting no changes to her neck and back pain.

76. On or about October 16, 2017, Patient B returned to Respondent, reporting no changes to her neck and back pain. Patient B reported that she requires additional eye surgery to address retinal bleeding. Patient B's medications were refilled, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg. Patient B underwent a urine drug screen, which showed positive for Oxycodone and negative for all other substances.

77. On or about November 13, 2017, Patient B returned to Respondent, requesting a CESI to address increasing neck pain and headache. The plan was to proceed with CESI. Patient B's medications were filled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

78. On or about December 11, 2017, Patient B returned to Respondent. Patient B had sinus surgery and planned to undergo cataract surgery. Patient B requested CESI to address increasing neck pain and headache. The plan was to proceed with CESI. The medical records state, among other things, "the patient [B] will call to schedule when she is ready." Patient B's medications were filled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

79. On or about January 11, 2018, Patient B returned to Respondent. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

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80. On or about February 9, 2018, Patient B returned to Respondent, reporting that she had been taking ibuprofen 400 mg TID after "she claimed she needed more pain relief since I changed Norco to Oxycodone." There was a discussion about a repeat of CESI, but Patient B proceeded with eye surgery first.

81. On or about March 12, 2018, Patient B returned to Respondent, reporting radicular neck and back pain. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg. Patient B was instructed to stop ibuprofen to avoid kidney injury.

82. On or about April 9, 2018, Patient B returned to Respondent, requesting a repeat CESI to address radicular neck pain. Patient B's medications were refilled, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg. The plan was for Patient B to call for cervical or lumber epidural injections when she is ready.

83. On or about May 7, 2018, Patient B returned to Respondent, requesting a repeat Epidural Steroid Injection (ESI) to address radicular low back pain. The plan was to have Patient B discontinue Xarelto, bridge with Lovenox,[47] and proceed with the ESI. Patient B's medications were refilled without any additional changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

84. On or about June 4, 2018, Patient B followed up with Respondent after a right L4-5 ESI on May 18, 2018, reporting complete relief of the right leg pain and 75% relief of the low back pain. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

85. On or about July 2, 2018, Patient B returned to Respondent, reporting low back pain radiating to the left leg. The plan was to assess the complaint with an updated lumbar MRI as her symptoms were previously right-sided. Patient B's medications were continued without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

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[47] Lovenox (Enoxaparin) is a medication used to prevent and treat harmful blood clots.

86. On or about August 2, 2018, Patient B presented to Respondent for her medication refill to manage her chronic low back and neck pain. Her medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

87. On or about August 31, 2018, Patient B presented to Respondent for her medication refill to manage her chronic low back and neck pain. Her medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

88. On or about October 1, 2018, Patient B presented to Respondent for her medication refill to manage her chronic low back and neck pain. Her medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

89. On or about October 3, 2018, Patient B underwent a urine drug screen, which showed positive for Oxycodone and negative for all other substances tested.

90. On or about October 29, 2018, Patient B returned to Respondent for an evaluation of her low back pain. The plan was to proceed with an ESI. Patient B's MRI from October 22 2018 was significant for moderate lateral recess stenosis and foraminal stenosis at L4-5. Patient B's medications were refilled, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg. A thoracic MRI was ordered to assess mid back pain.

91. On or about November 26, 2018, Patient B returned to Respondent, following up after a left L4 and left L5 transforaminal ESI on November 16, 2018. Patient B reported 90% pain relief in the left leg. Patient B reported continued pain in the right leg. Patient B previously underwent a right L4-5 ESI on May 18, 2018, with complete relief of the right leg pain and 75% relief of the low back pain for two (2) months. The plan was to repeat right L4 and left L5 transforaminal ESI and refill medication, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg. The subjective section of the medical records noted that the "patient [B] also complains of moderate severe

exacerbation of left mid back pain below the left scapula." The report from the newly obtained thoracic MRI was added to the medical records, but no interpretation was made in the medical records.

92. On or about December 21, 2018, Patient B returned to Respondent, after a hospitalization for pneumonia. Patient B reported radicular neck and radicular low back pain. The plan was to obtain a new cervical MRI, consider CESI, and consider LESI. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

93. On or about January 22, 2019, Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg. There was no change from the treatment plan from December 2018.

94. On or about February 18, 2019, Patient B returned to Respondent after having undergone a sinuplasty.[48] Patient B reported upper back pain between the scapula. The medical records noted, among other things, "She [Patient B] has kidney insufficiency from HIV medications and hypertension" with kidney function at 38%. Patient B's medications were refilled, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg. At this time, a new cervical MRI was pending.

95. On or about March 18, 2019, Patient B returned to Respondent, reporting back pain with radiation to the left shoulder and arm. Patient B underwent a right L4-5 ESI on May 18, 2018, with complete pain relief of the right leg pain and 75% pain relief of the low back for two (2) months. Patient B reported that the radicular low back pain had returned. Previously Patient B underwent a bilateral L4-5 tf-ESI in 2015 with three (3) years of pain relief. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

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[48] Baloon sinuplasty is a minimally invasive technique that is used to treat chronic or recurrent sinusitis or sinus infections when medical therapy has not provided adequate relief.

96. On or about April 15, 2019, Patient B returned to Respondent, reporting neck pain radiating to the left arm. Patient B underwent a left C6-7 ESI on April 12, 2019, with 90% relief of her headache and 80% relief of her neck and shoulder pain. The plan was to proceed with a right sided C4-5 ESI to address the symptoms. The cervical MRI from February 20, 2019 listed in the chart was significant for right C5 nerve root impingement[49] and right anterior cord impingement.

97. On or about May 3, 2019, Patient B underwent a left C6-7 cervical epidural steroid injection under fluoroscopic guidance.

98. On or about May 13, 2019, Patient B returned to Respondent. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg. The plan was to proceed with CESI #2.

99. On or about June 10, 2019, Patient B returned to Respondent regarding her right upper neck pain and headache. Patient B underwent a right C4-5 ESI on May 31, 2019, and reported good relief for headache, but not shoulder pain. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

100. On or about July 8, 2019, Patient B returned to Respondent. In the medical records, it was noted that Patient B saw her orthopedic surgeon regarding left knee pain and the orthopedic surgeon recommended left knee CST injection. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

101. On or about September 30, 2019, Patient B returned to Respondent. The medical records for this visit state, among other things, that Patient B's left knee pain was doing well and that she did not need a CST injection. Respondent refilled Patient B's medications without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

[49] Impingement refers to a painful condition caused by rubbing or pressure on a tendon, nerve, etc., by adjacent structures.

102. On or about November 25, 2019, Patient B returned to Respondent. The medical records for this visit state, among other things, that Patient B's kidney biopsy showed no disease. It is also noted that Patient B's neurologist thought Patient B's kidney disease was secondary to poor perfusion from Congestive Heart Failur.[50] Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

103. On or about December 23, 2019, Patient B returned to Respondent. Patient B was evaluated for her neck and back pain. Patient B previously underwent right C4-5 ESI, with good relief for headache, but not shoulder pain. Patient B also had a left C6-7 CESI on April 12, 2019 with 90% relief of her headache and 80% relief of her neck and left shoulder pain. Respondent discussed with Patient B about pursuing a lumber ESI after her work-up for CHF was completed. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

104. On or about January 21, 2020, Patient B returned to Respondent, reporting neck and low back pain. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg. Patient B reported her pain was under control with medication and that she planned to undergo an echocardiogram[51] to evaluate her for CHF.

105. On or about February 27, 2020, Patient B returned to Respondent, reporting partial pain relief and no effects with medication. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

106. On or about April 15, 2020, Patient B was seen virtually by Respondent. Patient B underwent echocardiogram with no evidence of CHF. Patient B's neck and low back pain were unchanged. Patient B's medications were refilled without changes,

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[50] Congestive heart failure (CHF) is a condition in which the heart has trouble pumping blood through the body.

[51] An echocardiogram checks how your heart's chambers and valves are pumping blood through your heart.

including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

107. On or about May 12, 2020, Patient B was seen virtually by Respondent. Patient B was on Lasix[52] secondary to stage 3 renal insufficiency.[53] Respondent reviewed with Patient B safety precautions against COVID-19, as Patient B was at high risk for complications. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

108. On or about June 16, 2020, Patient B returned to Respondent, reporting unchanged pain. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

109. On or about August 11, 2020, Patient B returned to Respondent, reporting low back pain with radicular symptoms down the bilateral legs. Respondent prescribed Xarelto for hypercoagulation[54] with a plan to bridge with lovenox, prior to her ESI procedure.

110. On or about September 8, 2020, Patient B returned to Respondent, reporting left sided radicular low back pain. Patient B underwent a right L4-5 ESI on August 27, 2020 and reported resolution of her radicular pain. Respondent discussed with Patient B about left sided ESI. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

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[52] Lasix (Furosemide) is a diuretic, which can be used to treat fluid retention (edema) and swelling caused by congestive heart failure, liver disease, kidney disease, and other medical conditions. A diuretic is any substance that promotes diuresis, the increased production of urine.

[53] Renal insufficiency refers to kidney failure, a condition in which the kidneys lose the ability to remove waste and balance fluids.

[54] Hypercoagulation is a condition that causes your blood to clot more easily than normal.

111. On or about October 5, 2020, Patient B returned to Respondent, reporting low back pain radiating down the left lateral calf along the L5 dermatome. Patient B previously underwent a successful LESI in August 2020 that led to a resolution of her radicular pain on the right. The medical records noted, among other things, that Patient B's viral count is undetectable due to a new antiviral medication. According to the medical records, Respondent [purportedly] reviewed CURES report,[55] ordered a urine drug screen, and considered a repeat LESI and imaging. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

112. On or about November 2, 2020, Patient B returned to Respondent complaining of radicular low back pain down the left leg. Patient B had groin pain that was worked-up by her Primary Care Physician (PCP). The medical records state, among other things, "urine drug test reviewed showed that she is compliant."

113. On or about November 30, 2020, Patient B returned to Respondent, reporting low back pain with radicular symptoms down the left leg and bilateral lower extremity numbness. The physical examination was significant for lumbar paraspinal tenderness and slight weakness at the left EHL at 4+/5. Patient B was diagnosed with lumber stenosis, lumbar radiculopathy, and lumber disc protrusion. Patient B was prescribed Oxycontin 40 mg TID and Oxycodone TID (MEDD = 225 mg). There was no indication in the medical record that Respondent reviewed CURES report(s) or checked a urine drug screen. A lumber MRI was pending.

114. On or about December 29, 2020, Patient B returned to Respondent, requesting a new MRI to address low back pain radiating to the left lateral leg and calf. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

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[55] CURES is the Controlled Substances Utilization Review and Evaluation System (CURES), a database of schedule II, III, and IV controlled substance prescriptions dispensed in California, serving the public health, regulatory oversight agencies, and law-enforcement.

115. On or about January 25, 2021, Patient B returned to Respondent, reporting low back pain with radiation to the left lower extremity. A new MRI from January 2021 was reviewed, which revealed L4-5 anterolisthesis[56] and L5-S1 moderate to severe foraminal stenosis. Physical examination was significant for negative SLR [straight leg raise] and slightly decreased motor function at the left EHL[57] at 4+/5. The plan was to proceed with a left L4-5 and left L5 transforaminal epidural steroid injection. Patient B's medications were refilled without changes, including, but not limited to, OxyCodone 10 mg and OxyContin 40 mg.

116. During the time period that Respondent prescribed controlled substances to Patient B, in or around April, 2016 through January 25, 2021, Respondent failed to adequately utilize a pain management agreement with Patient B.

117. During the time period that Respondent prescribed controlled substances to Patient B, in or around April, 2016 through January 25, 2021, Respondent failed to adequately check CURES reports and/or adequately utilize urine drug screens and/or adequately discuss the results of urine drug screens with Patient B.

118. Before initiating opioid therapy with Patient B, Respondent failed to obtain a pain management agreement with Patient B.

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[56] In anterolisthesis, the upper vertebral body is positioned abnormally compared to the vertebral body below it.

[57] The exterior halluces longus (EHL) is a thin muscle, situated between the Tibialis anterior and the Extensor Digitorum Longus in the anterior compartment of the lower leg.

119. Respondent committed repeated negligent acts in his care and treatment of Patient B, including, but not limited to:

(a) Paragraphs 56 through 118, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to obtain a pain management agreement prior to initiating opioid therapy on Patient B and/or failed to adequately utilize a pain management agreement while prescribing controlled substances to Patient B;

(c) Respondent inappropriately prescribed controlled substance(s) with Morphine Equivalent Dosage (MED) in excess of 80 mg per day and/or Morphine Milligram Equivalents (MME) in excess of 90 mg per day; and

(d) Respondent failed to adequately check CURES reports and/or adequately utilize urine drug screens and/or adequately discuss the results of urine drug screens with Patient B.

Patient C

120. Patient C first began treatment with Respondent in 1994.[58] Patient C suffered from chronic pain following lumbar fusion after she fell off a cliff and fractured her spine. Patient C suffered from Complex Regional Pain Syndrome (CRPS)[59] following her right foot fracture.

121. On or about June 9, 2016, Patient C returned to Respondent, reporting stable and unchanged low back pain. Respondent prescribed MS Contin 60 mg, Neurontin 300 mg oral capsule, Norco 10 mg 325 mg oral tablet, and Soma 350 mg oral tablet to Patient C. The lumber MRI from 2007 showed posterior pedicle screw fusion at L4-5. There was disc degeneration at L3-4 and L5-S1. There was no spinal stenosis, spondylolisthesis, or multi-level lumbar facet arthropathy.

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[58] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[59] Complex Regional Pain Syndrome (CRPS) refers to chronic arm or leg pain developing after injury, surgery, stroke, or heart attack.

122. On or about August 5, 2016, Patient C returned to Respondent, reporting increased low back pain for walking up and down the stairs at a friend's house where she was looking after a pet. Patient C's medications were refilled without changes, including, but not limited to, Norco 10 mg-325 mg, MS Contin 60 mg, Soma 450 mg, and Neurontin 300 mg.

123. On or about October 28, 2016, Patient C returned to Respondent, after fracturing 3 right foot metatarsals in August 2016. Patient C was wearing a boot and complained of ongoing burning and hypersensitivity in the foot. Patient C planned to look for a physician within [insurance] network to undergo a lumbar sympathetic block[60] and she was referred for acupuncture.

124. On or about January 19, 2017, Patient C returned to Respondent, reporting improved burning and hypersensitivity in her right foot with acupuncture. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 60 mg QID, Norco 10 mg-325 mg QID, Gabapentin 300 mg TID, and Soma.

125. On or about March 17, 2017, Patient C returned to Respondent. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 60 mg, Norco 10 mg-325 mg, Neurontin 300 mg, Soma 350 mg.

126. On or about May 12, 2017, Patient C returned to Respondent, reporting concern about undergoing surgery as it would exacerbate her CRPS. The plan was to continue her medication and to follow-up with acupuncture for CRPS.

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[60] A lumber sympathetic block is an injection of medication that helps relieve lower back or leg pain.

127. On or about August 4, 2017, Patient C returned to Respondent, reporting that she was using a bone stimulator for her 3rd metatarsal fracture, which was not healing. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 60 mg, Soma 350 mg, Neurontin 300 mg, Norco 10 mg.

128. On or about September 28, 2017, Patient C underwent a left saphenous nerve block[61] under ultrasound guidance and a left sciatic nerve block[62] under ultrasound guidance.

129. On or about December 19, 2017 Patient C returned to Respondent, after right foot surgery for non-healing foot fracture, suffered on September 22, 2017. The medical records indicate that Patient C's CRPS pain resolved after six (6) sessions of acupuncture. The plan was to continue her medications without change, including, but not limited to, MS Contin 60 mg, Soma 350 mg, Norco 10 mg – 325 mg, and Neurontin 300 mg.

130. On or about February 12, 2018, Patient C returned to Respondent, complaining of 8/10 pain with MS Contin since surgery. The plan was to continue medications without change.

131. On or about April 6, 2018, Patient C returned to Respondent. The medical records indicate, among other things, that Patient C would be undergoing a lumbar sympathetic block from her HMO physician. The plan was to continue her medication.

132. On or about April 6, 2018, Patient C underwent a urine drug screen, which was positive for gabapentin, morphine, and hydromorphone.[63]

133. On or about May 31, 2018, Patient C returned to Respondent, reporting mild right foot pain. Patient C obtained a CT, which showed that her right foot fracture had not healed after fracturing the 3rd metatarsal bone after a fall in August 2016. The MS

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[61] The saphenous nerve block is indicated whenever the need exists for anesthesia of the lower leg or foot along its neural distribution. It is commonly used in conjunction with a popliteal sciatic nerve block to provide complete anesthesia of the lower leg for various surgical and non-surgical procedures.

[62] A sciatic nerve block is a nerve block that uses local anesthetic to achieve analgesia in the leg.

[63] Hydromorphone is a narcotic, which can be used to treat moderate to severe pain.

Contin was reduced from 60 mg QID to 60 mg TID.

134. On or about July 25, 2018, Patient C returned to Respondent, reporting mild right foot pain. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 60 mg, Norco 10 mg – 325 mg, Soma 350 mg, and Gabapentin 300 mg. Respondent recommended acupuncture.

135. On or about September 20, 2018, Patient C returned to Respondent, reporting mild right foot pain.

136. On or about November 15, 2018, Patient C returned to Respondent, reporting unchanged low back and leg pain. Patient C's medications were continued without changes, including, but not limited to, MS Contin 60 mg, Norco 10 mg – 325 mg, Soma 350 mg, and gabapentin 300 mg.

137. On or about January 10, 2019, Patient C returned to Respondent, reporting unchanged low back and leg pain. Patient C's medications were continued without changes, including, but not limited to, MS Contin 60 mg, Norco 10 mg – 325 mg, Soma 350 mg, and gabapentin 300 mg.

138. On or about February 7, 2019, Patient C returned to Respondent, reporting unchanged low back and leg pain. Patient C's medications were continued without changes, including, but not limited to, MS Contin 60 mg, Norco 10 mg – 325 mg, Soma 350 mg, and gabapentin 300 mg. MEDD at this time was 240 mg per day.

139. On or about April 4, 2019, Patient C fell at home and reported increased low back and shoulder pain. Patient C's primary care physician ordered x-ray examination(s). Patient C's medications were continued without changes, including, but not limited to, MS Contin 60 mg, Norco 10 mg – 325 mg, Soma 350 mg, and gabapentin 300 mg.

140. On or about June 3, 2019, Patient C returned to Respondent, reporting unchanged low back and leg pain. Patient C's medications were continued without changes, including, but not limited to, MS Contin 60 mg, Norco 10 mg – 325 mg, Soma 350 mg, and gabapentin 300 mg. Patient C's urine drug screen from this date was positive for gabapentin, morphine, and hydromorphone.

141. On or about July 31, 2019, Patient C returned to Respondent, reporting unchanged low back and leg pain. Patient C's medications were continued without changes.

142. On or about October 9, 2019, Patient C returned to Respondent, reporting unchanged low back and leg pain. Trigger point injections were performed on Patient C. Patient C's medications were continued without changes.

143. On or about December 18, 2019, Patient C returned to Respondent, reporting unchanged low back and leg pain. Patient C had not obtained her x-ray examinations or lumbar MRI at that time. Patient C reported pain in her right buttock, radiating to the posterior lateral right leg that was worse with sitting. Patient C reports that she "does not want to go to pain management physician in her HMO [insurance network] since they want her to go to counseling." Patient C had a past medical history of L4-5 fusion. Respondent prescribed MS Contin 60 mg TID, Norco 10 TID, Neurontin 300 mg BID, and Soma 350 mg BID (MEDD = 210 mg). Respondent's physical examination of Patient C was significant for marked tenderness with extension, tenderness with palpation of the lumbar paraspinal muscles, right foot slightly darker discoloration, warm to touch, decreased ROM (range of motion), and hypersensitivity to light touch. Patient C was diagnosed with lumbar facet arthropathy, lumber disc protrusion, lumbar radiculopathy, and CRPS. The plan was to continue her MS Contin and Norco medications, wean off of Soma (although same quantity was prescribed as the previous month), continue Neurontin, await new lumbar imaging, and consider epidural steroid injection (ESI).

144. On or about February 13, 2020, Patient C returned to Respondent, reporting exacerbation of her chronic low back pain. Patient C's primary care physician ordered a CT scan of Patient C's lumbar spine. Patient C was unable to obtain an MRI as she had an implanted bone stimulator. Respondent reviewed the CT scan results, which was significant for intact hardware at L4-5 and Degenerative Disk Disease[64] at L3-4 and L5-

[64] Degenerative Disk Disease is when normal changes that take place in the disks of your spine cause pain.

S1. According to the medical records, Respondent discussed with Patient C that Patient C should follow up with a spine surgeon to remove bone stimulator and to follow up with a provider in her HMO insurance network for Epidural Steroid Injection.

145. On or about April 9, 2020, Patient C was evaluated virtually by Respondent. Patient C reported tolerating weaning off of MS Contin and Norco. MS Contin was reduced from 60 mg BID to 30 mg TID. Norco was decreased from BID to 1 pill daily. MEDD was now 100 mg.

146. On or about June 9, 2020, Patient C returned to Respondent and received trigger point injections. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 30 mg three (3) times a day and Norco 10 mg – 325 mg once a day.

147. On or about July 9, 2020, Patient C returned to Respondent, reporting that trigger point injections were successful with pain management. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 30 mg q.8h. and Norco 10 mg – 325 mg daily p.r.n.

148. On or about August 6, 2020, Patient C returned to Respondent, reporting no change in her low back pain. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 30 mg #90 and Norco 10 mg – 325 mg # 30.

149. On or about September 3, 2020, Patient C returned to Respondent, reporting no change in her low back pain. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 30 mg # 90 and Norco 10 mg – 325 mg once a day.

150. On or about October 1, 2020, Patient C returned to Respondent, reporting that she was unable to find a spine surgeon who was willing to remove her bone stimulator. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 30 mg # 90 and Norco 10 mg – 325 mg once a day. Patient C underwent a urine drug screening.

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151. On or about October 30, 2020, Patient C returned to Respondent, reporting no change in her low back pain. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 30 mg #90 and Norco 10 mg – 325 mg, once a day, #30.

152. On or about November 30, 2020, Patient C returned to Respondent, reporting no change in her low back pain. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 30 mg, three (3) times per day, Norco 10 mg – 325 mg, once a day, and gabapentin 300 mg, twice a day #60.

153. On or about December 30, 2020, Patient C returned to Respondent, reporting unchanged pain. Patient C did not have melanoma surgery as the surgery center was closed due to Covid-19 pandemic. Patient C's medications were refilled without changes, including, but not limited to, MS Contin 30 mg q.8.h. #90 and Norco 10 mg – 325 mg, daily, p.r.n.

154. During the time period that Respondent prescribed controlled substances to Patient C, in or around June 9, 2016 through December 30, 2020, Respondent failed to adequately utilize a pain management agreement with Patient C.

155. During the time period that Respondent prescribed controlled substances to Patient C, in or around June 9, 2016 through December 30, 2020, Respondent failed to adequately check CURES reports and/or adequately utilize urine drug screens and/or adequately discuss the results of urine drug screens with Patient C.

156. Before initiating opioid therapy with Patient C, Respondent failed to obtain a pain management agreement with Patient C.

157. During the time period that Respondent prescribed controlled substances to Patient C, between in or around June 9, 2016 to May 31, 2018, Respondent prescribed to Patient C, MS Contin 60 mg q.i.d., Norco 10 mg – 325 mg q.i.d., for MED of 260 mg daily. Between May 31, 2018 to April 8, 2020, Respondent prescribed to Patient C, MS Contin 60 mg t.i.d., and between April 9, 2020 through December 30, 2020, Respondent prescribed to Patient C, MS Contin 30 mg t.i.d., and Norco 1 pill per day, for a MED of 100 mg.

158. Respondent committed repeated negligent acts in his care and treatment of Patient C, including, but not limited to:

(a) Paragraphs 120 through 157, above, are hereby incorporated by reference and realleged as if fully set forth herein.

(b) Respondent failed to obtain a pain management agreement prior to initiating opioid therapy on Patient C and/or failed to adequately utilize a pain management agreement while prescribing controlled substances to Patient C;

(c) Respondent inappropriately prescribed controlled substance(s) with Morphine Equivalent Dosage (MED) in excess of 80 mg per day and/or Morphine Milligram Equivalents (MME) in excess of 90 mg per day; and

(d) Respondent failed to adequately check CURES reports and/or adequately utilize urine drug screens and/or adequately discuss the results of urine drug screens with Patient C.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

159. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 71070 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in his care and treatment of Patient A, Patient B, and Patient C, as more particularly alleged in paragraphs 9 through 158, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

160. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 71070 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 9 through 159, above, which are hereby incorporated by reference 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 71070, issued to Daniel Quoc Le, M.D.;

2. Revoking, suspending or denying approval of Respondent Daniel Quoc Le, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Daniel Quoc Le, 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; and

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

DATED: JUL 20 2022

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

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